
SECTION 11

COMPLETING THE PLAN OF CARE FORM

Learning Objectives

1. Correctly complete a CAP/C Plan of Care form.

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LOCATION OF THE PLAN OF CARE FORM

The plan of care form can be found on the web at <http://www.ncdhhs.gov/dma/formsprov.html#capc>.

On the web, the plan of care form is divided into two sections. You will need both sections. They are titled 'CAP/C Cost Summary Form' and 'CAP/C Plan of Care Form'.

In addition, the last two pages of the Plan of Care form, which require signatures, are available in Spanish, titled 'CAP/C Plan of Care, Sections G and H – Spanish'.

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SUBMITTING THE PLAN OF CARE FORM

- May be filled out on the computer, but cannot be submitted electronically.

Please print out the completed form, obtain the appropriate signatures, and mail it.

- Make sure the name and MID number are on every page, even blank pages.
- There is a sample completed form in Chapter 10 of the CAP/C Manual.

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PLAN OF CARE FORM

CAP/C Plan of Care Client: _____ MID: _____
Community Alternatives Program for Children (CAP/C) Plan of Care
North Carolina Division of Medical Assistance

CAP/C CASE MANAGEMENT AGENCY _____
CASE MANAGER/TITLE _____ PHONE NUMBER _____ EMAIL _____

INITIAL, Medicaid application date _____ CNR, due date _____
 REVISION, effective date _____ LEVEL OF CARE _____

The Plan of Care is to document formal and informal services to be provided to the client. It is also used to outline the goals and interventions for the client and staff, and to record the client's acceptance of CAP/C as an alternative to institutional placement. The Plan must be revised as needed according to changes in the client's situation. Each Plan and each revision must be approved according to CAP/C policies and procedures.

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Enter the client's name and MID on the top of each page.

Enter the name of the CAP/C Case Management agency. Enter the name of the client's CAP/C Case Manager. Enter the Case Manager's phone number and email address where he/she can be reached by the DMA Nurse Consultant for questions.

Initial, Medicaid application date

Check this box if the child is not presently on CAP/C and is applying for services. The Medicaid application date is used in determining the CAP Effective Date. It is also helpful to include the Medicaid application deadline date. This date is used to make sure that the child is approved for CAP/C prior to the application deadline. Your Nurse Consultant does not know these dates unless you provide them!

CNR, due date

Check this box if this plan of care was done as part of the annual Continued Need review. The CNR due date is always the 5th of the month following the date the ORIGINAL FL-2 was approved.

If the FL-2 was approved on June 16, the CNR is due July 5.

If the FL-2 was approved February 1, the CNR is due March 5.

The CNR date never changes, even if you get a new FL-2 or change the level of care.

Revision, effective date

Check this box if you are making a change to the assessment in between annual CNRs. This is the date that the change takes effect. It can be up to 30 days prior to the date the paperwork is RECEIVED by DMA.

Level of Care

Indicate the client's level of care as IC, SC (with aide), SC (with nurse) , or SC (Hospital).

COMPLETING THE PLAN OF CARE FORM – SECTION A, GOALS AND INTERVENTIONS

| A. GOALS & INTERVENTIONS | |
|---|-------------------------|
| Use this space to list goals and the interventions related to accomplishing these goals. Select as many interventions as apply. Use the comments space to individualize the plan of care. You may also add additional goals or interventions as applicable. If you need additional space, please continue in section F. | |
| 1. Goal: The client will be able to maintain his/her health, safety, and well-being in the home environment rather than in an institution. | |
| 1. Interventions: | |
| <input type="checkbox"/> CAP/C Nursing Services will supplement and support the client's informal support system by providing direct care to the client and education to caregivers in accordance with the RN and/or LPN scope of practice and a nursing careplan written by the provider agency that is designed to maintain or improve the client's current health status. | Comments/Progress Notes |
| <input type="checkbox"/> CAP/C Nurse Aide Services will supplement and support the client's informal support system by providing help with personal hygiene, ambulation, feeding, and home management in accordance with the CNA I or CNA II scope of practice and a careplan developed by the provider agency and overseen by a Registered Nurse. | Comments/Progress Notes |
| <input type="checkbox"/> CAP/C Case Management Services will assess the needs of the client and caregivers; plan care; and locate, coordinate, and monitor services and supplies, including the provision of CAP/C Waiver Supplies and Home Modifications in accordance with the regulations of the CAP/C program. | Comments/Progress Notes |
| <input type="checkbox"/> CAP/C Respite Services, whether institutional or in-home, will provide temporary support to informal caregivers for a range of needs, and will be provided in accordance with the client's level of care, licensing requirements of the provider agency, and regulations of the CAP/C program. | Comments/Progress Notes |
| <input type="checkbox"/> Therapies, whether Physical Therapy, Occupational Therapy, Speech Therapy, or some combination of the above, will provide direct care to the client and education to caregivers in accordance with licensing requirements and a careplan written by the provider agency that is designed to maintain or improve the client's current health and functional status. | Comments/Progress Notes |
| 2. Goal: | |
| 2. Interventions: | |
| <input type="checkbox"/> | Comments/Progress Notes |

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Check all appropriate interventions for Goal 1. Use the space under 'comments/progress notes' to individualize the intervention to the specific client. You may add additional goals using section F and/or additional sheets. CAP/C goals usually involve maintaining and/or improving the client's health, safety, functioning, and independence. For each goal, list the interventions to meet that goal, the services and supports needed for the intervention, and any comments. Progress toward plan of care goals may be documented on this form or within your case management notes.

COMPLETING THE PLAN OF CARE FORM – SECTION B, COST SUMMARY

| | | | |
|---|--|--------|-----|
| CAP/IC PLAN OF CARE | | CLIENT | |
| | | MID | |
| B. COST SUMMARY | | DATE | LOC |
| Total Services and Supplies | | | |
| Please put only ONE service or supply in each box. | | | |
| P=Purchase C=Capped Rental R= Ongoing Rental <MMA=Less Than Maximum Medicaid Allowable | | | |
| List all services to be provided. When payer is not Medicaid, enter one of the following codes in Column S: | | | |
| 1=Insurance 2=Family/Friends 3=School System 4=WIC 5=CSHS 6=Outpatient 7= | | | |
| Medical Supplies must be itemized on Page 3, with the total brought forward below. Regularly scheduled services should be listed first. List short-term intensive services below. Short-Term Intensive services, Case Management Assessment (if applicable), Home Modifications, and Respite Services may be prorated over 12 months. | | | |

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Make sure that the client's name, MID, the POC effective date, and the client's level of care are at the top of each page.

The cost summary is divided into two sections: the first page summarizes all the client's services and supplies, and shows the actual monthly budget for the client. The remaining pages are the medical supplies, itemized.

Please place only one item in each row of the cost summary. Although there may be room, please don't place 2 items within the same row.

COMPLETING THE PLAN OF CARE FORM – SECTION B, COST SUMMARY, CONT'D.

| SERVICE | CODE | PROVIDER AGENCY | FREQUENCY DATE(S) OF SERVICE | P C R | ON BUDGET FROM/TO | COST/UNIT SOURCE | AVERAGE MONTHLY COSTS | | | |
|--|-------|-----------------|------------------------------|-------|-------------------|---|-----------------------|-------|------|--|
| | | | | | | | MEDICAID | OTHER | S | |
| Case Management | | | | | | <input type="checkbox"/> MMA <input type="checkbox"/> Other | #/year | | | |
| Case Management | | | | | | <input type="checkbox"/> MMA <input type="checkbox"/> Other | /mo | | | |
| Hourly Nursing scheduled | T1000 | | | | | <input type="checkbox"/> MMA <input type="checkbox"/> Other | /hr | | | |
| Hourly Nursing respite | T1005 | | | | | <input type="checkbox"/> MMA <input type="checkbox"/> Other | /hr | | | |
| Institutional respite | H0045 | | | | | <input type="checkbox"/> MMA <input type="checkbox"/> Other | /day | | | |
| Nurse Aide scheduled | S5125 | | | | | <input type="checkbox"/> MMA <input type="checkbox"/> Other | /hr | | | |
| Nurse Aide respite | S5150 | | | | | <input type="checkbox"/> MMA <input type="checkbox"/> Other | /hr | | | |
| Nursing Visits | 550 | | | | | <input type="checkbox"/> MMA <input type="checkbox"/> Other | /visit | | | |
| Physical Therapy | | | | | | <input type="checkbox"/> MMA <input type="checkbox"/> Other | | | | |
| Occupational Therapy | | | | | | <input type="checkbox"/> MMA <input type="checkbox"/> Other | | | | |
| Speech Therapy | | | | | | <input type="checkbox"/> MMA <input type="checkbox"/> Other | | | | |
| Home Modifications | S5165 | | | | | <input type="checkbox"/> MMA <input type="checkbox"/> Other | | | | |
| Medical Supplies | | | | | | | | | | |
| GRAND TOTAL ALL SERVICES AND SUPPLIES | | | | | | | | 0.00 | 0.00 | |
| COMMENTS | | | | | | | | | | |

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First Page

Service

Use the first 'Case Management' line for the time it takes to do your annual assessment.

Use the second line 'Case Management' line for the estimated monthly amount of ongoing case management that you will provide.

Hourly respite should be placed on the cost summary as a yearly allotment.

Under nursing visits, be sure to include the every-other-month supply visit from the home health agency (if applicable).

Nursing visits and therapy services are State Plan services, not waiver services, so you don't need to calculate the cost; simply indicate the agency and the frequency.

Home modifications are also prorated, starting the date of delivery and ending 12 months later. The prorated cost should be included on all plans of care for the duration of the proration period. A copy of the quote should be attached for each home modification.

You do not need to enter anything under 'medical supplies'.

Use a separate line for each short-term intensive service. Short-term intensive services are prorated. On revisions and CNR plans, remember to include a short-term intensive service that is still in the proration period. It is a good idea to plan all your school-related short-term-intensive services for the year at the time of the CNR.

COMPLETING THE PLAN OF CARE FORM – SECTION B, COST SUMMARY, CONT'D.

| SERVICE | CODE | PROVIDER AGENCY | FREQUENCY DATE(S) OF SERVICE | P C R | ON BUDGET FROM/TO | COST/UNIT SOURCE | AVERAGE MONTHLY COSTS | | |
|--|-------|-----------------|------------------------------|-------|-------------------|------------------|-----------------------|-------|-------|
| | | | | | | | MEDICAID | OTHER | TOTAL |
| Case Management | | | | | | <MMA Other | | | |
| Case Management | | | | | | <MMA Other | | | |
| Hourly Nursing scheduled | T1000 | | | | | <MMA Other | | | |
| Hourly Nursing respite | T1005 | | | | | <MMA Other | | | |
| Institutional respite | H0045 | | | | | <MMA Other | | | |
| Nurse Aide scheduled | S5125 | | | | | <MMA Other | | | |
| Nurse Aide respite | S5150 | | | | | <MMA Other | | | |
| Nursing Visits | 550 | | | | | <MMA Other | | | |
| Physical Therapy | | | | | | <MMA Other | | | |
| Occupational Therapy | | | | | | <MMA Other | | | |
| Speech Therapy | | | | | | <MMA Other | | | |
| Home Modifications | S5165 | | | | | <MMA Other | | | |
| Medical Supplies | | | | | | | | | |
| GRAND TOTAL ALL SERVICES AND SUPPLIES | | | | | | | 0.00 | 0.00 | |
| COMMENTS | | | | | | | | | |

Page 2

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First Page

Code

Enter the code for the service from the CAP/C fee schedule.

Provider Agency

List the agency that will provide and bill for the service. If the service is to be reimbursed by Medicaid, the agency must be enrolled by DMA to provide the specific service. For CAP/C services, the agency must be enrolled by DMA as a CAP provider for the specific service. If the service is to be paid for completely by insurance or another third party, enter the name of the provider agency.

COMPLETING THE PLAN OF CARE FORM – SECTION B, COST SUMMARY, CONT'D.

| SERVICE | CODE | PROVIDER AGENCY | FREQUENCY OF SERVICE | P/C/R | ON BUDGET FROM/TO | COST/UNIT SOURCE | AVERAGE MONTHLY COSTS | | |
|--|-------|-----------------|----------------------|-------|-------------------|------------------|-----------------------|-------|-------|
| | | | | | | | MEDICAL | OTHER | TOTAL |
| Case Management | | | | | | per yr | | | |
| Case Management | | | | | | per mo | | | |
| Hourly Nursing scheduled | T1000 | | | | | per hr | | | |
| Hourly Nursing respite | T1005 | | | | | per hr | | | |
| Institutional respite | H0045 | | | | | per day | | | |
| Nurse Aide scheduled | S5125 | | | | | per hr | | | |
| Nurse Aide respite | S5150 | | | | | per hr | | | |
| Nursing Visits | S50 | | | | | per visit | | | |
| Physical Therapy | | | | | | per session | | | |
| Occupational Therapy | | | | | | per session | | | |
| Speech Therapy | | | | | | per session | | | |
| Home Modifications | S5165 | | | | | per visit | | | |
| Medical Supplies | | | | | | | | | |
| GRAND TOTAL ALL SERVICES AND SUPPLIES | | | | | | | 0.00 | 0.00 | |
| COMMENTS | | | | | | | | | |

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Frequency

List the anticipated frequency of the service. Abbreviate visits with a **V**; hours with an **H**; days with a **D**; weeks with a **W**; months with an **M**; and year with a **Y**.

For case management assessment, enter the total time for completing the annual assessment (for both assessors, if applicable).

For ongoing case management, show the average number of hours expected to be used per month. This amount is expected to be an estimate. If the experience with the case shows the estimate is high or low, revise the Plan of Care.

For scheduled nurse or nurse aide services, show the hours per week.

For In-Home respite hours, show the hours per year.

For Institutional respite hours, show the hours per year.

For therapies and nurse or nurse aide visits, show the number of visits per week or month. Note that a home health agency providing supplies may bill for a nurse visit every 60 days, except when that home health agency is also providing the LPN or RN care for that same patient.

For medical supplies, enter "N/A."

For short term intensive services, indicate the dates of the short-term-intensive period and the hours per day and number of days.

P/C/R

On this page, this column is left blank. You will use this column on the page of itemized medical supplies.

On Budget From/To

For prorated services such as case management assessment and short-term-intensive services, enter the start and end date of the proration period. For other services, leave blank.

COMPLETING THE PLAN OF CARE FORM – SECTION B, COST SUMMARY, CONT'D.

| SERVICE | CODE | PROVIDER AGENCY | FREQUENCY OF SERVICE | PERIOD OF R | ON BUDGET FROM/TO | COST/UNIT SOURCE | AVERAGE MONTHLY COST | | |
|--|-------|-----------------|----------------------|-------------|-------------------|------------------|----------------------|-------|-------|
| | | | | | | | MEDICAID | OTHER | TOTAL |
| Case Management | | | | | | per af | | | |
| Case Management | | | | | | afmo | | | |
| Hourly Nursing scheduled | T1000 | | | | | per hr | | | |
| Hourly Nursing respite | T1005 | | | | | per hr | | | |
| Institutional respite | H0045 | | | | | per day | | | |
| Nurse Aide scheduled | S5125 | | | | | per hr | | | |
| Nurse Aide respite | S5150 | | | | | per hr | | | |
| Nursing Visits | 550 | | | | | per visit | | | |
| Physical Therapy | | | | | | per session | | | |
| Occupational Therapy | | | | | | per session | | | |
| Speech Therapy | | | | | | per session | | | |
| Home Modifications | S5165 | | | | | per project | | | |
| Medical Supplies | | | | | | | | | |
| GRAND TOTAL ALL SERVICES AND SUPPLIES | | | | | | | 0.00 | 0.00 | |
| COMMENTS | | | | | | | | | |

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Cost/Unit Source

Show the unit rate that will be reimbursed by Medicaid in direct relationship to what is shown in the frequency column. For example, if the frequency column lists hours, show the unit cost in cost per hour.

The amount shown in this column is either the amount charged by the provider or the maximum Medicaid allowable charge, whichever is less.

Check the box titled <MMA if the price on the Medicaid column of the cost summary is intentionally less than the amount indicated on the fee schedule for that service.

Check the box titled other, when the price on the cost summary differs from the amount on the fee schedule because it is being provided by another payer source.

COMPLETING THE PLAN OF CARE FORM – SECTION B, COST SUMMARY, CONT'D.

| SERVICE | CODE | PROVIDER AGENCY | FREQUENCY OF SERVICE | PERIOD | ON BUDGET FROM/TO | COST/UNIT SOURCE | AVERAGE MONTHLY COST | | |
|--|-------|-----------------|----------------------|--------|-------------------|------------------|----------------------|-------|---|
| | | | | | | | MEDICAID | OTHER | S |
| Case Management | | | | | | .00 | | | |
| Case Management | | | | | | .00 | | | |
| Hourly Nursing scheduled | T1000 | | | | | .00 | | | |
| Hourly Nursing respite | T1005 | | | | | .00 | | | |
| Institutional respite | H0045 | | | | | .00 | | | |
| Nurse Aide scheduled | S5125 | | | | | .00 | | | |
| Nurse Aide respite | S5150 | | | | | .00 | | | |
| Nursing Visits | 550 | | | | | .00 | | | |
| Physical Therapy | | | | | | .00 | | | |
| Occupational Therapy | | | | | | .00 | | | |
| Speech Therapy | | | | | | .00 | | | |
| Home Modifications | S5165 | | | | | .00 | | | |
| Medical Supplies | | | | | | .00 | | | |
| GRAND TOTAL ALL SERVICES AND SUPPLIES | | | | | | | 0.00 | 0.00 | |
| COMMENTS | | | | | | | | | |

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First Page Average Monthly Cost

Use the following procedures to calculate the average monthly cost:

Daily to monthly costs are converted by multiplying daily cost by 30.

Weekly to monthly costs are converted by multiplying weekly costs by 4.3.

Every other week to monthly is converted by multiplying weekly cost by 2.15.

If a service is prorated, the prorated cost is shown as the average monthly cost.

NOTE: The proration procedure is used to calculate the average cost on the Cost Summary. It does not affect how services are billed. Providers bill for services as they are provided. For example, if a home modification costs \$600, the cost is prorated as \$50; however, the entire \$600 charge is billed when the item is delivered to the client.

List the average monthly cost of each service under the appropriate column.

MEDICAID: List the amount to be paid by Medicaid.

Remember that Medicaid is the payer of last resort. Services, which may be paid by another party, such as a private insurer, must be billed to that party before billing Medicaid. When there is a third party involved in payment, Medicaid may only be billed the difference between the amount reimbursed by the third party and the maximum Medicaid allowable charge.

OTHER: List the amount to be paid by other funding sources.

Source

For services in the 'other' column, enter the code for the source of payment in the column headed with an S. Use the codes at the top of the form. If a source is not listed, use 7 and identify the source next to the code.

COMPLETING THE PLAN OF CARE FORM – SECTION B, COST SUMMARY, CONT'D.

| SERVICE | CODE | PROVIDER AGENCY | DATE(S) OF SERVICE | FREQUENCY PER WEEK | ON BUDGET FROM/TO | COST/UNIT SOURCE | AVERAGE MONTHLY COSTS | | |
|--|-------|-----------------|--------------------|--------------------|-------------------|------------------|-----------------------|-------|-------|
| | | | | | | | MEDICAID | OTHER | TOTAL |
| Case Management | | | | | | 0.00 | | | |
| Case Management | | | | | | 0.00 | | | |
| Hourly Nursing scheduled | T1000 | | | | | 0.00 | | | |
| Hourly Nursing respite | T1005 | | | | | 0.00 | | | |
| Institutional respite | H0045 | | | | | 0.00 | | | |
| Nurse Aide scheduled | S5125 | | | | | 0.00 | | | |
| Nurse Aide respite | S5150 | | | | | 0.00 | | | |
| Nursing Visits | 550 | | | | | 0.00 | | | |
| Physical Therapy | | | | | | 0.00 | | | |
| Occupational Therapy | | | | | | 0.00 | | | |
| Speech Therapy | | | | | | 0.00 | | | |
| Home Modifications | S5165 | | | | | 0.00 | | | |
| Medical Supplies | | | | | | 0.00 | | | |
| GRAND TOTAL ALL SERVICES AND SUPPLIES | | | | | | | 0.00 | 0.00 | |
| COMMENTS | | | | | | | | | |

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The grand total at the bottom of the Medicaid column on this page is the amount that must be less than or equal to the budget limit for that client's level of care.

Use the comments space to enter insurance information, explain discrepancies, track respite time, or whatever else you or DMA need to know.

COMPLETING THE PLAN OF CARE FORM – SECTION B, COST SUMMARY, CONT'D.

| MEDICAL SUPPLIES | CODE | PROVIDER AGENCY | FREQUENCY OR AMOUNT PER MONTH | P/C/R | ON BUDGET FROM/TO | COST/UNIT SOURCE | AVERAGE MONTHLY COSTS | | |
|---|------|-----------------|-------------------------------|-------|-------------------|------------------|-----------------------|-------|---|
| | | | | | | | MEDICAID | OTHER | S |
| | | | | | | | | | |
| TOTAL THIS PAGE | | | | | | | 0.00 | 0.00 | |
| COMMENTS | | | | | | | | | |
| formula: ___ calories per can / 100 calories = ___ units per can X ___ cans per month X \$ ___ per unit Indicate percent covered by private insurance, if applicable. Explain any irregularities in the type or amount of supplies used. | | | | | | | | | |

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Second Page

Use this part to itemize all medical supplies including DME, home health supplies, orthotics and prosthetics, waiver supplies, home modifications, and items provided by other sources .

Medical Supplies

Enter the name of the supply.

Code

This is optional. It is a good idea to be aware of the code and the price for each item, so that you can manage care cost-effectively, but you are not required to submit that information to DMA on the cost summary.

Provider Agency

List the agency that will provide and bill for the service. If the service is to be reimbursed by Medicaid, the agency must be enrolled by DMA as a Medicaid provider. If the service is to be paid for completely by insurance or another third party, enter the name of the provider agency.

Frequency or Amount Per Month

For one time purchases, enter 'one time purchase'

For rentals, enter '1/M'.

For other equipment and supplies used on an ongoing basis, enter how many you anticipate will be needed each month or year.

P/C/R

You may leave this column blank.

**COMPLETING THE PLAN OF CARE FORM –
SECTION B, COST SUMMARY, CONT'D.**

| MEDICAL SUPPLIES | CODE | PROVIDER AGENCY | FREQUENCY OR AMOUNT PER MONTH | P R | ON BUDGET FROM/TO | COST/UNIT SOURCE | AVERAGE MONTHLY COST | | |
|--|------|-----------------|-------------------------------|-----|-------------------|---|----------------------|-------|----|
| | | | | | | | MEDICAID | OTHER | \$ |
| | | | | | | <input type="checkbox"/> MMA <input type="checkbox"/> Other | | | |
| TOTAL THIS PAGE | | | | | | | 0.00 | 0.00 | |
| (TOTAL PAGE 3A + PAGE 3B) | | | | | | TOTAL SUPPLIES | 0.00 | 0.00 | |
| COMMENTS | | | | | | | | | |
| Indicate percent covered by private insurance, if applicable. Explain any irregularities in the type or amount of supplies used. | | | | | | | | | |
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On Budget From/To

If you have listed a home modification here, you would enter the proration period in this column..

Cost/Unit Source

This is optional. It is a good idea to be aware of the code and the price for each item, so that you can manage care cost-effectively, but you are not required to submit that information to DMA on the cost summary.

COMPLETING THE PLAN OF CARE FORM – SECTION B, COST SUMMARY, CONT'D.

| MEDICAL SUPPLIES | CODE | PROVIDER AGENCY | FREQUENCY OR AMOUNT PER MONTH | P C | ON BUDGET FROM/TO | COST/UNIT SOURCE | AVERAGE MONTHLY COST | | |
|--|------|-----------------|-------------------------------|-----|-----------------------|------------------|----------------------|-------|---------|
| | | | | | | | MEDICAID | OTHER | \$ |
| | | | | | | | | | |
| | | | | | | MMA Other | | | |
| TOTAL THIS PAGE | | | | | | | 0.00 | 0.00 | |
| (TOTAL PAGE 3A + PAGE 3B) | | | | | TOTAL SUPPLIES | | 0.00 | 0.00 | |
| COMMENTS | | | | | | | | | |
| Indicate percent covered by private insurance, if applicable. Explain any irregularities in the type or amount of supplies used. | | | | | | | | | |
| | | | | | | | | | Page 3B |

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Source

For services in the 'other' column, enter the code for the source of payment in the column headed with an S. Use the codes at the top of the form. If a source is not listed, use 7 and identify the source next to the code.

COMPLETING THE PLAN OF CARE FORM – SECTION C, INFORMAL SUPPORT

CAF/C Plan of Care Client: _____ MID: _____

C. INFORMAL SUPPORT
 Include information about the support to be provided by unpaid caregivers. Enter the name; a check if living in the client's household; the approximate age; the relationship; the tasks performed/support provided; and when the tasks will be performed. Please provide SPECIFIC hours for availability.

| Name | <input type="checkbox"/> | Age | Relationship | Tasks Performed/Support Provided | Availability work hours, days commute time |
|------|--------------------------|-----|---|---|--|
| | <input type="checkbox"/> | | <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> G-father <input type="checkbox"/> G-mother <input type="checkbox"/> Other relative <input type="checkbox"/> Foster parent <input type="checkbox"/> Friend <input type="checkbox"/> Neighbor <input type="checkbox"/> Volunteer <input type="checkbox"/> Other, _____ | <input type="checkbox"/> Grooming <input type="checkbox"/> Bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Elimination <input type="checkbox"/> Transfer <input type="checkbox"/> Walking <input type="checkbox"/> Wheelchair use <input type="checkbox"/> Eating <input type="checkbox"/> Medication Administration <input type="checkbox"/> Socialization <input type="checkbox"/> Other, please specify: _____ <input type="checkbox"/> All | |

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GENERALLY, formal support is defined as paid caregivers – CAP/C staff, school or daycare staff, and staff paid by private insurance or other funding sources. Informal support is defined as unpaid caregivers – family, neighbors, friends, community organizations, church groups and other informal sources of help.

Show the following about the client's informal support system:

Please list all individuals in the household, even if they are incapable of providing care to the client.

1. The name of the individual or organization.
2. If the source of help is an individual,
 - mark the box in the column after the person's name if that person lives in the same household as the client, and
 - enter the approximate age of the individual.
3. Check the appropriate box to indicate the relationship of the source to the client. The 'volunteer' category includes all organizations that may provide informal support, such as church groups, service organizations, and other similar entries.
4. Check the appropriate boxes for the specific tasks performed or type of support provided.
5. Be VERY SPECIFIC about hours of availability/work hours, especially for in-home caregivers. Days and hours should be listed. Avoid generalization such as 'after work' or 'on weekends'.

COMPLETING THE PLAN OF CARE FORM – SECTION D, 24 HR COVERAGE SCHEDULE

| D. 24-HOUR COVERAGE | |
|---|---|
| Use this calendar to show coverage plans, including paid and unpaid caregivers. Write the hours covered each day, beginning after midnight, and who is covering (e.g., "12 - 8 a.m. – Sam Jones"). For nurse/aide coverage, assume that your plan of care is approved as written. | |
| | Time Covered/Name of Person Covering |
| Monday | <input style="width: 100%; height: 20px;" type="text"/> |
| Tuesday | <input style="width: 100%; height: 20px;" type="text"/> |
| Wednesday | <input style="width: 100%; height: 20px;" type="text"/> |
| Thursday | <input style="width: 100%; height: 20px;" type="text"/> |
| Friday | <input style="width: 100%; height: 20px;" type="text"/> |
| Saturday | <input style="width: 100%; height: 20px;" type="text"/> |
| Sunday | <input style="width: 100%; height: 20px;" type="text"/> |

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Complete this item for all CAP/C plans of care. The entries are for a 24 hour day beginning at midnight. The services must correlate to the formal and informal services listed on other sections of the plan of care. If a child attends school or a daycare program, include that time on the schedule and indicate who is responsible for him/her while at school/daycare. The total number of CAP/C hours should match what is requested on the cost summary , and should correlate with caregiver availability as noted in the informal support section.

There are two 24-Hour Coverage Schedules on the plan of care. The second one is optional. It should be used for varying schedules (i.e., a parent rotates day/night shift, so there are two different CAP/C schedules,) or for temporary changes (such as to indicate what the schedule will be during short-term-intensive services).

This schedule will be considered the “typical” schedule, with the understanding that families have the right to change it within the week. This “typical” schedule of nurse or nurse aide hours will also go on the service authorization.

COMPLETING THE PLAN OF CARE FORM – SECTION E, REASON FOR REVISION

D. **REASON FOR REVISION** - Please be specific. Do not simply state what was revised; explain the reason that it needed to be revised.
 Initial CNR
 Revision, reason: _____

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If this plan of care is part of an initial or a CNR, simply check the appropriate box. If this plan of care is a revision, explain the reason for the revision here. Be very specific. Do not simply restate the revision that was made; please give the reason the revision was made. For instance, don't just state "increase in nursing hours". Instead, state "Increase in nursing hours because patient has acute respiratory illness and is now requiring suctioning while asleep as well as while awake."

COMPLETING THE PLAN OF CARE FORM – SECTION F, ADDITIONAL INFORMATION

F. ADDITIONAL INFORMATION - Use the space below to expand on any of the previous sections in which you did not have enough room to include all information. Please refer to the section title.

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Use this space for additional goals, support persons, financial information, or anything else you did not have enough room on the form to address completely.

COMPLETING THE PLAN OF CARE FORM – SECTION G, SIGNATURES

G. AGREEMENTS – This must be signed by the case manager with each and every plan of care submission. It must be signed by the caregiver (and legal guardian, if applicable) whenever the revision involves a change in a waiver service or supply. See chapters 10 and 12 of the CAP/C manual for more detailed instructions.

The following persons have reviewed the Plan of Care and agree to participate in the Plan.

| | | |
|---|---|------|
| CASE MANAGER | Signature/Title | Date |
| CAREGIVER (SPECIFY RELATIONSHIP) | Signature Witness Signature for mark | Date |
| LEGAL GUARDIAN (SPECIFY RELATIONSHIP/TITLE) | Signature Witness signature XXXXX | Date |
| OTHER (SPECIFY RELATIONSHIP) | Signature Witness signature for mark | Date |

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This item is completed to indicate that the signers have reviewed and agreed to the plan.

The caregiver/legal guardian should not be given a blank plan of care to sign.

The case manager should not keep an undated caregiver/legal guardian signature on file to copy and use so that he/she does not have to obtain the parents signature each submission.

The case manager must sign all plans of care.

The caregiver/legal guardian signature is required on all initials, all CNRs, and revisions that affect waiver supplies and services.

If the caregiver and legal guardian are not the same person, both signatures must be obtained.

The decision on whether to request the physician's signature is made by the family and case manager on a case-by-case basis.

COMPLETING THE PLAN OF CARE FORM – SECTION H, SIGNATURES, CONT'D.

H. Client Statement of Understanding – This should be signed by the care manager, the caregiver, the caregiver and the legal guardian (if the caregiver, at the time of the initial plan of care, at the time of each CAP/C, and any other time that one of the above parties deem appropriate.

By signing this Plan of Care, I, as the primary caregiver (parent or guardian) for _____, acknowledge my understanding of the Community Alternatives Program for Children (CAP/C).

Unless I have had:

1. My child has the choice of seeking nursing staff by care instead of participating in the Community Alternatives Program.
2. My child has the choice of medical providers (for example, nursing assistants).
3. My child, the recipient, will receive the services shown in the Plan of Care, and these services may be changed as needed.
4. I have been informed of my right to appeal the denial of or limitation on the Community Alternatives Program, as well as the right to appeal any change in, or denial of, services provided through CAP/C.
5. My child, the recipient, must receive Child Care equivalent to care received in order to make the child eligible for the program.
6. CAP/C is assigned to implement, not provide, the formal and informal services, including the parent's/guardian's responsibility, directly available to my child.
7. As the primary caregiver, I will actively participate in planning for my child's care.
8. Child's nursing hours and other services may be changed over time, resulting in an increase or decrease in services, based on the medical needs of my child.
9. The level of care needs of my child may change over time, thus resulting in an increase or decrease in budget.
10. CAP/C services will be terminated if my child meets any of the following criteria:
 - no longer lives in suitable, primary residence;
 - all circumstances no longer require nursing staff by care as determined through the medical prior approval process;
 - no longer requires medical coverage of CAP/C services in addition to CAP/C case management to remain safely at home;
 - CAP/C services are no longer needed;
 - no longer eligible for Medicaid under CAP/C;
 - my child (the recipient) reaches 19 years of age;
 - the case of child and well-being cannot be maintained at home;
 - local, county or state health care facilities.
11. The provider (nursing agency) I choose may have certain requirements regarding my participation in my child's treatment and enrollment in this agency.
12. The Care Manager is responsible for coordinating the assessment plan of care, and authorizing and monitoring CAP/C services to ensure the services meet or fall through program guidelines, funding and that those funding commitments to my care manager by rearing their telephone calls, being available for home visits, and informing their changes in my child's condition, hospitalizations, agencies, state the county, and new equipment.
13. The Division of Medical Assistance has final approval authority over the plan of care. My care manager is unable to approve or deny any services or supplies.

| | | |
|---|----------------------------------|-------------|
| NAME OF CLIENT: _____ | | |
| SIGNATURE OF CAREGIVER: _____ | WITNESS SIGNATURE FOR BAP: _____ | DATE: _____ |
| SIGNATURE OF LEGAL GUARDIAN IF NOT CAREGIVER: _____ | WITNESS SIGNATURE FOR BAP: _____ | DATE: _____ |
| SIGNATURE OF CARE MANAGER: _____ | WITNESS SIGNATURE FOR BAP: _____ | DATE: _____ |

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This statement must be reviewed and signed by the client's representative before initial CAP/C participation and continuing CAP/C participation at the time of the CNR can be approved.

If the representative signs by a mark, it must be witnessed. A family member or another individual chosen by the family member is preferred to be the witness. The case manager may not witness the representative's mark.

The signature of the representative indicates that he/she has been given freedom of choice, has chosen CAP/C participation, understands the statement regarding CAP/C eligibility/changes in the plan of care/terminations/right to appeal, and agrees to be an active participant in the plan of care.

If the caregiver and the legal guardian are not the same person, both signatures must be obtained.

CAP/C clients who are 18-19 years of age and who have the primary responsibility for making decisions about their care may sign this page.

SUMMARY

- Don't put two different services or supplies in the same box on the cost summary.
- Medicaid pays only up to the maximum Medicaid allowable for a service or supply.
- If your last plan of care was amended by DMA, make sure those changes are reflected on the current plan of care.
- Be as detailed as possible, especially about caregiver availability and reason for revision.
- Parents should never sign a blank plan of care, and case managers should not keep a copy of the parent signature on file for repeated use.
- The case manager must sign every plan of care that is submitted.

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REVIEW QUESTIONS

Please make sure that you can answer the following questions before proceeding to the next section.

1. To convert the amount of a weekly service frequency into a monthly service frequency, multiply by:
 - A. you don't need to multiply anything
 - B. 4
 - C. 4.3

2. The start of the 'on budget from/to' period for a home modification is:
 - A. The month in which the physician wrote the order
 - B. The month in which you received prior approval
 - C. The month in which the item was actually delivered to the client
 - D. The month that Medicaid paid the claim.

3. Each day of the 24 hour coverage schedule starts at _____ and ends at _____.

4. True or False: Only the primary caregiver needs to sign the plan of care. If there is a different person who is the legal guardian, it is not necessary for that person to sign.

5. The informal support system should list:
 - A. Only those people able to provide medical care for the child
 - B. Only those people in the child's household
 - C. All of the people in the child's household and anyone else who provides any type of support

REVIEW ANSWERS

1. C, 4.3
2. C, the month in which it was delivered to the client
3. Midnight to Midnight
4. False. The caregiver and the legal guardian, if not the same person, both need to sign the Plan of Care.
5. C, All sources of informal support should be listed, even if they do not live in the home, or even if all they provide for the client is socialization.