



Community Based Adult Services (CBAS) Individual Plan of Care (IPC)

Part
1

PARTICIPANT NAME:		SEX: <input type="checkbox"/> M <input type="checkbox"/> F
DATE OF BIRTH (MM/DD/YY):	CIN:	
CENTER NAME:	PROVIDER NUMBER (NPI):	
MANAGED CARE PLAN NAME:		
DATES OF SERVICE: FROM:	TO:	TAR CONTROL NUMBER (TCN):

(#) TREATMENT AUTHORIZATION AND ELIGIBILITY

Initial TAR Reauthorization TAR Change TAR

(#) _____ Planned Days/Week TB Clearance Date (initial TAR only): _____

Yes No N/A If this is a reauthorization TAR, the participant's condition would likely deteriorate if the CBAS services were terminated or decreased.

Yes No N/A If this is a reauthorization TAR, the participant's condition would likely deteriorate if the CBAS frequency of services were changed

The individual meets the following CBAS eligibility categories; in addition to required medical necessity criteria in WIC 14525 and 14526.2, and Medi-Cal 2020 Waiver STC 44d: *(Check all that apply)*

- Category 1:** Nursing Facility Level A (NF-A) or above
- Category 2:** Organic, Acquired or Traumatic Brain Injury and/or Chronic Mental Illness
- Category 4:** Mild Cognitive Impairment including moderate Alzheimer's disease or other dementias
- Category 5:** Individuals who have Developmental Disabilities

(#) DIAGNOSES AND ICD CODES

PRIMARY DIAGNOSES

Include diagnoses as provided or confirmed by the personal health care provider(s)

ICD CODE

SECONDARY DIGANOSSES

Include diagnoses as provided or confirmed by the personal health care provider(s)

ICD CODE

PRIMARY DIAGNOSES	ICD CODE	SECONDARY DIGANOSSES	ICD CODE
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	
6.		6.	



(#) MEDICATIONS *(Frequency and dosage not required)*

1.	6.	11.	OVER-THE-COUNTER MEDICATION AND/OR SUPPLEMENTS
2.	7.	12.	
3.	8.	13.	
4.	9.	14.	
5.	10.	15.	

(#) ACTIVE PERSONAL MEDICAL / MENTAL HEALTH CARE PROVIDER(S)

NAME	PHYSICIAN SPECIALTY	ADDRESS	PHONE

(#) ADL/IADLs STATUS

(Check only one box per row)

Independent: able to perform for self with or without device
Needs Supervision: no physical help required but needs to be monitored, even with device
Needs Assistance: physical help or cueing required, even with device
Dependent: unable to do for self, even with physical help, cueing or device

ADLs	INDEPENDENT	NEEDS SUPERVISION	NEEDS ASSISTANCE	DEPENDENT
Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IADLs	INDEPENDENT	NEEDS SUPERVISION	NEEDS ASSISTANCE	DEPENDENT
Accessing Resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Mgmt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Money Mgmt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



(#) CURRENT ASSISTIVE / ADAPTIVE DEVICES *(Check all that apply)*

- None
- AAC Device
- Glasses or Other Vision Aids
- Wheelchair
- Othosis/Prosthesis
- Dentures
- Walker
- Gait Belt
- Crutches:
- Hoyer Lift
- Cane
- Hearing Device
- Assistive Communication Devices
- Specialized Eating Equipment/Utensils
- Respiratory Equipment (specify): _____
- Other (specify): _____

(#) CONTINENCE INFORMATION *(Check all that apply)*

- None
- Incontinent of bladder: Occasionally Frequently Always
- Incontinent of bowel: Occasionally Frequently Always
- External/internal catheter
- Ostomy
- Other (specify): _____

(#) NUTRITIONAL INFORMATION *(Check all that apply)*

- None Underweight Overweight Obese BMI _____ (If known) Feeding tube
- Therapeutic/special diet
- Difficulty chewing and/or swallowing Cannot feed self
- Other (specify): _____

(#) OTHER LONG TERM SUPPORT SERVICES (if known) *(Check all that apply)*

SUPPORT SERVICE	LIVING ARRANGEMENT
<input type="checkbox"/> Not Known	<input type="checkbox"/> ICF/DD-H
<input type="checkbox"/> NONE	<input type="checkbox"/> Community Care Licensed Facility (e.g. Residential Care Facility)
<input type="checkbox"/> IHSS	<input type="checkbox"/> Other Congregate Living
<input type="checkbox"/> MSSP	<input type="checkbox"/> Lives alone

(#) OTHER HEALTH SERVICES (if known). Within the past 6 months

(Check all that apply)

Currently receiving **Home Health Services**? Yes No Hospice Care? Yes No

Explain: _____



Mental Health Services.

Explain: _____

Hospitalization Yes No Medical Psychiatric

times admitted _____ # times admitted within 30-days for same condition _____

Emergency Department Visit(s) #: _____

Nursing Facility. Explain: _____

Other Health Services.

Explain: _____

RISK FACTORS

Part
2

DRAFT



CARE PLAN

Part
3

(#) PARTICIPANT GOALS

GOALS FOR ATTENDING CBAS PROGRAM

1.

2.

3.

HEALTH GOALS

1.

2.

3.

OTHER GOALS

1.

2.

3.

(#) CENTER FOCUS AREAS TO SUPPORT PARTICIPANT GOALS

1.

2.

3.

4.

5.



(#) PARTICIPANT'S INDIVIDUAL PLAN OF CARE

PARTICIPANT NAME:

CIN:

PROFESSIONAL NURSING

Participant Goal(s):

1. Need / Problem:		New this IPC. <input type="checkbox"/> Yes <input type="checkbox"/> No
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Treatment / Intervention	Frequency	Goal
<div style="position: absolute; top: 50%; left: 50%; transform: translate(-50%, -50%); opacity: 0.3; font-size: 48px; pointer-events: none;">DRAFT</div>		

2. Need / Problem:		New this IPC. <input type="checkbox"/> Yes <input type="checkbox"/> No
--------------------	--	--

Treatment / Intervention	Frequency	Goal
<div style="position: absolute; top: 50%; left: 50%; transform: translate(-50%, -50%); opacity: 0.3; font-size: 48px; pointer-events: none;">DRAFT</div>		

3. Need / Problem:		New this IPC. <input type="checkbox"/> Yes <input type="checkbox"/> No
--------------------	--	--

Treatment / Intervention	Frequency	Goal
<div style="position: absolute; top: 50%; left: 50%; transform: translate(-50%, -50%); opacity: 0.3; font-size: 48px; pointer-events: none;">DRAFT</div>		



(#) PARTICIPANT'S INDIVIDUAL PLAN OF CARE

PARTICIPANT NAME:

CIN:

4. Need / Problem:	New this IPC. <input type="checkbox"/> Yes <input type="checkbox"/> No
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Treatment / Intervention	Frequency	Goal

5. Need / Problem:	New this IPC. <input type="checkbox"/> Yes <input type="checkbox"/> No
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Treatment / Intervention	Frequency	Goal

PERSONAL CARE

Participant Goal(s):

1. Need / Problem:	New this IPC. <input type="checkbox"/> Yes <input type="checkbox"/> No
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Treatment / Intervention	Frequency	Goal



(#) PARTICIPANT'S INDIVIDUAL PLAN OF CARE

PARTICIPANT NAME:

CIN:

2. Need / Problem:		New this IPC. <input type="checkbox"/> Yes <input type="checkbox"/> No
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Treatment / Intervention	Frequency	Goal

3. Need / Problem:		New this IPC. <input type="checkbox"/> Yes <input type="checkbox"/> No
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Treatment / Intervention	Frequency	Goal

4. Need / Problem:		New this IPC. <input type="checkbox"/> Yes <input type="checkbox"/> No
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Treatment / Intervention	Frequency	Goal



(#) PARTICIPANT'S INDIVIDUAL PLAN OF CARE

PARTICIPANT NAME:

CIN:

5. Need / Problem:

New this IPC. Yes No

Treatment / Intervention	Frequency	Goal
<p style="text-align: center; font-size: 48px; opacity: 0.3; transform: rotate(-30deg);">DRAFT</p>		

- SOCIAL SERVICES
- THERAPUETIC ACTIVITIES
- PHYSICAL THERAPY MAINTENANCE PROGRAM
- OCCUPATIONAL THERAPY MAINTENANCE PROGRAM
- NUTRITION / DIET
- PHYSICAL THERAPY
- OCCUPATIONAL THERAPY
- SPEECH AND LANGUAGE PATHOLOGY SERVICES
- REGISTERED DIETICIAN SERVICES
- MENTAL HEALTH SERVICES

ADDITIONAL INFORMATION *(about participant status/needs and significant changes in condition since last IPC)*

DRAFT



SIGNATURES OF MULTIDISCIPLINARY TEAM AND PROGRAM DIRECTOR

Part
4

Signatures of the Multidisciplinary Team
Pursuant to section 14529 of the Welfare and Institutions Code,
signing below certifies agreement with the treatments
designated in the IPC that are consistent with the signer's scope of practice

PRINTED NAME	SIGNATURE	DATE OF SIGNATURE
		RN
		SW
		PT
		OT

By signing below I certify that I have reviewed and concur with this IPC

PRINTED NAME	SIGNATURE OF THE PRIMARY / PERSONAL HEALTH CARE PROVIDER OR CBAS CENTER PHYSICIAN	DATE OF SIGNATURE

I certify that services will be provided as scheduled on this IPC unless otherwise noted in the participant's health record.

PRINTED NAME	SIGNATURE	DATE OF SIGNATURE
	Program Director	