New Jersey Department of Human Services
Division of Aging Services

PLAN OF CARE

1. **Participant Name** *(print)*	2. **Plan of Care Date** *(mm/dd/yyyy)*	2A. **Closed Date** *(mm/dd/yyyy)*	3. **ID No. (JACC, SAMS, or Other)**
4. **Case Manager Name** *(print)*	5. **Plan of Care Renewal/ Reassessment Due** *(mm/dd/yyyy)*		6. **Program:** ☐ JACC ☐ Area Plan Contract ☐ Other
7. **Residential Setting** ☐ Group Home ☐ Room Rental ☐ Apt. Boarding Home Class ☐ A, ☐B or ☐C ☐ Shelter ☐ House ☐ Sr. Apt.	7A. **Alone** ☐ **With Others** ☐		7B. **Date of Birth:** *(mm/dd/yyyy)*

8	9	10	Services				Costs		Providers		Monitoring			Updates*	
			11	12	13	14	15	16	17	18	19	20	21	22	23
Date	**Problem Statement*: Identify Assessed Needs, Risk Factors and Personal Goals**	**Need Codes ***	**Service(s) Needed**	**Desired Outcome ***	**Units Per Visit**	**Frequency ***	**Unit Cost (JACC Only)**	**Payment Source***	**Provider Type ***	**Provider**	**Monitoring Method ***	**Monitoring Frequency ***	**Unmet Need Code * (if applicable)**	**Initials (CM, Clients)**	**Date**

** See Code List on page 2.*

PLAN OF CARE (Continued)

1. Participant Name *(print)*	2. Plan of Care Date *(mm/dd/yyyy)*	3. ID No. (JACC, SAMS, or Other)

25. Special Instructions/Comments: [Include all of the following which apply – (1) Incorporate Client Preferences or Concerns; (2) Expound on Unmet Needs; and (3) Describe Back-up Plans, explaining any situations considered to be at-risk concerns for the safety and/or well-being of the participant and listing the interventions to respond to such safety concerns (including who is responsible with emergency contact information).] ☐ **N/A upon completion of initial POC**

Comment	Date	Comment	Date

Back-up Plan:

Safety / Emergency / Community-Wide Disaster:

Yes	No	
☐	☐	**I agree with this Plan of Care.**
☐	☐	**I had the freedom to choose the services in this Plan of Care.**
☐	☐	**I had the freedom to choose the providers of my services based on available providers.**
☐	☐	**I helped develop this Plan of Care.**
☐	☐	**I am aware of my rights and responsibilities as a participant of this program (as contained in the Participant Agreement).**
☐	☐	**I am aware that the services outlined in this Plan of Care are not guaranteed.**
☐	☐	**I have been advised of the potential risk factors outlined in this Plan of Care.**
☐	☐	**I understand and accept these potential risk factors.**

Signature_____ ____/____/____

☐ Participant** / ☐ Representative** Date

Signatures:

Care Manager (CM): _____ Date: _____

CM Supervisor: _____ Date: _____

Other: _____ Date: _____

Other: _____ Date: _____

** Note: All participants are evaluated at least annually to confirm that they continue to meet both the financial criteria and clinical eligibility requirements of this program (as applicable).

* Code List

Problem Statement: (Column #9)
Briefly describe the client's individual circumstances which serve as the basis for each assessed need.

Need Codes: (Column #10)
Identify the Code by which each assessed need is best categorized.
Client Unable to:
1. Perform ADL (specify letter)
   a. Bathing
   b. Dressing
   c. Toilet Use
   d. Transferring
   e. Locomotion
   f. Bed Mobility
   g. Eating

Need Codes, Continued
2. Perform IADL (specify letter)
   a. Meal Preparation
   b. Housework
   c. Managing Finances
   d. Medication Management
   e. Phone Use
   f. Shopping
   g. Transportation
   h. Accessing Resources
   i. Laundry
   j. Personal Hygiene
3. Personal Goal
4. Communication Needs
5. Social Isolation
6. Caregiver Relief
7. Mental Health
8. Other (specify) _____

Need Codes, Continued
9. Risk Factors
   a. Personal Safety Risk
   b. Health Condition Risk
   c. Behavioral Risk
   d. Environmental Risk
   e. Medication Risk
   f. Other Risk (specify) _____

Desired Outcome Code: (Column # 12)
1. Maintenance
2. Independence
3. Rehabilitation
4. Prevention
5. Caregiver Relief
6. Other (specify) _____

Frequency: (Column # 14)
D- Daily (specify # of days per week)
W- Weekly
B- Bi-weekly
M- Monthly
Q- Quarterly
A- Annually
O- Other (specify) _____

Payment Source: (Column #16)
1. Medicaid
2. Medicare
3. Other Third Party Liability (TPL)
4. Local Community-Based Organization
5. County Funded Program
6. State Funded Program
7. Informal Support
8. Private Pay
9. APC Funded
10. Other (specify) _____

Provider Type: (Column #17)
J- JACC Agency
M- Medicare
PEP- Participant-Employed Provider
P- Private Provider
F- Facility
I- Informal Support

Monitoring Method: (Column #19)
C- Participant Record / Chart
R- Receipts
S- On-Site Review
D- Documentation (specify) _____
T- Time Sheets
P- Phone Contact With _____
O- Other (specify) _____

Monitoring Frequency: (Column #20)
D- Daily
W- Weekly
B- Bi-weekly
M- Monthly
Q- Quarterly
A- Annually
R- Random
O- Other (specify) _____
U- Upon reported completion

Unmet Need Codes (Column # 21)
1. Not available
2. Not affordable
3. Waiting List
4. Frequency not adequate
5. Refused
6. Other (specify) - expound on reason if necessary in Column #26

Updates (Columns # 22 and 23)
Completed only as necessary if changes are made throughout the duration of the Plan of Care.