



## 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):
PLANNED DAYS/WEEK: <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun		

### (1) TREATMENT AUTHORIZATION AND ELIGIBILITY

Initial TAR     Reauthorization TAR     Change TAR

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 denied.

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:

- Category 1:** Nursing Facility Level A (NF-A) or above
- Category 2:** Organic, Acquired or Traumatic Brain Injury and/or Chronic Mental Illness
- Category 3:** Alzheimer's disease or other dementias
- Category 4:** Mild Cognitive Impairment including moderate Alzheimer's disease or other dementias
- Category 5:** Individuals who have Developmental Disabilities

### (2) DIAGNOSES AND ICD CODES

	ICD CODE		ICD CODE
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	



**PARTICIPANT NAME:** \_\_\_\_\_ **CIN:** \_\_\_\_\_

**DATES OF SERVICE:** \_\_\_\_\_ **TO** \_\_\_\_\_

**(3) MEDICATIONS**

Center administers participant's prescribed medication(s) Yes \_\_\_ No \_\_\_

Participant self-administers prescribed medication(s) at center Yes \_\_\_ No \_\_\_

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

**(4) ACTIVE PERSONAL MEDICAL / MENTAL HEALTH CARE PROVIDER(S)**

NAME	PHYSICIAN SPECIALTY	ADDRESS	PHONE

**(5) ADL/IADLs  
STATUS**

**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"/>



**PARTICIPANT NAME:** \_\_\_\_\_ **CIN:** \_\_\_\_\_

**DATES OF SERVICE:** \_\_\_\_\_ **TO** \_\_\_\_\_

**(6) CURRENT ASSISTIVE / ADAPTIVE DEVICES**

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

**(7) CONTINENCE INFORMATION**

- N/A
- Incontinent of bladder:     Occasionally       Frequently       Always
- Incontinent of bowel:     Occasionally       Frequently       Always
- External/internal catheter     Ostomy     Other (specify): \_\_\_\_\_

**(8) NUTRITIONAL INFORMATION**

- Underweight     Overweight     Obese     BMI \_\_\_\_\_     BMI Not Known
- Feeding tube     Therapeutic/special diet: \_\_\_\_\_
- Difficulty chewing and/or swallowing     Other (specify): \_\_\_\_\_

**(9) LIVING ARRANGEMENT / HOUSEHOLD COMPOSITION AND  
NON-CBAS LONG TERM SUPPORT SERVICES (if known)**

**LIVING ARRANGEMENT/HOUSEHOLD COMPOSITION**

**Type of Residence:**

- Personal Residence (house/apartment)
- Community Care Licensed Facility (e.g. Residential Care Facility)     Other Congregate Living
- ICF/DD-H     Homeless/Temporary Shelter     Other (specify): \_\_\_\_\_

**Household Composition:**

- Alone     Relative (specify): \_\_\_\_\_     Non-relative (specify): \_\_\_\_\_

**SUPPORT SERVICES (IN ADDITION TO CBAS)**

- Not Known     None
- IHSS (In Home Supportive Services) (Number of Hours/Month: \_\_\_\_\_)
- Care Management Program -  MSSP     Regional Center Services     Other (specify): \_\_\_\_\_



**PARTICIPANT NAME:** \_\_\_\_\_ **CIN:** \_\_\_\_\_

**DATES OF SERVICE:** \_\_\_\_\_ **TO** \_\_\_\_\_

- Veterans Administration Services: \_\_\_\_\_
- Home Delivered Meals       Friendly Visitor/Senior Companion/Peer Counselor
- Telephone Reassurance     Transportation     Durable Medical Equipment     Representative Payee
- Conservatorship             Other (specify): \_\_\_\_\_

**(10) OTHER HEALTH SERVICES (if known)**

**WITHIN THE PAST 6 MONTHS**

- None
- Not Known
- Emergency Department Visit(s)
  - # visits: \_\_\_\_\_
  - Explain: \_\_\_\_\_
- Medical Hospitalization(s)
  - # times admitted: \_\_\_\_\_
  - Explain: \_\_\_\_\_
- Psychiatric Hospitalization(s)
  - # times admitted: \_\_\_\_\_
  - Explain: \_\_\_\_\_
- Nursing Facility
  - Explain: \_\_\_\_\_
- Home Health Services
  - Currently receiving
  - Explain: \_\_\_\_\_
- Hospice Care
  - Currently receiving
  - Explain: \_\_\_\_\_
- Mental Health Outpatient Services.
  - Currently receiving
  - Explain: \_\_\_\_\_



**PARTICIPANT NAME:** \_\_\_\_\_ **CIN:** \_\_\_\_\_

**DATES OF SERVICE:** \_\_\_\_\_ **TO** \_\_\_\_\_

**(11) RISK FACTORS** (check all that apply at time of IPC completion)

**INTERNAL/CLINICAL RISK FACTORS**

- None
- Mental Illness
- Substance Use/Abuse
- Multimorbidity (2+ chronic conditions)
- Cognitive Impairment
- Polypharmacy (6+)
- Medication Mismanagement
- ADL Functional Limitations (3+)
- High Fall Risk
- Chronic Pain
- Frailty
- Wandering/Exit-Seeking Behavior
- Other (specify): \_\_\_\_\_

**EXTERNAL RISK FACTORS/SOCIAL DETERMINANTS OF HEALTH**

- None
- Lives Alone
  - At Risk When Home Alone
- Limited or No Social Supports/Family
- Caregiver Inconsistency
- Caregiver Stress/Depression
- IHSS Inconsistency
- Social Isolation/Loneliness
- Elder Abuse/Neglect
- Emergency Department (ED) visit within 30 days
- Hospitalization (unplanned) within 60 days
- Unstable or Unsafe Housing
- Homeless/history of homelessness
- Financial Insecurity/Poverty/Lack of Resources
- Food Insecurity
- Lack of Transportation to Medical Visits
- Limited Health Literacy
- Language/Communication Barriers
- Other (specify): \_\_\_\_\_



**PARTICIPANT NAME:** \_\_\_\_\_ **CIN:** \_\_\_\_\_

**DATES OF SERVICE:** \_\_\_\_\_ **TO** \_\_\_\_\_

**Part  
2**

**(12) GOALS/DESIRED OUTCOMES IDENTIFIED BY PARTICIPANT OR AUTHORIZED REPRESENTATIVE DURING ASSESSMENT PROCESS (as expressed by the participant)**

1. \_\_\_\_\_

Participant expressed his/her goals/desired outcomes during the following assessment(s):  
 NUR    SS    ACT    PT    OT    SPEECH    RD    MH

2. \_\_\_\_\_

Participant expressed his/her goals/desired outcomes during the following assessment(s):  
 NUR    SS    ACT    PT    OT    SPEECH    RD    MH

3. \_\_\_\_\_

Participant expressed his/her goals/desired outcomes during the following assessment(s):  
 NUR    SS    ACT    PT    OT    SPEECH    RD    MH

4. \_\_\_\_\_

Participant expressed his/her goals/desired outcomes during the following assessment(s):  
 NUR    SS    ACT    PT    OT    SPEECH    RD    MH

5. \_\_\_\_\_

Participant expressed his/her goals/desired outcomes during the following assessment(s):  
 NUR    SS    ACT    PT    OT    SPEECH    RD    MH

MDT has reviewed the participant goals/desired outcomes above and has addressed them in this care plan in Boxes 13 and 14 as appropriate.

Additional Information: Use space to include any additional explanations about participant goals/desired outcomes. Include the participant's strengths and abilities to address their goals/desired outcomes.



**PARTICIPANT NAME:** \_\_\_\_\_ **CIN:** \_\_\_\_\_

**DATES OF SERVICE:** \_\_\_\_\_ **TO** \_\_\_\_\_

**(13) CORE SERVICES**

**PROFESSIONAL NURSING**

**Nursing care plan addresses Box 12 #** \_\_\_\_\_ **N/A**

1. Need / Problem

[Redacted area for Need / Problem]

Treatment(s) / Intervention(s)

Frequency

Goal(s)

2. Need / Problem (Identified by Discipline):

[Redacted area for Need / Problem (Identified by Discipline)]

Treatment(s) / Intervention(s)

Frequency

Goal(s)

3. Need / Problem (Identified by Discipline):

[Redacted area for Need / Problem (Identified by Discipline)]

Treatment(s) / Intervention(s)

Frequency

Goal(s)



**PARTICIPANT NAME:** \_\_\_\_\_ **CIN:** \_\_\_\_\_

**DATES OF SERVICE:** \_\_\_\_\_ **TO** \_\_\_\_\_

**PROFESSIONAL NURSING**

4. Need / Problem (Identified by Discipline):

Treatment(s) / Intervention(s)	Frequency	Goal(s)

5. Need / Problem (Identified by Discipline):

Treatment(s) / Intervention(s)	Frequency	Goal(s)

6. Need / Problem (Identified by Discipline):

Treatment(s) / Intervention(s)	Frequency	Goal(s)



**PARTICIPANT NAME:** \_\_\_\_\_ **CIN:** \_\_\_\_\_

**DATES OF SERVICE:** \_\_\_\_\_ **TO** \_\_\_\_\_

**PERSONAL CARE SERVICES**

**Personal Care Services care plan addresses Box 12 #** \_\_\_\_\_ **N/A**

1. Need / Problem (Identified by Discipline):

[Greyed-out area for text entry]

Treatment(s) / Intervention(s)

Frequency

Goal(s)

**SOCIAL SERVICES**

**Social Services care plan addresses Box 12 #** \_\_\_\_\_ **N/A**

1. Need / Problem (Identified by Discipline):

[Greyed-out area for text entry]

Treatment(s) / Intervention(s)

Frequency

Goal(s)



**PARTICIPANT NAME:** \_\_\_\_\_ **CIN:** \_\_\_\_\_

**DATES OF SERVICE:** \_\_\_\_\_ **TO** \_\_\_\_\_

**THERAPEUTIC ACTIVITIES**

Therapeutic Activities care plan addresses Box 12 # \_\_\_\_\_ N/A

1. Need / Problem (Identified by Discipline):

\_\_\_\_\_

Treatment(s) / Intervention(s)

Frequency

Goal(s)

2. Need / Problem (Identified by Discipline):

\_\_\_\_\_

Treatment(s) / Intervention(s)

Frequency

Goal(s)



**PARTICIPANT NAME:** \_\_\_\_\_ **CIN:** \_\_\_\_\_

**DATES OF SERVICE:** \_\_\_\_\_ **TO** \_\_\_\_\_

**PHYSICAL THERAPY MAINTENANCE PROGRAM**

**PT Maintenance Program care plan addresses Box 12 #** \_\_\_\_\_ **N/A**

1. Need / Problem (Identified by Discipline):

[Greyed-out area for text entry]

Treatment(s) / Intervention(s)

Frequency

Goal(s)

**OCCUPATIONAL THERAPY MAINTENANCE PROGRAM**

**OT Maintenance Program care plan addresses Box 12 #** \_\_\_\_\_ **N/A**

1. Need / Problem (Identified by Discipline):

[Greyed-out area for text entry]

Treatment(s) / Intervention(s)

Frequency

Goal(s)



**PARTICIPANT NAME:** \_\_\_\_\_ **CIN:** \_\_\_\_\_

**DATES OF SERVICE:** \_\_\_\_\_ **TO** \_\_\_\_\_

**(14) ADDITIONAL SERVICES**

**PHYSICAL THERAPY**

**Physical Therapy care plan addresses Box 12 #** \_\_\_\_\_ **N/A**

1. Need / Problem (Identified by Discipline):

\_\_\_\_\_

Treatment(s) / Intervention(s)	Frequency	Goal(s)
_____		

**OCCUPATIONAL THERAPY**

**Occupational Therapy care plan addresses Box 12 #** \_\_\_\_\_ **N/A**

1. Need / Problem (Identified by Discipline):

\_\_\_\_\_

Treatment(s) / Intervention(s)	Frequency	Goal(s)
_____		



**PARTICIPANT NAME:** \_\_\_\_\_ **CIN:** \_\_\_\_\_

**DATES OF SERVICE:** \_\_\_\_\_ **TO** \_\_\_\_\_

**SPEECH AND LANGUAGE PATHOLOGY SERVICES**

**Speech/Language Pathology Services care plan addresses Box 12 #** \_\_\_\_\_ **N/A**

1. Need / Problem (Identified by Discipline):

[Greyed-out area for text entry]

Treatment(s) / Intervention(s)

Frequency

Goal(s)

**REGISTERED DIETICIAN SERVICES**

**Registered Dietician Services care plan addresses Box 12 #** \_\_\_\_\_ **N/A**

1. Need / Problem (Identified by Discipline):

[Greyed-out area for text entry]

Treatment(s) / Intervention(s)

Frequency

Goal(s)

**MENTAL HEALTH SERVICES**

**Mental Health Services care plan addresses Box 12 #** \_\_\_\_\_ **N/A**

1. Need / Problem (Identified by Discipline):

[Greyed-out area for text entry]

Treatment(s) / Intervention(s)

Frequency

Goal(s)



**PARTICIPANT NAME:** \_\_\_\_\_ **CIN:** \_\_\_\_\_

**DATES OF SERVICE:** \_\_\_\_\_ **TO** \_\_\_\_\_

**(15) CHANGES SINCE PREVIOUS IPC (For reauthorization TARs only, include significant changes in participant's condition and/or care plan since last IPC)**

**(16) ADDITIONAL INFORMATION (Include critical history/information not included elsewhere in this IPC and relevant to the authorization of this TAR.)**

DRAFT



**PARTICIPANT NAME:** \_\_\_\_\_ **CIN:** \_\_\_\_\_

**DATES OF SERVICE:** \_\_\_\_\_ **TO** \_\_\_\_\_

**(17) SIGNATURES OF MULTIDISCIPLINARY TEAM AND PROGRAM DIRECTOR**

**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 the information contained in this IPC is the result of an MDT person-centered planning process and is documented in the center records. Services scheduled on this IPC, and their outcomes, will be provided or otherwise noted in the participant's health record.

PRINTED NAME	SIGNATURE	DATE OF SIGNATURE
	Program Director	