

COMMUNITY-BASED ADULT SERVICES
INDIVIDUAL PLAN OF CARE (IPC)

Participant Name: _____

TAR Control Number (TCN): _____

Center Name: _____

Provider Number (NPI): _____

Dates of Service (DOS): From: _____ To: _____

NOTE: Definitions of all key words in this IPC can be found in the Medi-Cal Inpatient/Outpatient Provider Manual.

(1) Check box that applies to this IPC: Initial TAR Reauthorization TAR Change TAR
 (#) _____ Planned Days/Week TB Clearance Date (initial TAR only): _____
 The signature page of the *History and Physical* form accompanies this IPC and documents the request for CBAS services (initial TARs only). Yes No NA

Comment [PD1]: Consider adding: Participant CIN; Payor; Managed Care Plan Name

Comment [PD2]: Consider naming this box – Treatment Authorization and Eligibility and including information from Boxes 5-9 and Box 20

Comment [PD3]: For discussion: Policy never implemented. Per statute, State would develop with CAADS. We never agreed on form. Do we want to begin this effort to standardize again and incorporate as part of Quality Strategy?

Comment [PD4]: Consider documenting changes from last IPC and auth period to this IPC

(2) DIAGNOSES AND ICD CODES			
Primary Diagnoses Include diagnoses as provided or confirmed by the personal health care provider(s)	ICD Code	Secondary Diagnoses Include diagnoses as provided or confirmed by the personal health care provider(s)	ICD Code
1		1 Is there a value to distinguishing	
2		2 between primary and secondary dx?	
3		3	
4		4	
5		5	
6		6	

(3) MEDICATIONS (frequency and dosage not required)	Active Prescriptions	
	1	12
2	13	
3	14	
4	15	
5	16	
No Medications or Supplements O	Over-The-Counter Medications &/or Supplements	
	6	1
	7	2
	8	3
	9	4
	10	5
	11	6

(4) Active Personal Medical/Mental Health Care Provider(s) (Is this useful to MCOs?)	Name	Address	Phone

Comment [BL5]: Consider identifying if Primary Care Physician, Psychiatrist, Cardiologist, etc.

COMMUNITY-BASED ADULT SERVICES
INDIVIDUAL PLAN OF CARE (IPC)

Participant Name: _____

TAR Control Number (TCN): _____

Center Name: _____

Provider Number (NPI): _____

Dates of Service (DOS): From: _____ To: _____

Criteria Verification

- ~~All boxes checked must be supported by appropriate documentation in the participant's health record.~~
- ~~All information presented must be based on multidisciplinary team assessments completed at the center.~~
- ~~All participants must meet the eligibility and medical necessity criteria specified in Box 5, item number 2, in addition to meeting the specified criteria of any one or more of the following CBAS categories A through E.~~

Formatted: Strikethrough

(5) Category A: For those individuals who meet Nursing Facility-A (NF-A) Level of Care (LOC):

Formatted: Strikethrough

Participant Does
~~NOT~~ Fall Within
Category A

➤ Check box if the participant does NOT fall within Category A.

➤ Check the boxes next to the criteria indicating the participant meets the stated criteria.

Formatted: Strikethrough

Formatted: Strikethrough

Formatted: Strikethrough

Formatted: Strikethrough

1. Has been determined to meet the NF-A LOC or above; **AND**
2. Meets the following eligibility and medical necessity criteria:

- a. 18 years of age or older and has one or more chronic or post-acute medical, cognitive, or mental health conditions, and a physician, nurse practitioner, or other health care provider has, within his or her scope of practice, requested CBAS services.

- b. The person requires ongoing or intermittent protective supervision, skilled observation, assessment, or intervention by a skilled health or mental health professional to improve, stabilize, maintain, or minimize deterioration of the medical, cognitive, or mental health condition.

- c. The person requires CBAS services, as defined in W&I Code, Section 14550 (BOXES 19 through 22), that are individualized and planned, including, when necessary, the coordination of formal and informal services outside of the CBAS program to support the individual and his or her family or caregiver in the living arrangement of his or her choice and to avoid or delay the use of institutional services, including, but not limited to, hospital emergency department services, inpatient acute care hospital services, inpatient mental health services, or placement in a nursing facility or a nursing or intermediate care facility for the developmentally disabled providing continuous nursing care.

- d. If a resident of an ICF/DD-H, the resident has disabilities and a level of functioning that are of such a nature that, without supplemental intervention through CBAS, placement to a more costly institutional level of care would be likely to occur.

- e. Except for participants residing in an ICF/DD-H, the person must meet all of the following:
 - i. The participant has one or more chronic or post-acute medical, cognitive, or mental health conditions that are identified by the participant's personal health care provider as requiring one or more of the following, without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization, or other institutionalization:
 - Monitoring,
 - Treatment or
 - Intervention.

- Monitoring,
- Treatment or
- Intervention.

- ii. The participant's network of non-CBAS center supports is insufficient to maintain the individual in the community, demonstrated by a least one of the following:
 - The participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision.

- The participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant.

- The participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant.

- iii. A high potential exists for the deterioration of the participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if CBAS services are not provided.

- iv. The participant's condition or conditions require CBAS services, on each day of attendance that are individualized and designed to maintain the ability of the participant to remain in the community and avoid emergency department visits, hospitalizations, or other institutionalization.

Participant Name: _____

TAR Control Number (TCN): _____

Center Name: _____

Provider Number (NPI): _____

Dates of Service (DOS): From: _____ To: _____

(6) CATEGORY B: For individuals who have an organic, acquired or traumatic brain injury and/or chronic mental illness:

<input type="checkbox"/> Participant Does NOT Fall Within Category B	<input type="checkbox"/> Check box if the participant does NOT fall within Category B. <input type="checkbox"/> Check the boxes next to the criteria indicating the participant meets the stated criteria.
<input type="checkbox"/>	1. Has been diagnosed by a physician as having an organic, acquired or traumatic brain injury, and/or has a chronic mental illness; AND
<input type="checkbox"/>	2. Meets CBAS eligibility and medical necessity criteria specified above in BOX 5, NUMBER 2; AND
<input type="checkbox"/>	3. The individual must demonstrate a need for assistance or supervision with at least: a. Two of the following activities of daily living (ADLs)/instrumental activities of daily living (IADLs): bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management and hygiene; OR b. One ADL/IADL listed above, and one of the following: money management, accessing resources, meal preparation, or transportation.

Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough

(7) CATEGORY C: For individuals with Alzheimer's Disease or other dementia:

<input type="checkbox"/> Participant Does NOT Fall Within Category C	<input type="checkbox"/> Check box if the participant does NOT fall within Category C. <input type="checkbox"/> Check the boxes next to the criteria indicating the participant meets the stated criteria.
<input type="checkbox"/>	1. Individuals have moderate to severe Alzheimer's Disease or other dementia, characterized by the descriptors of, or equivalent to, Stages 5, 6, or 7 Alzheimer's Disease; AND <ul style="list-style-type: none">Stage 5: Moderately severe cognitive decline. Major gaps in memory and deficits in cognitive function emerge. Some assistance with day to day activities becomes essential.Stage 6: Severe cognitive decline. Memory difficulties continue to worsen, significant personality changes may emerge, and affected individuals need extensive help with daily activities.Stage 7: Very severe cognitive decline. This is the final stage of the disease when individuals lose the ability to respond to their environment, the ability to speak, and, ultimately, the ability to control movement.
<input type="checkbox"/>	2. Meets CBAS eligibility and medical necessity criteria specified above in BOX 5, NUMBER 2.

Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough

(8) CATEGORY D: For individuals with mild cognitive impairment including moderate Alzheimer's Disease or other dementia:

<input type="checkbox"/> Participant Does NOT Fall Within Category D	<input type="checkbox"/> Check box if the participant does NOT fall within Category D. <input type="checkbox"/> Check the boxes next to the criteria indicating the participant meets the stated criteria.
<input type="checkbox"/>	1. Individuals have mild cognitive impairment or moderate Alzheimer's disease or other dementia, characterized by the descriptors of, or equivalent to, Stage 4 Alzheimer's Disease, defined as mild or early stage Alzheimer's disease, characterized by one or more of the following; AND : <ul style="list-style-type: none">Decreased knowledge of recent events;Impaired ability to perform challenging mental arithmetic;Decreased capacity to perform complex tasks;Reduced memory of personal history;The affected individual may seem subdued and withdrawn, especially in socially or mentally challenging situations.
<input type="checkbox"/>	2. Meets CBAS eligibility and medical necessity criteria specified above in BOX 5, NUMBER 2; AND
<input type="checkbox"/>	3. The individual must demonstrate a need for assistance or supervision with two of the following ADLs/IADLs: bathing, dressing, self-feeding, toileting, ambulation, transferring, medication management, and hygiene.

Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough

COMMUNITY-BASED ADULT SERVICES
INDIVIDUAL PLAN OF CARE (IPC)

Participant Name: _____

TAR Control Number (TCN): _____

Center Name: _____

Provider Number (NPI): _____

Dates of Service (DOS): From: _____ To: _____

(9) CATEGORY E: For individuals who have developmental disabilities:

Participant Does NOT Fall Within Category E <input type="checkbox"/>	<input type="checkbox"/> Check box if the participant does NOT fall within Category E.
	<input type="checkbox"/> Check the boxes next to the criteria indicating the participant meets the stated criteria.
<input type="checkbox"/>	1. Meets the criteria for regional center eligibility; AND
<input type="checkbox"/>	2. Meets CBAS eligibility and medical necessity criteria specified above in BOX 5, NUMBER 2.

Formatted: Strikethrough

Formatted: Strikethrough

Formatted: Strikethrough

Formatted: Strikethrough

(11) ADL/IADL LIMITATIONS (Check only one box per row):

	Independent (able to perform for self with or without device)	Needs Supervision (no physical help required but needs cueing or to be monitored, even with device)	Needs Assistance (physical help required, even with device)	Dependent (unable to do for self, even with physical help, cueing or device)
ADLs				
Amputation	<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				
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"/>

Comment [BL6]: Box 10 . Recommend that mental health information is included in Box 15

Comment [BL7]: Consider changing title to "ADL/IADL Status" (more positive than "Limitations")

Comment [BL8]: Discuss definitions and how they align with functional assessment screening tools

COMMUNITY-BASED ADULT SERVICES
INDIVIDUAL PLAN OF CARE (IPC)

Participant Name: _____

TAR Control Number (TCN): _____

Center Name: _____

Provider Number (NPI): _____

Dates of Service (DOS): From: _____ To: _____

(12) CURRENT ASSISTIVE/ADAPTIVE DEVICES (Check all that apply):			
<input type="checkbox"/>	None	<input type="checkbox"/>	AAC Device
<input type="checkbox"/>	Wheelchair	<input type="checkbox"/>	Orthosis/Prosthesis
<input type="checkbox"/>	Walker	<input type="checkbox"/>	Gait Belt
<input type="checkbox"/>	Crutches	<input type="checkbox"/>	Hoyer Lift
<input type="checkbox"/>	Cane	<input type="checkbox"/>	Hearing Device
<input type="checkbox"/>		<input type="checkbox"/>	Glasses or Other Vision Aid
<input type="checkbox"/>		<input type="checkbox"/>	Dentures
<input type="checkbox"/>		<input type="checkbox"/>	Respiratory Equipment (specify): _____
<input type="checkbox"/>		<input type="checkbox"/>	Other (specify): _____
(13) CONTINENCE INFORMATION (Check all that apply):			
<input type="checkbox"/>	None		
<input type="checkbox"/>	Incontinent of bladder:	<input type="checkbox"/>	Occasionally
		<input type="checkbox"/>	Frequently
		<input type="checkbox"/>	Always
<input type="checkbox"/>	Incontinent of bowel:	<input type="checkbox"/>	Occasionally
		<input type="checkbox"/>	Frequently
		<input type="checkbox"/>	Always
<input type="checkbox"/>	External/internal catheter		
<input type="checkbox"/>	Ostomy		
<input type="checkbox"/>	Other (specify): _____		
(14) FEEDING NUTRITIONAL INFORMATION (Check all that apply):			
<input type="checkbox"/>	None	<input type="checkbox"/>	Underweight
		<input type="checkbox"/>	Overweight
		<input type="checkbox"/>	Obese
		<input type="checkbox"/>	BMI _____ (If known)
		<input type="checkbox"/>	Feeding tube
<input type="checkbox"/>	Therapeutic/special diet		
<input type="checkbox"/>	Difficulty chewing and/or swallowing		
<input type="checkbox"/>	Cannot feed self		
<input type="checkbox"/>	Other (specify): _____		
(15) OTHER LONG TERM SUPPORT SERVICES (if known). Check all that apply:			
SUPPORT SERVICE		DESCRIBE how or why the support service is insufficient	
<input type="checkbox"/>	Not Known	Explain: _____	
<input type="checkbox"/>	NONE	-----	
<input type="checkbox"/>	IHSS/PCSP Services	Hours authorized per week/month: _____	
<input type="checkbox"/>	MSSP		
LIVING ARRANGEMENT			
<input type="checkbox"/>	ICF/DD-H	Explain: _____	
<input type="checkbox"/>	Lives in a Community Care Licensed Facility (e.g. Residential Care Facility)	Explain: _____	
<input type="checkbox"/>	Other Congregate Living		
<input type="checkbox"/>	Lives alone		

Comment [BL9]: Consider adding "Assistive Communication Devices"

Comment [BL10]: Recommend defining frequency terms with objective measures, e.g., define "occasionally" as having a certain # of episodes per day or week.

Comment [BL11]: Consider specifying participant's weight at time of IPC and the amount of weight lost/gained within specific time period.

Comment [BL12]: Recommend including additional services such as Mental/Behavioral Health Services (provided by the Managed Care Plan, County Behavioral Health), Paid Caregivers (other than IHSS), Home Delivered Meals, Friendly Visitor, Care Management (managed care plan, behavioral health, aging services providers, other), Transportation, Durable Medical Equipment.

Recommend determining/documenting if participant needs to be referred to these services in addition to documenting if the participant uses these services and if insufficient.

Comment [BL13]: Recommend identifying if lives with spouse/family (household composition)

COMMUNITY-BASED ADULT SERVICES
INDIVIDUAL PLAN OF CARE (IPC)

Participant Name: _____ TAR Control Number (TCN): _____
 Center Name: _____ Provider Number (NPI): _____
 Dates of Service (DOS): From: _____ To: _____

(16) NON-CBAS-CENTER HEALTH SUPPORT/SERVICES (if known). Within the past 6 months ...Check all that apply:

>>>Is the participant currently receiving Home Health Agency Services? Yes No
 Hospice Care? Yes No
 Explain: _____

>>>Is the participant currently receiving Hospice Services? Yes No
 If the participant is currently receiving either home health agency or hospice services, please specify:

Service	Frequency
_____	_____
_____	_____
_____	_____
_____	_____

Urgent Care. Explain: _____

Mental Health Services. Explain: _____ Hospitalization Yes N # times admitted _____ #
 times admitted within 30-days for same condition _____

Emergency Department Visit(s)- Explain#: _____

Nursing Facility. Explain: _____

Other Health Services. Explain: _____

Comment [BL14]: Consider providing reason for utilization if known

Comment [BL15]: Recommend distinguishing between medical and psychiatric hospitalization

(17) RISK FACTORS (check all conditions that are demonstrated at the time of IPC completion)

- | | |
|---|---|
| <input type="checkbox"/> Inappropriate Affect, Appearance or Behavior | <input type="checkbox"/> Dementia Related Behavioral Problems |
| <input type="checkbox"/> Poor Judgment | <input type="checkbox"/> Assessed Fall Risk |
| <input type="checkbox"/> Medication Mismanagement | <input type="checkbox"/> Self-isolates |
| <input type="checkbox"/> Lives alone | |
| <input type="checkbox"/> Self Neglect | <input type="checkbox"/> Frailty |
| <input type="checkbox"/> APS referral | <input type="checkbox"/> Clinical Depression |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Inconsistent IHSS |
| <input type="checkbox"/> 6+ Medications | |
| <input type="checkbox"/> Two or More Chronic Conditions | <input type="checkbox"/> Other (specify): _____ |

Comment [BL16]: Perhaps categorize risk factors as "Internal" and "External."

Internal would include certain Medical Conditions/Diagnoses such as Diabetes, Congestive Heart Failure, Hypertension, Chronic Obstructive Pulmonary Disease, Dementia/Cognitive Impairment, Poor Judgment; Malnutrition, Obesity, Chronic Pain; Mental Disorder/Substance Use; Multimorbidity (2+ chronic conditions); Medications such as psychotropics, anxiolytics, pain meds; Polypharmacy (6+); Fall Risk; Self-neglect.

External would include social determinants such as living alone, limited or no social supports, unstable housing/homeless, poverty, food insecurity, elder abuse/neglect, lack of transportation to medical appointments, language barrier, caregiver inconsistency, stress, depression. Additional risk factors are ED visit within past 30 days and prior unplanned hospitalization in past 60 days.

There are validated risk assessment screening tools for ED use and at time of hospital discharge.

COMMUNITY-BASED ADULT SERVICES
INDIVIDUAL PLAN OF CARE (IPC)

Participant Name: _____

TAR Control Number (TCN): _____

Center Name: _____

Provider Number (NPI): _____

Dates of Service (DOS): From: _____ To: _____

(18) AT RISK FOR ADMISSION TO ACUTE OR INSTITUTIONAL CARE (if known). Check all that apply:

Within the last 6 months, the participant was admitted to the following level(s) of acute or institutional care:

Not Known. Explain: _____

None.

Acute Care Hospital. Explain: _____

Nursing Facility. Explain: _____

ICF/DD or ICF/DD-N. Explain: _____

Other. Explain: _____

Last Known Discharge Date from an Acute or Institutional Level of Care: _____

(19) CBAS Core Services — all of these services are required each day of attendance: check yes/no box in the left handed column for each service listed.

Yes — No
 —

A. Professional Nursing Services

One or more of the following professional nursing services on each day of attendance:

N1 Observation, assessment, and monitoring of the participant's general health status and changes in his/her condition, risk factors, and the participant's specific medical, cognitive, or mental health condition or conditions upon which admission to the CBAS center was based.

N2 Monitoring and assessment of the participant's medication regimen, administration and recording of the participant's prescribed medication, and intervention, as needed, based upon the assessment and participant's reactions to his/her medications.

N3 Oral or written communication with the participant's personal health care provider, other qualified health care or social service provider, or the participant's family or other caregiver, regarding changes in the participant's condition, signs or symptoms.

N4 Supervision of the provision of personal care services for the participant, and assistance, as needed.

N5 Provision of skilled nursing care and intervention, within scope of practice, to participants, as needed, based upon an assessment of the participant, his/her ability to provide self care while at the CBAS center, and any health care provider orders.

Formatted: Strikethrough

Comment [LM17]: These could be moved to be an Appendix for reference only.

Formatted: Strikethrough

Formatted: Strikethrough

Formatted: Strikethrough

Formatted: Strikethrough

Formatted: Strikethrough

COMMUNITY-BASED ADULT SERVICES
INDIVIDUAL PLAN OF CARE (IPC)

Participant Name: _____

TAR Control Number (TCN): _____

Center Name: _____

Provider Number (NPI): _____

Dates of Service (DOS): From: _____ To: _____

Yes	No	B. Personal Care Services/Social Services
<input type="checkbox"/>	<input type="checkbox"/>	<p>One or both of the following core <u>personal care services</u> or <u>social services</u> on each day of attendance:</p> <p>P1 <u>One or both of the following personal care services:</u></p> <p style="padding-left: 20px;">P1a <u>Supervision of, or assistance with, ADLs or IADLs.</u></p> <p style="padding-left: 20px;">P1b <u>Protective group supervision and interventions to assure participant safety and to minimize the risk of injury, accident, inappropriate behavior, or wandering.</u></p> <p>P2 <u>One or more of the following social services provided by the CBAS center social worker or social worker assistant:</u></p> <p style="padding-left: 20px;">P2a <u>Observation, assessment, and monitoring of the participant's psychosocial status.</u></p> <p style="padding-left: 20px;">P2b <u>Group work to address psychosocial issues.</u></p> <p style="padding-left: 20px;">P2c <u>Care coordination.</u></p>
Yes	No	C. Therapeutic Activities
<input type="checkbox"/>	<input type="checkbox"/>	<p>One or both of the following <u>therapeutic activities</u> provided by the CBAS center activity coordinator or other trained CBAS center personnel on each day of attendance:</p> <p>A1 <u>Group or individual activities to enhance the social, physical, or cognitive functioning of the participant.</u></p> <p>A2 <u>Facilitated participation in group or individual activities for those participants whose frailty or cognitive functioning level precludes them from active participation in scheduled activities.</u></p>
Yes	No	D. Meal Service
<input type="checkbox"/>	<input type="checkbox"/>	M <u>At least one meal offered per day.</u>

Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough

Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough

Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough
Formatted: Strikethrough

(20) TAR FOR REAUTHORIZATION OF CBAS SERVICES		
Yes	No	NA
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<p>If this is a reauthorization TAR, the participant's condition would likely deteriorate if the CBAS services were <u>denied/terminated</u></p> <p>If this is a reauthorization TAR, the participant's condition would likely deteriorate if the CBAS <u>frequency of services were changed</u></p>		

Comment [PD18]: Consider moving to Box 1 and/or combining with eligibility criteria wherever they end up.

Comment [BL19]: Consider the following additional information /categories in IPC: Demographic, Cultural, Religious, Legal Status (conservator), Advanced Directives, Psycho-Social, Socio-Economic, Caregiver Status, etc.

Comment [PD20]: Consider participant statement of need, preferences and choices that precedes Box 21. E.g., overarching goals like being able to dress oneself to what they prefer to do at the center.

COMMUNITY-BASED ADULT SERVICES
INDIVIDUAL PLAN OF CARE (IPC)

Participant Name: _____

TAR Control Number (TCN): _____

Center Name: _____

Provider Number (NPI): _____

Dates of Service (DOS): From: _____ To: _____

(21) Participant's Individual Plan of Care (Core Services) (must be consistent with information provided in this IPC)

Comment [PD21]: Consider incorporating progress achieved on previous TAR period goals for each discipline or goal area.

CBAS CORE SERVICES (Box 21)	Participant Problem (must include a <u>measurable</u> starting point)	Treatments/ Interventions (Include whether individual and/or group intervention, and any out-of-center activities)	Frequency of Treatment/ Intervention (e.g., 2x per week)	Discipline Specific Objective/Goal of Treatment/ Intervention (must include <u>measurable</u> objectives/goals)
Professional Nursing Services	Participant's Personal Goal Discipline Specific Statement			

COMMUNITY-BASED ADULT SERVICES
INDIVIDUAL PLAN OF CARE (IPC)

Participant Name: _____

TAR Control Number (TCN): _____

Center Name: _____

Provider Number (NPI): _____

Dates of Service (DOS): From: _____ To: _____

(21) Participant's Individual Plan of Care (Core Services) (must be consistent with information provided in this IPC)

CBAS CORE SERVICES (Box 21)	Participant Problem (must include a <u>measurable</u> starting point)	Treatments/ Interventions (Include whether individual and/or group intervention, and any out-of-center activities)	Frequency of Treatment/ Intervention (e.g., 2x per week)	Discipline Specific Objective/Goal of Treatment/ Intervention (must include <u>measurable</u> objectives/goals)
Personal Care Services	Participant's Personal Goal Discipline Specific Statement			
Social Services	Participant's Personal Goal Discipline Specific Statement			

COMMUNITY-BASED ADULT SERVICES
INDIVIDUAL PLAN OF CARE (IPC)

Participant Name: _____

TAR Control Number (TCN): _____

Center Name: _____

Provider Number (NPI): _____

Dates of Service (DOS): From: _____ To: _____

(21) Participant's Individual Plan of Care (Core Services) (must be consistent with information provided in this IPC)

CBAS CORE SERVICES (Box 21)	Participant Problem (must include a measurable starting point)	Treatments/ Interventions (Include whether individual and/or group intervention, and any out-of-center activities)	Frequency of Treatment/ Intervention (e.g., 2x per week)	Discipline Specific Objective/Goal of Treatment/ Intervention (must include measurable objectives/goals)
Therapeutic Activities	Participant's Personal Goal Discipline Specific Statement			
Physical Therapy Maintenance Program	Participant's Personal Goal Discipline Specific Statement			
Occupational Therapy Maintenance Program	Participant's Personal Goal Discipline Specific Statement			
Nutrition/Diet <input type="checkbox"/> Regular Diet <input type="checkbox"/> Special Diet Specify: _____ <input type="checkbox"/> NPO (may receive NG, GT or IV feedings at home)	Participant's Personal Goal Discipline Specific Statement			

COMMUNITY-BASED ADULT SERVICES
INDIVIDUAL PLAN OF CARE (IPC)

Participant Name: _____

TAR Control Number (TCN): _____

Center Name: _____

Provider Number (NPI): _____

Dates of Service (DOS): From: _____ To: _____

(22) Participant's Individual Plan of Care (Additional Services) (must be consistent with information provided in this IPC)

CBAS ADDITIONAL SERVICES (Box 22)	Participant Problem (must include a <u>measurable</u> starting point)	Treatments/ Interventions (Include amount [e.g., 15 minutes] of intervention, the duration of intervention [e.g., for 2 weeks], whether individual and/or group intervention, and any out-of-center activities)	Frequency of Treatment/ Intervention (e.g., 2x per week)	Discipline Specific Objective/Goal of Treatment/ Intervention (must include <u>measurable</u> objectives/goals)
Physical Therapy				
Occupational Therapy				

State of California
 Health and Human Services Agency
 Participant Name: _____

**COMMUNITY-BASED ADULT SERVICES
 INDIVIDUAL PLAN OF CARE (IPC)**

Department of Health Care Services

TAR Control Number (TCN): _____

Center Name: _____

Provider Number (NPI): _____

Dates of Service (DOS): From: _____ To: _____

(22) Participant's Individual Plan of Care (Additional Services) (must be consistent with information provided in this IPC)

CBAS ADDITIONAL SERVICES (Box 22)	Participant Problem (must include a <u>measurable</u> starting point)	Treatments/ Interventions (Include amount [e.g., 15 minutes] of intervention, the duration of intervention [e.g., for 2 weeks], whether individual and/or group intervention, and any out-of-center activities)	Frequency of Treatment/ Intervention (e.g., 2x per week)	Discipline Specific Objective/Goal of Treatment/ Intervention (must include <u>measurable</u> objectives/goals)
Speech and Language Pathology Services				
Registered Dietitian Services				
Mental Health Services				
Other (please specify)				

COMMUNITY-BASED ADULT SERVICES
INDIVIDUAL PLAN OF CARE (IPC)

Participant Name: _____

TAR Control Number (TCN): _____

Center Name: _____

Provider Number (NPI): _____

Dates of Service (DOS): From: _____ To: _____

(23) Text Box for Additional Information (Optional)

**This text box is available for the CBAS Center's use in providing information not explained elsewhere in this IPC that is relevant to the authorization of this TAR.
Please do not repeat information previously explained.**

Please Reference Box Number Being Discussed.

DRAFT

COMMUNITY-BASED ADULT SERVICES
INDIVIDUAL PLAN OF CARE (IPC)

Participant Name: _____ TAR Control Number (TCN): _____
 Center Name: _____ Provider Number (NPI): _____
 Dates of Service (DOS): From: _____ To: _____

(24) 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 Signing
		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 Signing
By signing below, I certify that <u>all assessments have been completed</u> and that <u>the participant meets the CBAS eligibility and medical necessity criteria</u> as specified in this IPC, effective on this date**:_____.		
I further 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 Signing
	Program Director	

Comment [LM22]: It would expedite submission if the program director would suffice as attestation that all signaures are on file or in the process of being collected. This could be verified easily.

** The TAR will NOT be approved for CBAS services provided prior to this date.

Privacy Statement:
The information requested on this form is required by the Department of Health Care Services, for the purpose of adjudication of Treatment Authorization Requests (TARs) for Community-Based Adult Services (CBAS) services. Failure to provide this mandatory information may result in denial of the TAR for CBAS services.