STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
INDIVIDUAL PLAN OF CARE
DHCS 0020 (REV 07/2019)

COMMUNITY-BASED CBAS ADULT SERVICES

Center Name:	**Provider # (NPI):**
Participant Name:	
Date of Birth (MM/DD/YY):	CIN:
Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female	
Managed Care Plan Name:	
Dates of Service: From: _____ To: _____	Planned Days/Week (#_____)
TAR Control Number (TCN):	

(1) TREATMENT AUTHORIZATION REQUEST (TAR) AND ELIGIBILITY

☐ Initial TAR ☐ Reauthorization TAR ☐ Change TAR

TB Clearance Date (initial TAR only): _____

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

☐ The individual meets all CBAS eligibility and medical necessity criteria and one or more of the following CBAS medical criteria categories as set forth in the current Medi-Cal 1115(a) Demonstration Waiver, entitled California Medi-Cal 2020:

- ☐ **Category 1**: Nursing Facility Level A (NF-A) or above
- ☐ **Category 2**: Organic, acquired or traumatic brain injury and/or chronic mental disorder
- ☐ **Category 3**: Alzheimer's disease or other dementias at moderate to severe level
- ☐ **Category 4**: Mild cognitive impairment including Alzheimer's disease or other dementias
- ☐ **Category 5**: Individuals who have developmental disabilities

(2) DIAGNOSES AND ICD CODES

Diagnosis	ICD Code	Diagnosis	ICD Code
1.		**2.**	
3.		**4.**	
5.		**6.**	
7.		**8.**	
9.		**10.**	
11.		**12.**	
13.		**14.**	

COMMUNITY-BASED CBAS ADULT SERVICES

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

Diagnosis	ICD Code	Diagnosis	ICD Code
15.		**16.**	
17.		**18.**	
19.		**20.**	

(3) MEDICATIONS

☐ No medications or supplements

ACTIVE PRESCRIPTIONS		OVER-THE-COUNTER MEDICATION AND/OR SUPPLEMENTS
1.	**2.**	
3.	**4.**	
5.	**6.**	
7.	**8.**	**1.**
9.	**10.**	**2.**
11.	**12.**	**3.**
13.	**14.**	**4.**
15.	**16.**	**5.**
17.	**18.**	**6.**
19.	**20.**	**7.**
21.	**22.**	**8.**
23.	**24.**	**9.**
25.	**26.**	**10.**

Center administers participant's prescribed medication(s) ☐ Yes ☐ No
Participant self-administers prescribed medication(s) at center ☐ Yes ☐ No

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

NAME	PROVIDER SPECIALTY	ADDRESS	PHONE

COMMUNITY-BASED CBAS ADULT SERVICES

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

(5) ADL/IADLs

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	☐	☐	☐	☐
Bathing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Self-Feeding	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Transferring	☐	☐	☐	☐

IADLs	INDEPENDENT	NEEDS SUPERVISION	NEEDS ASSISTANCE	DEPENDENT
Accessing Resources	☐	☐	☐	☐
Hygiene	☐	☐	☐	☐
Meal Preparation	☐	☐	☐	☐
Medication Mgmt.	☐	☐	☐	☐
Money Mgmt.	☐	☐	☐	☐
Transportation	☐	☐	☐	☐

(6) CURRENT ASSISTIVE/ADAPTIVE DEVICES

☐ None

☐ Wheelchair ☐ Walker ☐ Gait Belt ☐ Crutches ☐ Hoyer Lift ☐ Cane

☐ Dentures ☐ Glasses or Other Vision Aids ☐ Orthosis/Prothesis

☐ Hearing Device ☐ Augmentative and Alternative Communication (AAC) Device

☐ Specialized Eating Equipment/Utensils

☐ Respiratory Equipment (specify): _____

☐ Other (specify): _____

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

(7) CONTINENCE INFORMATION

☐ Continent

☐ Incontinent of bladder: ☐ Occasionally ☐ Frequently ☐ Always

☐ Incontinent of bowel: ☐ Occasionally ☐ Frequently ☐ Always

☐ External/internal catheter ☐ Ostomy

☐ Other (specify): _____

(8) NUTRITIONAL INFORMATION

☐ Body Mass Index (BMI) _____ ☐ Underweight ☐ Normal ☐ Overweight ☐ Obese

☐ BMI Not Known ☐ Feeding tube ☐ Special/therapeutic diet (specify): _____

☐ Difficulty chewing and/or swallowing ☐ Needs dietary counseling and education

☐ 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): _____

This space intentionally left blank.

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

SUPPORT SERVICES (IN ADDITION TO CBAS)

☐ Not known ☐ None

☐ IHSS (In Home Supportive Services) (Number of Hours/Month: _____)

☐ Care Management Program: ☐ MSSP ☐ Regional Center

☐ Other (specify): _____

☐ Veterans Administration Services (specify): _____

☐ Home Delivered Meals ☐ Friendly Visitor/Senior Companion/Peer Counselor

☐ Telephone Reassurance ☐ Transportation

☐ 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: _____

COMMUNITY-BASED CBAS ADULT SERVICES

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

OTHER HEALTH SERVICES (if known) Continued

WITHIN THE PAST 6 MONTHS

☐ Hospice Care

☐ Currently receiving

Explain: _____

☐ Mental Health Outpatient Services

☐ Currently receiving

Explain: _____

☐ Other (specify): _____

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

INTERNAL/CLINICAL RISK FACTORS

☐ None

☐ Mental Illness

☐ Substance Use/Abuse

☐ Cognitive Impairment

☐ Polypharmacy (6+)

☐ Medication Mismanagement

☐ ADL Functional Limitations (3+)

☐ High Fall Risk

☐ Chronic Pain

☐ Frailty

☐ Wandering/Exit-Seeking Behavior

☐ Significant Sensory Impairment

☐ Other (specify): _____

EXTERNAL RISK FACTORS/SOCIAL DETERMINANTS OF HEALTH

☐ None

☐ At Risk When Home Alone

☐ Limited or No Social Supports/Family

☐ Caregiver Stress/Inconsistency

☐ IHSS Inconsistency

☐ Social Isolation/Loneliness

☐ 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:	
Dates of Service: From: _____ To: _____	CIN:

(12) NEEDS/GOALS/DESIRED OUTCOMES EXPRESSED BY PARTICIPANT OR AUTHORIZED REPRESENTATIVE DURING ASSESSMENT PROCESS	
1.	
Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH	
2.	
Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH	
3.	
Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH	
4.	
Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH	
5.	
Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH	
Additional Information: Use space to include any additional explanations about participant needs/goals/desired outcomes, including the participant's strengths and abilities.	

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

(13) CORE SERVICES		
PROFESSIONAL NURSING SERVICES **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

PROFESSIONAL NURSING SERVICES
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

3. Need/Problem

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

4. Need/Problem

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

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

PERSONAL CARE SERVICES
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

SOCIAL SERVICES
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

1. Need/Problem

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

2. Need/Problem

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

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

SOCIAL SERVICES
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

3. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
4. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

THERAPEUTIC ACTIVITIES
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

THERAPEUTIC ACTIVITIES – PHYSICAL THERAPY MAINTENANCE PROGRAM **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

THERAPEUTIC ACTIVITIES – OCCUPATIONAL THERAPY MAINTENANCE PROGRAM **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

(14) ADDITIONAL SERVICES		
PHYSICAL THERAPY **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

OCCUPATIONAL THERAPY
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

SPEECH THERAPY
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

REGISTERED DIETICIAN SERVICES
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

1. Need/Problem

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

2. Need/Problem

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

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

BEHAVIORAL HEALTH SERVICES
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

TRANSPORTATION SERVICES
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

(15) SIGNIFICANT CHANGES SINCE PREVIOUS IPC (For reauthorization TARs only)

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

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

(17) SIGNATURES OF MULTIDISCIPLINARY TEAM AND PROGRAM DIRECTOR

Signatures of the Multidisciplinary Team (MDT)

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	
	AC	
	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
☐ Primary/Personal Health Care Provider	☐ CBAS Center Physician	

By signing below, I certify the following: (1) all assessments have been completed and the participant meets all CBAS eligibility and medical necessity criteria as specified in this IPC effective on this date: _____ (NOTE: The TAR will not be approved for CBAS services prior to this date); (2) information contained in this IPC is the result of an MDT person-centered planning process and is documented in the center records; and (3) services scheduled in this IPC will be provided, unless otherwise noted in the health record, after approval of the participant's CBAS eligibility and TAR, and after the participant or authorized representative has signed the CBAS Participation Agreement (Form CDA 7000), no later than the first day of enrollment, consenting to services.

PRINTED NAME	SIGNATURE	DATE OF SIGNATURE
	Program Director	

Privacy Statement: The information requested on this form is required by the Department of Health Care Services, Fee-for-Service or Managed Care Plans, for the purpose of adjudication of TARS for CBAS services. Failure to provide this mandatory information may result in denial of the TAR for CBAS services.

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

Please use this page to document additional Box 13 and 14 services.

_____ SERVICES **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

Please use this page to document additional Box 13 and 14 services.

_____ SERVICES **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

Please use this page to document additional Box 13 and 14 services.

_____ SERVICES **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)