MONTHLY/QUARTERLY CARE PLAN REVIEW

Client Information

The purpose of this section is to determine if your plan of care is effective. Now is the time to update information that has changed and discuss recent changes that might affect your care plan.

Please complete the following information for the client.

Consumer Name:

Address:

City:

State:

Zip Code:

Phone (Home): Phone (Mobile):

Describe the overall condition of the participant, including any health concerns noted on the day of the home visit; the general condition of the home environment and summarize your discussion and concerns noted on the day of the home visit. Use reverse page, if needed. Use the discussion topics in the next section to capture notes on those items.

_____

_____

Health & Medical Review

Have there been changes in your health? ❒No ❒Yes, if yes summarize below

_____

_____

_____

Any new medications changes or new medical needs? Also, ask about PRN medication usage, if applicable.
❒No ❒Yes

_____

_____

_____

QUARTERLY CARE PLAN REVIEW

What other in-home care do you receive?

_____

_____

Have there been any other changes or events since the last review that have a substantial impact on the client's wellbeing or need for services i.e. has your support system changed? ❒No ❒Yes , if yes please summarize below

_____

_____

_____

_____

Progress on Goals

Care Plan Goal/Description

_____

_____

_____

_____

_____

_____

❒ Goal met/discontinue
❒ Goal being met/ongoing care
❒ Continue working toward goal
❒ Try new strategy
❒ Revise Goal
❒Other:_____

_____

_____

_____

Care Plan Goal/Description

_____

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_____

❒ Goal met/discontinue
❒ Goal being met/ongoing care
❒ Continue working toward goal
❒ Try new strategy
❒ Revise Goal
❒Other:_____

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QUARTERLY CARE PLAN REVIEW

Care Plan Goal/Description

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❒ Goal met/discontinue
❒ Goal being met/ongoing care
❒ Continue working toward goal
❒ Try new strategy
❒ Revise Goal
❒Other:________________________________

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Care Plan Goal/Description

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❒ Goal met/discontinue
❒ Goal being met/ongoing care
❒ Continue working toward goal
❒ Try new strategy
❒ Revise Goal
❒Other:________________________________

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Care Plan Goal/Description

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❒ Goal met/discontinue
❒ Goal being met/ongoing care
❒ Continue working toward goal
❒ Try new strategy
❒ Revise Goal
❒Other:________________________________

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QUARTERLY CARE PLAN REVIEW

Care Plan Goal/Description

_____

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❒ Goal met/discontinue
❒ Goal being met/ongoing care
❒ Continue working toward goal
❒ Try new strategy
❒ Revise Goal
❒Other:_____

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Care Plan Goal Notes/Summary

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Long Term Care Service Enrollment

This section is used to update this and any other long term services enrollment. As you know, you're enrolled in the Centennial Care Medicaid Waiver upon referral to the Adult Protective Service Homecare Program.

Have you been contacted by the Centennial Care Medicaid Waiver or any other Long Term Service Program? ❒Yes ❒No

_____

_____

Have you enrolled in any other longterm service programs? ❒No ❒Yes

_____

_____

Are there any other longterm service programs you want to learn about? ❒No ❒Yes

_____

_____

QUARTERLY CARE PLAN REVIEW

Client Satisfaction Survey

This part of your review deals with the performance of your caregiver. If there are items that you need to address, request or change, now is the time to do it.

How much help has your homemaker been? ❒Not helpful ❒Somewhat helpful ❒Very helpful

_____

_____

Is your homemaker punctual? ❒Yes ❒No

_____

_____

Does your homemaker stay scheduled time? ❒Yes ❒No

_____

_____

What day(s) does your caregiver visit you?

❒Monday❒ Tuesday ❒Wednesday ❒Thursday❒ Friday ❒Saturday ❒Sunday

_____

_____

What time of day does your caregiver visit you? ❒Morning ❒Noon❒ Afternoon ❒Evening

_____

Does your caregiver rush your services? ❒Yes ❒No

_____

_____

Does your caregiver spend too much time talking? ❒Yes ❒No

_____

_____

QUARTERLY CARE PLAN REVIEW

Does your caregiver clock in and out every time they work? ❒Yes ❒No

_____

_____

If your worker doesn't clock in on time, why?

_____

_____

Does your caregiver discuss their other clients with you? ❒No ❒Yes, If yes, please explain HIPPA basics to consumer, apologize for the behavior and explain that the matter will be fairly but thoroughly addressed.

_____

_____

_____

Participant Comments, Questions or Concerns

Do you have any comments or concerns that haven't been addressed? ❒Yes ❒No
Additional Comments or Concerns

_____

_____

_____

_____

_____

Next Review Date:_____

_____

Consumer Signature Date

_____

Employee Signature Date