State of California
Health and Human Services Agency

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

Department of Health Care Services

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: **O** Initial TAR **O** Reauthorization TAR **O** 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). **O** Yes **O** No **O** NA

(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	
2		2	
3		3	
4		4	
5		5	
6		6	

(3) MEDICATIONS (frequency and dosage not required)

No Medications or Supplements O

Active Prescriptions	**Over-The-Counter Medications &/or Supplements**
1	12
2	13
3	14
4	15
5	16
6	1
7	2
8	3
9	4
10	5
11	6

(4) Active Personal Medical/Mental Health Care Provider(s)

Name	**Address**	**Phone**

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Criteria Verification

- **All circles 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 specified criteria of any one or more of the following categories (A thru E).**

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

Participant Does NOT Fall Within Category A **O**	➢ Check circle if the participant does NOT fall within Category A. ➢ Check the circles next to the criteria indicating the participant meets the stated criteria.
O	1. Has been determined to meet the NF-A LOC or above; **AND**
O	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.
O	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.
O	c. The person requires CBAS services, as defined in W&I Code, Section 14550 (BOXES 20, 22 and 23), 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.
O	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.
O	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.
O	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.
O	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.
O	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.

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

Participant Does NOT Fall Within Category B **O**	➢ Check circle if the participant does NOT fall within Category B. ➢ Check the circles next to the criteria indicating the participant meets the stated criteria.
O	1. Has been diagnosed by a physician as having an organic, acquired or traumatic brain injury, and/or has a chronic mental illness; **AND**
O	2. Meets CBAS eligibility and medical necessity criteria specified above in BOX 5, NUMBER 2; **AND**
O	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
O	b. One ADL/IADL listed above, and one of the following: money management, accessing resources, meal preparation, or transportation.

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

Participant Does NOT Fall Within Category C **O**	➢ Check circle if the participant does NOT fall within Category C. ➢ Check the circles next to the criteria indicating the participant meets the stated criteria.
O	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** • 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.
O	2. Meets CBAS eligibility and medical necessity criteria specified above in BOX 5, NUMBER 2.

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

Participant Does NOT Fall Within Category D **O**	➢ Check circle if the participant does NOT fall within Category D. ➢ Check the circles next to the criteria indicating the participant meets the stated criteria.
O	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**: • 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.
O	2. Meets CBAS eligibility and medical necessity criteria specified above in BOX 5, NUMBER 2; **AND**
O	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.

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(9) CATEGORY E: For individuals who have developmental disabilities:	
Participant Does NOT Fall Within Category E **O**	➢ Check circle if the participant does NOT fall within Category E. ➢ Check the circles next to the criteria indicating the participant meets the stated criteria.
O **O**	1. Meets the criteria for regional center eligibility; **AND** 2. Meets CBAS eligibility and medical necessity criteria specified above in BOX 5, NUMBER 2.

(10) For those participants with a diagnosed chronic mental illness:

All participants with a primary or secondary diagnosis of chronic mental illness, pursuant to the California Code of Regulations, title 9, section 1830.205, as an included diagnosis for County Mental Health shall be provided information regarding availability of referral unless referral occurred prior to this TAR period. The CBAS center shall refer those participants that give consent for such referral. Check all that apply:

O No Mental Illness Diagnosis
O Excluded Diagnosis
O Referral Made: Date:_____
O Participant/Family Declined Referral
O Currently Being Served by County Mental Health
O Referral not Made (state reason):_____
_____
_____
_____

(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 cuing 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	---	---	---	---
Ambulation	**O**	**O**	**O**	**O**
Bathing	**O**	**O**	**O**	**O**
Dressing	**O**	**O**	**O**	**O**
Self-Feeding	**O**	**O**	**O**	**O**
Toileting	**O**	**O**	**O**	**O**
Transferring	**O**	**O**	**O**	**O**
IADLs	---	---	---	---
Accessing Resources	**O**	**O**	**O**	**O**
Hygiene	**O**	**O**	**O**	**O**
Meal Preparation	**O**	**O**	**O**	**O**
Medication Mgmt	**O**	**O**	**O**	**O**
Money Mgmt	**O**	**O**	**O**	**O**
Transportation	**O**	**O**	**O**	**O**

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(12) CURRENT ASSISTIVE/ADAPTIVE DEVICES (Check all that apply):

O	None	O	AAC Device	O	Glasses or Other Vision Aid
O	Wheelchair	O	Orthosis/Prosthesis	O	Dentures
O	Walker	O	Gait Belt	O	Respiratory Equipment (specify): _____
O	Crutches	O	Hoyer Lift	O	Other (specify): _____
O	Cane	O	Hearing Device		

(13) CONTINENCE INFORMATION (Check all that apply):

O None
O Incontinent of bladder: O Occasionally O Frequently O Always
O Incontinent of bowel: O Occasionally O Frequently O Always
O External/internal catheter
O Ostomy
O Other (specify):

(14) FEEDING INFORMATION (Check all that apply):

O None O Overweight O Underweight O Feeding tube O Therapeutic/special diet
O Difficulty chewing and/or swallowing O Cannot feed self
O Other (specify):

(15) NON-CBAS CENTER SUPPORT/SERVICES (if known). (Check all that apply):

	SUPPORT SERVICE	DESCRIBE (how or why the support service is insufficient)
O	Not Known	Explain: _____
O	NONE	----------
O	IHSS/PCSP Services	Hours authorized per week/month: _____
O	Targeted Case Management	Frequency: _____
O	Other Paid Caregiver(s)	Frequency: _____
O	ICF/DD-H	Explain: _____
O	Lives in a Community Care Licensed Facility (e.g., Residential Care Facility)	Explain: _____
O	Participates in a HCBS Waiver O MSSP O Assisted Living O NF A/B O In-Home Operations (IHO) O AIDS	Explain: _____

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(16) NON-CBAS CENTER SUPPORT/SERVICES (if known). (Check all that apply):

Within the last 6 months, the participant received the following non-institutional services:

O Not Known. Explain: _____

_____

_____

O None.

O Home Health Agency Services. Explain: _____

_____

_____

>>>Is the participant currently receiving **Home Health Agency Services**? **O** Yes **O** No

O Hospice Care. Explain: _____

_____

_____

>>>Is the participant currently receiving **Hospice Services**? **O** Yes **O** No

If the participant is currently receiving either home health agency or hospice services, please specify:

Service	Frequency

O Urgent Care. Explain: _____

_____

O Mental Health Services. Explain: _____

_____

O Emergency Department. Explain: _____

_____

O Other. Explain: _____

_____

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

O Inappropriate Affect, Appearance or Behavior
O Poor Judgment
O Medication Mismanagement
O Self Neglect
O Two or More Chronic Conditions
O Dementia Related Behavioral Problems
O Fall Risk
O Isolation
O Frailty
O Other (specify):_____

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(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:

O Not Known. Explain: _____

_____

_____

O None.

O Acute Care Hospital. Explain: _____

_____

_____

O Nursing Facility. Explain: _____

_____

_____

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

_____

_____

O Other. Explain: _____

_____

_____

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

(19)	
Yes **No**	CBAS Core Services – all of these services are required each day of attendance: check Yes/No circle in the left-handed column for each service listed:
O **O**	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.

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

(20) TAR FOR REAUTHORIZATION OF CBAS SERVICES			
Yes	No	NA	If this is a reauthorization TAR, the participant's condition would likely deteriorate if the CBAS services were denied.
O	**O**	**O**	

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(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)
Professional Nursing Services				

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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)
Personal Care Services				
Social Services				

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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				
Physical Therapy Maintenance Program				
Occupational Therapy Maintenance Program				
Nutrition/Diet **O** Regular Diet **O** Special Diet Specify: _____ _____ **O** NPO (may receive NG, GT or IV feedings at home)	----------	----------	----------	----------

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

Participant Name: _____ TAR Control Number (TCN): _____

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(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 measurable 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 measurable objectives/goals)
Physical Therapy				
Occupational Therapy				

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CBAS ADDITIONAL SERVICES (Box 22)	**Participant Problem** (must include a measurable 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 measurable objectives/goals)
Speech and Language Pathology Services				
Registered Dietitian Services				
Mental Health Services				
Other (please specify)				

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(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.

Participant Name: _____ TAR Control Number (TCN): _____

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(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 all assessments have been completed and that the participant meets the CBAS eligibility and medical necessity criteria 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	

** 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.