TOP AID
HEALTHCARE, INC

Top Aid Healthcare
51 Union ST Suite 204
Worcester MA, 01608
Phone 508-343-8555 Fax 508-519-0353
Email Adminassist@Topaidhealthcare.com

Plan Of Care

Date _____

Members Name _____ DOB _____

Address _____

Phone number _____ Level of AFC _____

AFC RN _____ Caregiver Name _____

Relationship _____ Medicaid Number _____

Advanced Directives
Member has Advance Directives Yes No
Intent: DNR ☐ Living ☐ Will ☐ Medical Power of Attorney ☐
Copy on File In Agency?
Patient was provided written and verbal information on Advanced Directives

Clinical Providers:

Name _____ Specialty _____

Phone _____ Fax _____

Address _____

Name _____ Specialty _____

Phone _____ Fax _____

Address _____

Name _____ Specialty _____

Phone _____ Fax _____

Address _____

Functional Limitations
☐ Amputation ☐ Paralysis ☐ Legally Blind ☐ Bowell/bladder incontinent ☐ Endurance
☐ Dyspnea ☐ Contracture ☐ Ambulation ☐ Hearing ☐ Speech
☐ Other: Fatigue, Weakness

Back Up Plan

Primary Contact _____ Phone _____

Address _____

Approved for AFC _____

Alternate Contact _____ Phone _____

Address _____

Approved for AFC _____

24:7 Care Plan

OTHER AGENCY INVOLVED (DDS, DMH, VNA, ADH, SCHOOL/WORK, COUNSELING, ECT)

Type of program _____

Name _____

Phone _____ Days of service _____

Type of program _____

Name _____

Phone _____ Days of service _____

Type of program _____

Name _____

Phone _____ Days of service _____

CULTURAL

Primary Language? ☐ English ☐ Spanish ☐ Chinese ☐ Russian ☐ Arabic ☐ Other/Unknown: Twi
Does Patient have Cultural practices that influence healthcare? ☐ YES ☐ NO
If yes, Please Explain
Is Religion Important to the member? ☐ YES ☐ NO
Patients Religious Preference?
Use of interpreter (select patient preference) ☐ Family ☐ Friend ☐ Professional ☐ Other
Patience primary source of emotional support:

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Community Support

Strength and preference

_____

_____

Ability to Monitor conditions: _____

Current and/or Potential Barriers: Assed: ☐ YES ☐ NO

List of Barriers N/A _____

_____

Desired outcomes: _____

Any Referrals needed to fulfill Plan of Care? ☐ YES ☐ NO

If yes List referrals _____

_____

Assistive devises/Equipment Used:

Mobility ☐ Independent ☐ Cueing/supervision ☐ Physical Assist
Members Preference
Caregiver responsibilities
Assistive devices/ Equipment Used:
Eating ☐ Independent ☐ Cueing/supervision ☐ Physical Assist
Members Preference
Caregiver responsibilities
Assistive devices/ Equipment Used:
Behavioral ☐ Wandering ☐ Verbally abusive ☐ Physical abusive ☐ Socially Inappropriate ☐ Resisting
Caregiver Interventions

Instrumental Activities of Dayli Living (IADL'S)

Personal Hygiene ☐ Independent ☐ Some Help ☐ Full Help

Members Preference

Caregiver responsibly

Assistive devises/Equipment

Managing Medication ☐ Independent ☐ Some Help ☐ Full Help

Members Preference

Caregiver responsibly

Assistive devises/Equipment

Managing Finances ☐ Independent ☐ Some Help ☐ Full Help

Members Preference

Caregiver responsibly

Assistive devises/Equipment

Laundry ☐ Independent ☐ Some Help ☐ Full Help

Members Preference

Caregiver responsibly

Assistive devises/Equipment

Shopping ☐ Independent ☐ Some Help ☐ Full Help

Members Preference

Caregiver responsibly

Assistive devises/Equipment

Housekeeping ☐ Independent ☐ Some Help ☐ Full Help

Members Preference

Caregiver responsibly

Assistive devises/Equipment

Meal Prep ☐ Independent ☐ Some Help ☐ Full Help

Members Preference

Caregiver responsibly

Assistive devises/Equipment

Transportation ☐ Independent ☐ Some Help ☐ Full Help

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Community Resources Needed

☐ YES ☐ NO

List Community Resources

_____

_____

Back up Plan _____

_____

Describe Individualized Back up Plan _____

_____

Health Status Report

_____

_____

_____

Current Medications

	Medication Name	Dosage	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			

Please List any known Allergies

_____

Nutrition

Type of diet _____

Food allergies _____

Meal Pattern _____

Food Preference _____

_____

Summary of daily Meal

_____

_____

_____

_____

Care Needs and Services (measurable objective and intervention) Unless otherwise indicated:

The caregiver will provide (Daily) assistance for all needs and care listed below.

- ✓ The CG (and alternate CG in absent of primary CG) will provide daily physical and emotional care to the consumer.
- ✓ The MDT will monitor, assess, and offer support and education as needed to both CG and consumer.
- ✓ The CG will notify Health Care team whenever incidents occur or when changes are observed in consumers condition.
- ✓ RN will educate Caregiver on the importance of consumer taking meds. As scheduled and on possible side effects of specific medications.
- ✓ RN/Care Manager will provide education to client and caregiver during monthly visits on variety of health issues (current or new) as well as any other issues (current or new) that the client might need help/benefits from.
- ✓ Caregiver and Client will demonstrate understanding compliance and knowledge of client illness and medications and needs for follow up care.
- ✓ Client will follow up with daily assistance provided by the caregiver.
- ✓ Client will follow up with RN/ Case Worker recommendations as needed over the duration of this care plan.
- ✓ Client will inform caregiver and or RN /Cased Worker if any new symptoms, issues, or changes occur to address them accordingly.
- ✓ Client will attend all schedule MD appointments have routine blood work and take daily medications without resistance

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Activities of daily Living (ADL'S)

Transfer ☐ Independent ☐ Cueing/supervision ☐ Physical Assist
Members Preference
Caregiver responsibilities
Assistive devices/ Equipment Used:
Toileting ☐ Independent ☐ Cueing/supervision ☐ Physical Assist
Members Preference
Caregiver responsibilities
Assistive devices/ Equipment Used:
Dressing ☐ Independent ☐ Cueing/supervision ☐ Physical Assist
Members Preference
Caregiver responsibilities
Assistive devices/ Equipment Used:
Bathing ☐ Independent ☐ Cueing/supervision ☐ Physical Assist
Members Preference
Caregiver responsibilities
Assistive devices/ Equipment Used:

Safety assessment indication: Please see complete safety assessment for additional information.

Home alone time to be no more than 3 Hours during a 24-hour period	☐ YES ☐ No
No home alone time allowed under any circumstances	☐ Yes ☐ No

Emergency Plan for Home Evaluation

Primary Exit _____

Secondary Exit _____

Meeting Place _____

Goals Provided necessary support to member with activities of daily living in order to help member or improve current level of functional status.

Achievement	Goal 1	Goal 2
The healthy change I would like to make is		
My Goal		
The steps I will take to achieve my goal are:		
What are the barriers that would interfere with achieving my goal?		
How will I overcome these obstacles?		
Who would help me achieve my goals?		
What resources are needed to meet my goal?		
Review		
Date of Competition		

Goals

_____

_____

_____

_____

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For Transition Planning:

☐ When the client moves from one level of services /supports or program to another within the organization date ______________________________

☐ When the client moves externally to another provider. Date ____________________

*********For Discharge only

- Client to be discharge from AFC program when no longer required AFC, requires care beyond the scope of the program, exhibits behavioral harmful to him/herself or others, chooses to be discontinue their participation, does not fulfill the responsibilities of the agreement, expires or transfers to another program.
- Client to be discharged to (Check one)

☐ Assisted Living Residence
☐ Congregate Housing
☐ Community Service Provider
☐ Hospice
☐ Long term Placement
☐ Rehabilitation Facility
☐ Rest Home
☐ Other ______________________

RN/CM Note 30 Day Follow up Call.

____

____

____

By signing and dating below, I attest that this plan has been completed with my input, reviewed with me in person and I have received a copy. I Understand that this meant to be a "living" document, changed to reflect ongoing care needs.

Member signature ______________________________ date __________

Caregiver Signature ______________________________ Date __________

AFC RN Signature ______________________________ Date __________

AFC CM Signature ______________________________ Date __________