PLAN FOR PROTECTIVE OVERSIGHT

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVER
Nursing Home Transition and Diversion (NHTD)

The location where PPO in kept in the participant's home is: _____

Participant Name: _____ CIN _____

Address: _____

Phone: (H)_____ (W)_____ (C) _____

1. Contacts

Legal Guardian Name (if applicable): _____Relationship: _____
Address: _____
Street City State Zip
Phone: Home (____) _____Work (____) _____Cell (____) _____

☐ **Guardianship verified, if applicable**

Primary Contact: _____Relationship: _____

Address: _____
Street City State Zip
Phone: Home (____) _____Work (____) _____Cell (____) _____

Other Contact: _____Relationship: _____

Address: _____
Street City State Zip
Phone: Home (____) _____Work (____) _____Cell (____) _____

Out-of-Area Emergency/Disaster Contact (not same as above), if available

Name: _____Relationship: _____

Address: _____
Street City State Zip
Phone: Home (____) _____Work (____) _____Cell (____) _____

2. Advance Directives

Health Care Agent Name (if applicable): _____

Address: _____
Street City State Zip
Phone: Home (____) _____Work (____) _____Cell (____) _____

For RRDS use only:

Effective date _____to_____

PLAN OF PROTECTIVE OVERSIGHT (continued)

Participant Name: _____

Alternate Health Care Agent Name (if applicable): _____

Address: _____
Street City State Zip
Phone: Home (____) _____ Work (____) _____ Cell (____) _____

☐ **Health Care Proxy verified, if applicable**

Is there a current Non-Hospital Do Not Resuscitate Order? ☐ Yes ☐ No

☐ **Non-Hospital DNR verified, if applicable**

3. Financial Contacts

Power of Attorney Name (if applicable): _____ Relationship: _____

Address: _____
Street City State Zip
Phone: Home (____) _____ Work (____) _____ Cell (____) _____

Specify type of assistance provided: _____

☐ **Power of Attorney verified, if applicable**

Rep. Payee Name (if applicable): _____ Relationship: _____

Address: _____
Street City State Zip
Phone: Home (____) _____ Work (____) _____ Cell (____) _____

Person/Agency who will assist with Financial Matters (if appropriate):

Name: _____ Relationship: _____

Address: _____
Street City State Zip
Phone: Home (____) _____ Work (____) _____ Cell (____) _____

4. Hospital Preference

Participant's choice of hospital: _____

5. Revisions made to page(s) 1 and/or 2

Change(s) made: _____

_____

_____
Name of Waiver Participant Signature Date

_____
Name of Guardian (if applicable) Signature Date

_____
Name of Service Coordinator Signature Date

PLAN OF PROTECTIVE OVERSIGHT (continued)

Participant Name: _____

6. Fire/Safety Disaster Plan

Yes	No		
☐	☐	Residence has Smoke Detector	Comments: _____
☐	☐	Residence has Carbon Monoxide Detector	Comments: _____
☐	☐	Participant able to access all available exits	Comments: _____
☐	☐	Participant is bed bound	If yes, plan of action: _____
☐	☐	Participant needs assistance in the case of evacuation	If yes, plan of action: _____
☐	☐	Participant needs help outside of informal supports if a disaster occurs	If yes, plan of action: _____
☐	☐	Evacuation Plan reviewed with participant/legal guardian and informal supports	Date reviewed: ____/____/_____ Date the local authorities were notified of assistance needed: ____/____/____
☐	☐	Discussed the need for a Disaster Preparedness Plan	Comments: _____
☐	☐	Discussed the need for a disaster kit	Dated discussed: ___/___/___
☐	☐	Participant uses oxygen	If yes, plan of action, in case of emergency: _____ Vendor Name and Telephone: _____
☐	☐	Participant uses ventilator	If yes, plan of action: _____ Vendor Name and Telephone: _____
☐	☐	Participant requires suctioning	If yes, plan of action: _____ Vendor Name and Telephone: _____
☐	☐	Power Company notified of all power-dependent life support equipment	Date notified: ____/____/_____ ☐ No life support used

7. Medications

Yes	No		
☐	☐	Does the participant need assistance with taking medications?	If yes, type of assistance provided: _____ By Whom: _____
☐	☐	Does the participant need assistance getting meds prescriptions filled?	If yes, type of assistance provided: _____ By whom: _____
☐	☐	Does the participant have someone to notify if there are concerns about their use of medications?	If yes, person(s) to contact: _____

PLAN OF PROTECTIVE OVERSIGHT (continued)

Participant Name: _____

8. Dietary

a. Who will be contacted if the participant experiences any changes in eating habits?

_____

9. Plan for Back-Up

a. Would the absence of waiver services or informal supports during scheduled/expected times jeopardize the participant's health and welfare?

☐ YES ☐ NO

If yes, list the waiver service and/or informal support and describe the back-up plan to be utilized:

_____

_____

_____

b. Would the absence of non-waiver services (e.g. nursing services) during scheduled times jeopardize the participant's health and safety:

☐ YES ☐ NO

If yes, list the non-waiver service(s) and describe the back-up plan to be utilized?

_____

_____

_____

_____

c. Does participant have any pets? ☐ YES ☐ NO If yes, type(s): _____

Who needs to be contacted to care for pets if participant becomes unable? _____

_____

10. Other – List all Assistive Technology, medical equipment, and emergency communication devices used by participant and contact/agency if repairs are needed:

Device Type and Description	Contact Name/Agency and Telephone Number/Ext.

PLAN OF PROTECTIVE OVERSIGHT (continued)

Participant Name: _____

11. Signatures of Individuals Participating in the Plan For Protective Oversight

_____ / /
Name of Waiver Participant Signature Date

_____ / /
Name of Legal Guardian (if applicable) Signature Date

_____ / /
Name of Informal Support Signature Date

_____ / /
Name of Informal Support Signature Date

_____ / /
Name of Formal Support/Title Agency Signature Date

_____ / /
Name of Formal Support/Title Agency Signature Date

_____ / /
Name of Service Coordinator Signature Date

_____ / /
Name of Service Coordinator Supervisor Signature Date

12. Regional Resource Development Specialist

The information provided in this Plan for Protective Oversight summarizes alternatives so that the participant's health and welfare can be maintained in the community and that he/she is not at risk for nursing home placement.

Comments: _____

_____
Name of RRDS Signature Date