

Ohio Department of Mental Health and Addiction Services

Sample Personal Care Plan Class Two Facilities

5122-30-26

Date of Plan:

Resident Name or Agency Identifier

Date of Admission

Date of Birth:

Previous Placement

Gender:

Male

Female

Reason for Personal Care Plan

Admission to Facility (completed within 14 days of the date of admission)

Significant Change

Explain Change

Name and address of Residential Care Facility

Name:

Address:

City:

State:

Zip Code:

County:

Telephone:

Name and contact information for current Behavioral Health Agency and Casemanager/CPST

Name:

Casemanager/CPST

Address:

City:

State:

Zip Code:

Phone:

Ext.

Cell Phone:

E-Mail:

Name and Contact Information for Medical Care Provider

Facility Name:

Provider Name:

Address:

City:

State:

Zip Code:

Phone:

Ext.

Cell Phone:

E-Mail:

Name or Agency Client Identifier:

Does the resident have a Dentist? Yes No If yes, please provide contact information:

Name:

Address:

City:

State:

Zip Code:

Phone:

Ext.:

Cell Phone:

E-Mail:

Does the resident have a guardian ? Yes No If yes, please provide contact information:

Name:

Address:

City:

State:

Zip Code:

Phone:

Cell Phone:

E-Mail:

Does the resident have a parole or probation officer? Yes No If yes, please provide contact information:

Name:

Address:

City:

State:

Zip Code:

Phone:

Ext.:

Cell Phone:

E-Mail:

Emergency Contact :

Name:

Relationship:

Address:

City:

State:

Zip Code:

Phone:

Cell Phone:

E-Mail:

Name or Agency Client Identifier:

Informal Supports (Friends/Family)

Name:

Relationship:

Address:

City:

State:

Zip Code:

Phone:

Cell Phone:

E-Mail:

Does the resident have:

Health Insurance? Yes No If yes, attach a copy.

Medical advanced directive? Yes No If yes, attach a copy.

Psychiatric advanced directive? Yes No If yes, attach a copy.

Declaration for mental health treatment? Yes No If yes, attach a copy.

What does the facility need to have to provide personal care services for the resident? (This may include items like a first floor bathroom, walk in shower, handicap access eating area, etc.)

What should staff be aware of when providing personal care services for the resident? (This may include special instructions about how to provide personal care to the resident)

Name or Agency Client Identifier:

Does the resident have any known allergies? Yes No Unknown **If yes, please list them below:**

List all diagnosed physical or mental health conditions:

List current medications and most common possible side effects: (Note - this information must be supplied by the agency physician, nurse or staff member with comparable scope of practice) Summer heat can negatively affect individuals taking psychotropic (mental health) medications. Please provide accommodation such as fans, air conditioning when available, wet towels, shade, etc during extremely warm/hot days.

Medications	Dosage	Frequency	Possible Severe Adverse Side Effect(s)	Potential Dangerous Interactions

Additional Comment

Name or Agency Client Identifier:

Does the resident have any physical limitations? Yes No

Does the resident have any dietary restrictions? Yes No **If yes, explain below, include religious, ethnic and cultural preferences**

Does the resident require the preparation of a special diet, as required by instructions of a physician or a licensed dietitian? Yes No **If yes, explain below (does not include therapeutic diet that modifies a regular diet, such as a low sodium diet)**

Please identify additional limitations to care, e.g. language or cognitive, or other factors, e.g. religious or cultural considerations, that are important to the provision of personal care services:

Date of last medical hospitalization?

Date of last mental health hospitalization?

Does resident have a current or past AOD abuse issue? Yes No **If yes, please describe:**

Name or Agency Client Identifier:

Does resident have a current or past history of violence towards others, including, but not limited to physical violence, sexual violence, use of weapons or homicide? Yes No If yes, describe:

Does resident have a current or past history of self-injury? Yes No If yes, describe:

Does resident have a recent or past history of suicide attempts? Yes No If yes, describe:

What are the personal care needs or concerns identified by the resident , casemanager or guardian/family members?

Name or Agency Client Identifier:

Does the resident require?

Assistance with Hygiene

Yes No

Comment:

Assistance with Walking/Moving

Yes No

Comment:

Assistance with Dressing

Yes No

Comment:

Assistance with Grooming/Hair Care

Yes No

Comment:

Assistance with Toileting

Yes No

Comment:

Assistance with Eating

Yes No

Comment:

Assistance with Nail Care

Yes No

Comment:

Assistance with Budget/Money Management

Yes No

Comment:

Preparation of Special Diets

Yes No

Comment:

Self Administration of Medication

Yes No

Comment:

Other:

Yes No

Unknown

Assistance

Prompting / Assistance Needed

Indicate Resident Independent

Prompting / Assistance Needed

Indicate Resident Independent

Prompting / Assistance Needed

Indicate Resident Independent

Prompting / Assistance Needed

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Responsible Party(s)

Treatment Provider Staff

RCF Staff Member Both

Treatment Provider Staff

RCF Staff Member Both

Treatment Provider Staff

RCF Staff Member Both

Treatment Provider Staff

RCF Staff Member Both

Treatment Provider Staff

RCF Staff Member Both

Treatment Provider Staff

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Treatment Provider Staff

RCF Staff Member Both

Treatment Provider Staff

RCF Staff Member Both

Treatment Provider Staff

RCF Staff Member Both

Treatment Provider Staff

RCF Staff Member Both

Treatment Provider Staff

RCF Staff Member Both

Resident Signature

Date

refused to sign

Residential Staff Signature

Date

Guardian/Family Signature

Date

not applicable

Casemanager/CPST Signature

Date

not applicable

Other Provider (if applicable)

Date