



MENTAL HEALTH PLAN OF CARE

Instructions: Case Manager to complete in collaboration with resident & Adult Care Facility (ACF) prior to admission. Provide detailed, individualized information. File original at ACF and copies with resident and agency.

1. Name _____
2. UCI/Client Number (Optional) _____
3. Date of Birth _____
4. Social Security Number _____
5. Referring Agency (Name, Address & Phone Number) _____

6. Current Case Manager (Name & Phone Number) _____

7. Previous Address of Client _____
8. Current Address of Client _____
9. ACF (Name, Address & Phone Number) _____

10. Does the person have Medical or Psychiatric Advanced Directives?
Yes _____ No _____ (If yes, please describe them, or attach a copy to this form)

11. Does the person have a guardian?
Yes _____ No _____ (If no, go to question #13)
12. Guardian (Name, Address & Phone Number) _____

13. Has the resident ever been convicted of a crime?
Yes _____ No _____ (If yes, explain. Include any interventions or facility responsibilities needed to successfully maintain resident in community setting.)

Client Name _____

Client ID _____

14. Emergency Contact Procedures

The ACF will follow these procedures:

- A) During regular business hours
 - 1) Contact Agency Case Management office
 - 2) Ask for assigned Case Manager
 - 3) If Case Manager is unavailable, ask for the Case Manager's Supervisor or the Director of Clinical Services
- B) After business hours, weekends and holidays
 - 1) Contact the Crisis Center Hotline (330) 452-6000
 - 2) Ask for the Agency's Case Manager on call
- C) Emergency medical/legal issues: Provide contacts (Name & Phone Number)
 - 1) Guardian _____
 - 2) Physician _____
 - 3) Ambulance _____
 - 4) Hospital _____
 - 5) Probation/Parole Dept. _____
 - 6) Police/Sheriff Dept. _____

15 Describe any preparation by ACF staff to provide optimal care for the resident.

16. Assistance with activities of daily living (include resident needs, issues, prompting required & responsible party). Attach additional sheets if necessary.
- Hygiene _____

 - Medication _____

 - Medical Appointment Transportation _____

 - Psychiatric Appointment Transportation _____

 - After Hours Transportation _____

 - Nutrition _____

Client Name _____

Client ID _____

- Scheduling of Appointments _____

- Budget/Finance _____

- Socialization Needs (Home/Community) _____

- Skills Training _____

- Resident's Comments _____

- Facility Operator's Comments _____

- Agency's Comments _____

17. List current medications. Document changes between plan reviews (Include date/change).

Date	Medication	Dosage/Directions	Side Effects

Use additional sheets as needed

Note: Some common side effects of medication are changes in behavior, weight gain or loss, severe skin rash, headaches lasting 2-3 days, diarrhea lasting 2-3 days. Should there be any sign of medication side effects, please notify the nurse/case manager at the appropriate agency.

Resident's Signature Date

Case Manager's Signature Date

Case Manager Supervisor's Signature Date

ACF Operator's Signature Date