



Medi-Cal In-Home Operations Branch  
Home- and Community-Based Services (HCBS)  
Manual Plan of Treatment (POT)

Enclosure 5A

**1. APPLICANT/PARTICIPANT INFORMATION**

Name: \_\_\_\_\_ CIN: \_\_\_\_\_ DOB: \_\_\_\_\_ M  F   
Last First

Address: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_  
Area code  
City State Zip code

Medical Record #: \_\_\_\_\_ Primary Caregiver: \_\_\_\_\_  
(Applicable for providers who use Medical Record #'s) Relationship to Applicant/Appli \_\_\_\_\_  
Primary Language: \_\_\_\_\_

**2. PROVIDER INFORMATION**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_  
Area code  
City State Zip code

Provider #: \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_  
Area code

Start of Care Date: \_\_\_\_\_ \*Treatment Period: \_\_\_\_\_  
(May cover up to 180 days maximum) FROM TO:

**3. PRIMARY CARE PHYSICIAN**

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_  
Area code  
City State Zip code

FAX #: ( ) \_\_\_\_\_  
Area code

Treatment Period: \_\_\_\_\_  
FROM TO

**\*Note: The treatment period may be less than the 180 days depending upon the licensure or certification requirements of the rendering provider.**

**4. MEDICAL INFORMATION – Include ICD-9 Codes where appropriate.  
Please add additional pages as needed.**

Primary Diagnosis \_\_\_\_\_ ICD-9 \_\_\_\_\_ Date of onset: \_\_\_\_\_

Secondary Diagnosis \_\_\_\_\_ ICD-9 \_\_\_\_\_ Date of onset: \_\_\_\_\_

Other Diagnosis \_\_\_\_\_ ICD-9 \_\_\_\_\_ Date of onset: \_\_\_\_\_

Other Diagnosis \_\_\_\_\_ ICD-9 \_\_\_\_\_ Date of onset: \_\_\_\_\_

Prognosis:  Excellent  Good  Fair  Poor

**5. MEDI-CAL HOME- AND COMMUNITY-BASED PROGRAM  
Please check all that apply.**

- Nursing Facility/Acute Hospital (NF/AH) Waiver  In-Home Operations (IHO) Waiver  
 Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)  Pediatric Day Health Care (PDHC)

**6. LEVEL OF CARE (LOC)  
Please check only one.**

**NOTE: The LOC determination will be made by the Medi-Cal In-Home Operations Branch and provided to the HCBS provider once determined.**

- Acute  NF B (DP)  
 Adult Subacute  Pediatric Subacute  
 NF A  Pediatric NF B  
 NF B



Treatment Period: \_\_\_\_\_  
FROM TO

**8. NONWAIVER SERVICES**  
Include all applicable services and frequency. May include those services funded by Medi-Cal, Regional Centers, California Children's Services, Independent Living Centers, In-Home Supportive Services, Department of Rehabilitation, Department of Mental Health, Private Insurance, and/or school-based services.  
Examples include: Adult Day Health Care, Pediatric Day Health Care, Medical Therapy Program, Housing Referrals, Social Service Referrals, and Vocational Rehabilitation. Please add additional pages as needed.

**9. NUTRITIONAL REQUIREMENTS**  
Please include type of diet, and method, amount, and frequency of feeding.

Treatment Period: \_\_\_\_\_  
FROM TO

**10. MEDICATION PLAN FOR HOME PROGRAM**  
Please add additional pages as needed.

Allergies: \_\_\_\_\_ Reaction (if known): --- \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency \_\_\_\_\_

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Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency \_\_\_\_\_

Who gives the medications to the patient? \_\_\_\_\_

Treatment Period: \_\_\_\_\_  
FROM TO

**11. TREATMENT PLAN FOR HOME PROGRAM**  
**Include all needed services, frequency, and duration of services and provider(s) of service(s).**

“The waiver applicant/participant and/or AR will hire and train the IHSS & WPCS providers in the waiver applicant/participant’s personal and medical care needs. The waiver applicant/participant and/or AR will direct the IHSS & WPCS providers to assist with all of the waiver applicant/participant’s activities of daily living, medication management, medical care, transfers, mobility, personal needs, house keeping, shopping, laundry & home care needs. The waiver applicant/participant and/or AR will instruct the IHSS & WPCS provider to dial 911 and ensure that the waiver applicant/participant will be transported immediately should he/she become incapacitated and unable to direct his/her own care. “

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Manual Plan of Treatment (POT)  
Participant's Name: \_\_\_\_\_  
Treatment Period: \_\_\_\_\_  
FROM TO

**12. FUNCTIONAL LIMITATIONS**  
**Please describe functional limitations per the physician's order within each category.**  
**Please add additional pages, as needed.**

No limitations noted.

**MOTOR:** May include limitations with walking and/or gross motor movement.

No limitations noted.

**SELF HELP:** May include limitations with activities of daily living such as bathing, toileting, eating, and dressing.

No limitations noted.

**COMMUNICATION/SENSORY:** May include limitations with hearing, speech, and/or sight.

Treatment Period: \_\_\_\_\_  
FROM TO

**13. ACTIVITIES**  
Include permitted activities per the physician's order, such as up with assistance, complete bedrest, up as tolerated, and/or use of adaptive equipment such as wheelchair, walker, etc.

No restrictions on activities.

**Safety precautions in use:**     Seizure precautions     Universal precautions     Other:  
**Rehabilitation Potential:**     Good     Fair     Poor

**14. MENTAL STATUS**  
May include information related to behavior and/or cognition such as aggression, depression, agitation, confusion, and developmental disabilities.

No limitations noted – oriented to name, date, place, and time.



Treatment Period: \_\_\_\_\_  
FROM TO

**15. DURABLE MEDICAL EQUIPMENT**  
Include all types of equipment used, providers of equipment, and funding sources (if known).

TYPE	PROVIDER NAME	FUNDING SOURCE

**16. MEDICAL SUPPLIES**  
Include all types of supplies used, providers of supplies, and funding sources (if known).

TYPE	PROVIDER NAME	FUNDING SOURCE

Treatment Period: \_\_\_\_\_  
 FROM TO

**17. THERAPIES/REFERRALS**  
**Check all that apply. Please include the date the referral was made and the reason why.**  
**If therapy is ongoing, please indicate the current progress/status in Section 20.**

- Physical Therapy  
 Date \_\_\_\_\_ Referral Reason \_\_\_\_\_
- Occupational Therapy  
 Date \_\_\_\_\_ Referral Reason \_\_\_\_\_
- Speech Therapy  
 Date \_\_\_\_\_ Referral Reason \_\_\_\_\_
- Enterostomal Therapy  
 Date \_\_\_\_\_ Referral Reason \_\_\_\_\_
- Medical Social Worker  
 Date \_\_\_\_\_ Referral Reason \_\_\_\_\_
- Nutritionist  
 Date \_\_\_\_\_ Referral Reason \_\_\_\_\_
- Other/List  
 Date \_\_\_\_\_ Referral Reason \_\_\_\_\_
- Other/List  
 Date \_\_\_\_\_ Referral Reason \_\_\_\_\_
- Other/List  
 Date \_\_\_\_\_ Referral Reason \_\_\_\_\_

**18. TREATMENT GOALS/DISCHARGE PLAN**  
**Please check only one.**

Upon completion of this treatment plan, the applicant/participant will be able to function independently and maintain himself/herself safely in the home setting.

Upon completion of this treatment plan, the applicant/participant will continue to need:  
 minimal     moderate     maximum support to be maintained safely in the home setting.  
 Describe specific goals and discharge plan, as related to the identified needs:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**19. TRAINING NEEDS FOR APPLICANT/PARTICIPANT/FAMILY**

- No training needs have been identified for the applicant/participant and/or the family during this treatment period.
- Yes, there are training needs for the applicant/participant and/or the family during this treatment period.  
 Date \_\_\_\_\_ training was conducted.



Treatment Period: \_\_\_\_\_  
 FROM TO

**21. After completing, please obtain original signatures. Keep the original and mail a copy to the appropriate IHO Regional Office attention to the Medi-Cal In-Home Operations assigned Nurse Case Manager.**

The POT must be signed by the applicant/participant, by the participant's primary caregiver or legal representative/legally responsible adult(s), and the primary care physician. Each provider must also sign the POT. Providers include: (1) Personal Care Agencies (PCA) representative; (2) Individual Nurse Provider (INP); and (3) Waiver Personal Care Services (WPCS) Providers. A WPCS provider must be described in the participant's primary care physician-signed POT. Each WPCS provider must sign the POT. A separate page for WPCS provider signatures may be attached to a POT provided by a Home Health Agency. Home Health Agency (HHA) provider representative completes the 485 plan of treatment not the POT.

_____ Applicant/Participant Signature	_____ Print Name	_____ Date
_____ Primary Caregiver Signature (as applicable)	_____ Print Name	_____ Date
_____ Physician Signature	_____ Print Name	_____ Date
_____ Provider Signature	_____ Print Name	_____ Date
_____ Provider Signature	_____ Print Name	_____ Date
_____ Provider Signature	_____ Print Name	_____ Date
_____ Provider Signature	_____ Print Name	_____ Date
_____ Provider Signature	_____ Print Name	_____ Date
_____ Provider Signature	_____ Print Name	_____ Date
_____ Provider Signature	_____ Print Name	_____ Date

**Please write in abbreviated form which provider type you are next to your signature.**

Example:

<i>John Doe - INP</i> _____ Provider Signature	<i>John Doe</i> _____ Print Name	<i>2/20/2014</i> _____ Date
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