Ohio Department of Mental Health and Addiction Services

Personal Care Plan
5122-30-26

Date of Plan:

Resident Name or Agency Identifier

Date of Admission

Date of Birth:

Previous Placement

Social Security Number:

Medicaid Number:

Medicare Number:

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 advance directive? ◯ Yes ◯ No If yes, attach a copy.

Psychiatric advance directive? ◯ 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 SUD 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	Responsible Party(s)
Assistance with Hygiene	◯ Yes ◯ No	◯ Prompting Assistance Needed	◯ Treatment Provider Staff
Comment:		◯ Indicate Resident Independent	◯ RCF Staff Member ◯ Both
Assistance with Walking/Moving	◯ Yes ◯ No	◯ Prompting Assistance Needed	◯ Treatment Provider Staff
Comment:		◯ Indicate Resident Independent	◯ RCF Staff Member ◯ Both
Assistance with Dressing	◯ Yes ◯ No	◯ Prompting Assistance Needed	◯ Treatment Provider Staff
Comment:		◯ Indicate Resident Independent	◯ RCF Staff Member ◯ Both
Assistance with Grooming/Hair Care	◯ Yes ◯ No	◯ Prompting Assistance Needed	◯ Treatment Provider Staff
Comment:		◯ Indicate Resident Independent	◯ RCF Staff Member ◯ Both
Assistance with Toileting	◯ Yes ◯ No	◯ Prompting Assistance Needed	◯ Treatment Provider Staff
Comment:		◯ Indicate Resident Independent	◯ RCF Staff Member ◯ Both
Assistance with Eating	◯ Yes ◯ No	◯ Prompting Assistance Needed	◯ Treatment Provider Staff
Comment:		◯ Indicate Resident Independent	◯ RCF Staff Member ◯ Both
Assistance with Nail Care	◯ Yes ◯ No	◯ Prompting Assistance Needed	◯ Treatment Provider Staff
Comment:		◯ Indicate Resident Independent	◯ RCF Staff Member ◯ Both
Assistance with Budget/Money Management	◯ Yes ◯ No	◯ Prompting Assistance Needed	◯ Treatment Provider Staff
Comment:		◯ Indicate Resident Independent	◯ RCF Staff Member ◯ Both
Preparation of Special Diets	◯ Yes ◯ No	◯ Prompting Assistance Needed	◯ Treatment Provider Staff
Comment:		◯ Indicate Resident Independent	◯ RCF Staff Member ◯ Both
Other:	◯ Yes ◯ No	◯ Prompting Assistance Needed	◯ Treatment Provider Staff
	◯ Unknown	◯ Indicate Resident Independent	◯ RCF Staff Member ◯ Both
Other:	◯ Yes ◯ No	◯ Prompting Assistance Needed	◯ Treatment Provider Staff
	◯ Unknown	◯ Indicate Resident Independent	◯ RCF Staff Member ◯ Both

Resident Signature	Date	◯ refused to sign
Residential Staff Signature	Date	
Guardian/Family Signature	Date	
Casemanager/CPST Signature	Date	
Other Provider (if applicable)	Date	