Pamela D. Wilson
Client Care Plan & Progress Notes

Personal Information for

Client Name (nickname):

DOB:

Last 4 of SSN:

Private Home Address (current living situation) Phone/Email Address:
Address
Telephone
Email:
Other:

Lock Box or Garage Code Access:

If Care Community (and not a private home):

Present Community (move-in date)

Community Name, Address, and Staff Member Contact Information:

Community Care Plan Assessment Meetings: (should occur every three months):

Prior Community Dates of Residence and Information:

HIPPA:

- HIPPA most recent completion date
- HIPPA documentation on file from other providers:
- HIPPA disclosure approved to the following individuals:

DNR/MOST Date of Completion or Update:

Background Related to Need for Care:

Current Care Plan Objectives (Updated every three months):

Monitoring at Each Visit:

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Legally Responsible Party Information:

Guardian / Medical Power of Attorney
Address, phone number, and email address

If Guardian, Due Date of Annual Report:

Conservator / Power of Attorney Information
Address, phone number, and email address

Confirm List of Legal Documents and Scanned Status:

- Medical POA
- Financial POA
- Living Will
- HIPPA
- Trust or Will
- Guardian or Conservator Forms

Client Descriptive Information (needed to complete the MOST form):

- Eye color
- Hair color
- Ethnicity

Family & Friend Information:

Primary family caregiver(s) and relationships (if applicable):

Level of Involvement of Available Family Members (and permission to contact):

Friend Information and Involvement (and permission to contact):

Emergency Information:

Emergency Contact Name/Phone:

Allergies (food or medications – describe the specific reaction):

Special Instructions
(Emergency directions, items in the household, the location of flash drive/passwords, etc.):

Pets:

Pet Type and Name:

Veterinary Information:

Veterinary Appointments (bullet point)

Special Instructions:

Non- Medical Caregiving Agency Information:

Present:

Current Non-Medical Caregiving Agency and Staff Contact Names:

Hourly rate:

Non-Medical Caregiving Agency Care Plan Assessment Meetings: (should occur every three months):

Caregiving Agency or Other Provider Care Plan Updates (Date/by Whom):

Initial Date of Hire:

Caregiver Schedule: Name of Caregiver, Day of Week, Hours Scheduled:

Past:

Past Non-Medical Caregiving Agency and Staff Contact Names:

Past Non-Medical Caregiving Agency Care Plan Assessment Meetings: (should occur every three months):

Past Caregiving Agency or Other Provider Care Plan Updates (Date/by Whom):

Initial Date of Hire/End Date of Service:

Past Caregiver Schedule: Name of Caregiver, Day of Week, Hours Scheduled:

Type of Medical Insurance/Long Term Care Insurance and Contact Information (if applicable):
Medicare:
Secondary Insurance
Prescription drug plan if separate:
Vision, dental or other plans:
Life Insurance Policy:

Medical Diagnosis (bullet each one):

Vaccinations (list type and date):

Past Abuse or Mental Health Issues (if applicable):

Present Primary Care Physician Information (name/type/address/phone/fax) (bullet each one):

Present Primary Care Physician Medical Appointments (scheduled/future/follow-ups/visit notes obtained):

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Past Primary Care Physician Information:

Past Primary Care Physician Information (name/type/address/phone/fax - last date of service) (bullet each one):

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Past Primary Care Physician Medical Appointments (scheduled/future/follow-ups) (bullet each one):

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Present Other Health Provider Information (medical specialists like cardiologists, neurologists, dentist, optometrist, etc.) (Bullet each one):

Present Other Health Provider appointments (scheduled/future/follow-ups/visit notes obtained)

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Past Other Health Provider Information (medical specialists, dentist, optometrist)

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Past Other Health Provider appointments (scheduled/future/follow-ups):

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Medical Equipment (provider/serial numbers, etc.- take photos for recordkeeping):

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Hospitalizations and Skilled Nursing Stays:

Past Hospitalizations (list admit, discharge date, reason):

Records Requested and Obtained (list details):

Past Skilled Nursing Home Stays (list admit and discharge date):

Records Requested and Obtained (list details):

Medical or Skilled Agency Information (this includes physical or occupational therapy, hospice, therapists /visit notes obtained**):**

Present:

Current Medical Caregiving Agency and Staff Contact Names:

Medical Caregiving Agency or Other Provider Care Plan Updates (Date/by Whom):

Initial Date of Hire:

Personnel Schedule: Name of Caregiver, Day of Week, Hours Scheduled:

Past:

Current Medical Caregiving Agency and Staff Contact Names:

Medical Caregiving Agency or Other Provider Care Plan Updates (Date/by Whom):

Initial Date of Hire/End Date of Service:

Personnel Schedule: Name of Caregiver, Day of Week, Hours Scheduled:

Other Professional Service Providers:

Present Attorney/CPA/Financial Planner etc. (if applicable):

Present Provider Appointment Dates:

Past Attorney/CPA/Financial Planner etc. (if applicable):

Past Provider Appointment Dates:

Location of Safety Deposit Box or Important Documents:

Other Personal Care Providers (beauticians, non-physician foot care, etc.)

Present Provider (contact information and rates):

Present Provider Appointment Dates:

Past Provider (contact information and rates):

Past Provider Appointment Dates:

Household Service Providers:

Present Service Provider Information (household repairs, lawn/snow, trash, etc.):

Present Service Provider Appointment Dates (bullet point):

Past Service Provider Information (household repairs, lawn/snow, etc.):

Past Service Provider Appointment Dates (bullet point):

Are there Homeowners, Vehicle, Umbrella, or Other Policies?:

Medication Management
Who manages?

Pharmacy:

Medication List (name/dosage/frequency in the chart below, if multiple prescribers make a chart for each prescribing physician):

Date of the Last Update and by whom (this list should be updated monthly):

Medication	Dosage	Frequency

Medications Added/Reason (bullet each one):

Medications Change Date/Reason (bullet each one):

Medications Discontinued/Reason for DC (bullet each one):

Vitals:

Date	BP	Pulse	Temp	Height	Weight	O2	Body Mass

Personal Preferences (likes/dislikes – this means if you could not speak, what would you want your care providers to know about you?

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Religious Preference:

Marital Status and Family Background:

Client Personal History (work/career, personal, geographical locations, military service, hobbies, etc.)

End of Life:

Information Needed for Death Certificate and End of Life Wishes
(Include will, living will, advance directives, burial or cremation, ceremony, etc., 5 Wishes):

- City and State where born
- Parent's names including mother's maiden name
- Level of education attained
- Working profession job title

Pre-Arrangement (Burial or Cremation) Information and Contact:

Medicaid Forecast (if applicable):
Confirm availability of documents:

- Birth certificate
- Photo identification
- Legal docs - POA etc.
- Verification of income letter from income sources

- Bank statements
- Medicare card
- Social security card (is there a rep payee?)
- Other insurance card
- Pre-paid irrevocable burial plan
- Life insurance
- Location of the safety deposit box

Client Progress Notes:

List the date and then create a detailed note about doctor appointments, phone calls, other contacts, and next steps here.

