Quality Care III, LLC

Date: 7/24

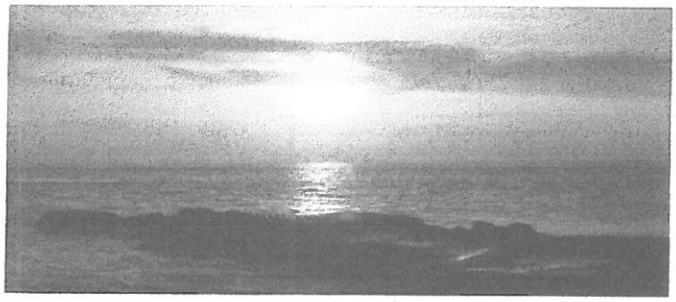
I [redacted] am acknowledging that on _____ I received an Inservice on the update to the Job description for which I was hired for, and the recent changes to the policy regarding the hiring process for administrative staff by the human Rights Committee of Quality Care III LLC. I have received copies of all updates for personal records.

I do understand that if I have any questions regarding any parts of my job I am to write down all of my concerns and questions to my immediate supervisor.

Staff Signature [redacted] Date 7/24/18

Qualified Professional [redacted] BS/AP Date 7-24-18

Quality Care III, LLC



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Staff Signatur[redacted] Date 7/24/18

Qualified Professional[redacted] BS/QP Date 7-24-18

Quality Care III, LLC

Date: 7-24-18

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Qualified Professional [redacted] BS/QP Date 7-24-18.

Quality Care III, LLC

Date: 7/24/18

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Staff Signature [redacted] Date 7/24/18

Qualified Professional [redacted] BS/QP Date 7-24-18

Quality Care III, LLC

Date: 6-24-18

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Staff Signature [redacted] Date 6-24-18

Qualified Professional [redacted] BS/DP Date 7-24-18

Quality Care III, LLC

Date: 7-24-18

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Staff Signature [redacted] Date 7-24-18

Qualified Professional [redacted] BS/QP Date 7-24-18

Quality Care III, LLC

Date: 7/24/18

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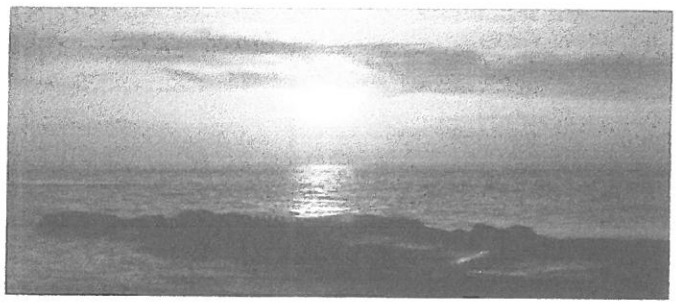
Staff Signature [redacted] Date 7/24/18

Qualified Professional [redacted] BS/QP Date 7.24.18

Quality Care III, LLC



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Staff Signature [redacted] Date 7/24/18

Qualified Professional [redacted] BS/QP Date 7-24-18

Human Rights Committee

I. Purpose:

The objective of this policy is to ensure that all consumers supported by Quality Care III. are afforded the opportunity to exercise them and that rights violations do not occur, in accordance with NCAC 27G. 0504. This policy applies to all locations operated by or under the supervision of Quality Care III.

II. Policy

The Human Rights Committee will monitor all services being provided to consumers supported by Quality Care III. This committee role will be but not limited to the review of restrictive interventions utilized in all facilities; reports of abuse, neglect or exploration; consumer grievances; and the hiring process of all administrative members such as Clinical Staff, QP and office personnel. The committee will also provide needed services that are available in the area program. The responsibility of each member is to ensure that the policies & procedures and practices of the organization is being performed and that each individual that is served rights are withheld to the extinct of the law.

Ill. Procedures:

A. The human rights committee will have a least one member who is a professional with training and experience in use of the type of interventions reviewed by the committee and who is not directly involved in the treatment or habilitation of the consumer.
B. Other members will consist of: 2- guardians, therapeutic provider, Consumer, President or his/her designee, Habilitation Technician, and Clinical Professionals.
C. The President appoints members. All members will serve one (2) year terms beginning January of each year. Members are eligible for more than one 2- year term.
D. The committee will receive specific training and orientation, be provide specific copies of related statutes and rules.
E. The committee will meet once per quarter or more frequently if needed. Meeting months are as follows: January, April, July and October.
F. Committee will maintain minutes of each meeting. The committee will record all activities, documents and any issues taken. The committee will follow up on all action taken. When identifying Clients, Clients are not identified by first and last name in minutes, oral or written reports. Identification is by first name, last name or initials.

Human Rights Committee

G. Members of the committee shall have access to consumer records on a need to know basis only upon the written consent of the consumer or his legally responsible person as specified in G.S. 122C-53 (a). Committee members must adhere to the same confidentiality requirements as all Quality Care III employees, contractors and other parties involved in provision of services.

H. The committee shall review all instances where a rights violation may have or is suspected of occurring.

J. The committee will review the frequencies and reason surrounding the use of restraints for behavioral or medical purposes.

K. The committee will review medication errors to ensure that people are provided the best treatment and care.

L. The committee will review all reports of substantiated allegations of abuse, neglect, mistreatment, and exploitation and other data that reveal Quality Care lll practices.

M. The committee is to review all behavior plans that include restrictive and intrusive behavior.

N. The committee is responsible to review all incident reports to gather data to find trends in behaviors.

O. The committee will be responsible for assuring that quality care is being done across the board by being responsible for the hiring process of all office personnel including QP. The committee will work with the share holders in making sure everyone is properly trained and that continued training continues throughout the employee employment with the agency.

F. The committee will meet quarterly during quarterly meetings to hold individual supervision of all administrative team members (this include, QP, nurses, clinical staff) to ensure quality service is being upheld according to everyone job responsibilities.

Quality Care III LLC

Admission Assessment

Individual Name:	Last Name:	First:	MI:	DOB:
Guardian of not their own				
Address/Number (Current)				
Emergency Contact				
Address/ Number (Agency) (Home)				
Responsible Person Emergency Contact (Agency)				
Record Number				
Medicaid Number				
Social Security Number				
Gender	Male	Female	Other	
Height/Weight				
Race				
Marital Status:	Single	Married	Divorce	Widowed	Other
Race	Black	White	Indian	Hispanic	Other:
Spoken language				
Have you ever been Incarcerated? If yes explain, when, where how long.				
Have you ever been convicted of a crime that involves sexual misconduct? If yes explain				

Are you currently on probation, if so, why, how long and who is the contact person for your probation.	
Explain any restrictions you may have in regard to your probation.	
Have you ever been convicted of posseing of any illegal Substance? If so, when was the conviction and for what substance.	
Have you ever been adjudicated as being incompetent.	Yes No Explain:
Source of Income	Work- Yes or No number of hours work per week Take home before taxes
Insurance	Medicaid Number: Medicare Number: Other:
Mental Health Diagnosis	Axis I Axis II Axis III Axis III Axis IV
List of Medication	1). 2). 3). 4). 5). 6). 7). 8). 9). 10).
Allergies	

Primary Physician	
Address/Number	
Psychiatrist	
Address/Number	
Dentist	
Address/Number	
Care Coordinator	
Agency	
Address/Number	
Pharmacy	
Address Number	
Preferred Hospital	
Needs/ Strength	

Follow-Up	
Signature of Individual/ or Legally Responsible Person	Date:

Person Completing Assessment_____Date_____

Quality Care III LLC. Treatment Team Summery

Consumer Name: [redacted] **Record Number:** [redacted]

Date: 05/30/2018

I. Introduction: [redacted]

Team Members Present: (See Attachment)

II. Agenda: update on his care and recent behaviors

III. Overview: current parole Violation

iv. Strengths: he has a support system that supports him.

v. Goals- To help his sister gain guardianship and planning for his return from jail.

vi. Crisis Intervention- Continue to monitor all behaviors and changes in his care

vii. Comments/Follow-up. During the meeting [redacted] care coordinators where present alone with MR. [redacted] the owner of Quality Care IIILLC, and [redacted] sister was via telephone. Well [redacted] recently had an incident where he violated his parole and was sent to jail. [redacted] was in jail at the time of the meeting. The team wanted to put things in place to present to the judge on [redacted] behalf. The team suggested that [redacted] sister try and obtain guardianship for him. [redacted] is not to have any unsupervised time. [redacted] will no longer attend RAC. Mr. [redacted] suggested that [redacted] get on some type of medication and will be setting him up an appointment with [redacted] (Carter Circle of Care). [redacted] sister would also like for the team to work on getting [redacted] a psychological. [redacted] parole hearing is 6-4-2018 and at that time his sister will inform Mike attorney of things that will be put in place in case [redacted] is release. The charges that [redacted] face is socializing with a minor.

viii. Significant events: when [redacted] goes to court and if by chance he is release he must be supervised 24/7.

ix. Summery- continue to monitor and document any negative behavior

Note: No other meeting has been scheduled at this time.

Qualified Professional/responsible person: [redacted] *BS/QP* *Date:* 5-30-2018

Quality Care III LLC

Treatment Team Meeting

Sign-In log [redacted]

Agency QP [redacted] Date 5-30-2018

Date	Print Name	Agency	Signature
5/31/18	[redacted]	QCTIII, LLC	[redacted]
5/30/18	[redacted]	Sandhills	[redacted]
5/30/18	[redacted]	Sandhills	[redacted]

Quality Care III LLC

Admission Assessment

Individual Name:	Last Name: [redacted] First: [redacted] MI: DOB: [redacted]
Guardian of not their own	[redacted] TO his own Guardian At this Time.
Address/Number (Current)	[redacted]
Emergency Contact	[redacted] OR Sister. [redacted]
Address/ Number (Agency) (Home)	[redacted]
Responsible Person Emergency Contact (Agency)	[redacted] -Quality Care III LLC.
Record Number	[redacted]
Medicaid Number	[redacted]
Social Security Number	[redacted]
Gender	(Male) Female Other
Height/Weight	5.10 [redacted]
[redacted]	[redacted] 240lbs?
Marital Status:	(Single) Married Divorce Widowed Other
Race	Black (White) Indian Hispanic Other:
Spoken language	English.
Have you ever been Incarcerated? If yes explain, when, where how long.	YES, INDIVIDUAL WAS IN JAIL FOR INDECENT LIBERTIES WITH A MINOR. HE WAS CHARGED AND SPENT SEVERAL YEARS.
Have you ever been convicted of a crime that involves sexual misconduct? If yes explain	YES, AS STATED BEFORE MIKE WAS IN JAIL FOR INDECENT LIBERTIES WITH A CHILD. MIKE HAS ALSO MADE SEVERAL UNCOMFORTABLE TO WOMEN IN THE PAST.

Are you currently on probation, if so, why, how long and who is the contact person for your probation.	[redacted] IS CURRENTLY ON PROBATION. HE HAS ATLEAST 4 YEAR BEFORE HE GETS OFF PAROLE. [redacted] PAROLE IS THROUGH CURRITAS COUNTY, AND HIS PAROLE OFFICER IS. MR. DRAH.
Explain any restrictions you may have in regard to your probation.	[redacted] IS NOT ALLOWED TO BE LEFT UNATTENDED. HE NEEDS 24 HOUR SUPERVISION. MIKE MUST NOT BE AROUND WHERE CHILDREN MIGHT BE. [redacted] IS TO REPORT TO PROBATION OFFICER MONTHLY.
Have you ever been convicted of posseing of any illegal Substance? If so, when was the conviction and for what substance.	N/A.
Have you ever been adjudicated as being incompetent.	Yes (No) Explain:
Source of Income	Work- Yes or No number of hours work per week Take home before taxes
Insurance	Medicaid Number: [redacted] Medicare Number: Other:
Mental Health Diagnosis	Axis I TBI. Axis II Axis III Axis III Axis IV
List of Medication	1). TEGRETOL 200mg TAB. 2). CALCIUM CITRATE. 3). NAPROXEN 375. 4). 5). 6). 7). 8). 9). 10).
Allergies	

Primary Physician	MARK Perini - 336-288-3672.
Address/Number	
Psychiatrist	Monarch.
Address/Number	Guilford Center.
Dentist	N/A.
Address/Number	
Care Coordinator	[redacted]
Agency	Sandhills Center.
Address/Number	[redacted]
Pharmacy	Monarch.
Address Number	
Preferred Hospital	Wesley Long.
Needs/ Strength	[redacted] has the desire to help people, he always like. to be the life of the party. He needs 24 hour supervision eventhough he is very independent. [redacted] sometimes get. very agitated and need for staff to talk to him to calm some of the agitation.

Follow-Up	[redacted] MAKE SURE he follows All the Rules of His probation unless he could be subject to go back to JAIL. [redacted] must Remember he is not Allowed to be Around no children. Staff must Advocate for [redacted] to get him into therapy to talk About his issues, [redacted] Parole officer number 336-803-4847.
Signature of Individual/ or Legally Responsible Person	Date:

Person Completing Assessment Lee Bradley BS/QP Date 7-16-2018.

Sandhills Center
Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph and Richmond Counties

North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Name: [redacted] Record Number: [redacted]

Medicaid ID: [redacted] **ISP Start Date: 2/17/2018**

Meeting Date: _1/30/2018
Update: 6/26/2018_____

Individual Support Plan For:
[redacted]

WHAT PEOPLE LIKE AND ADMIRE ABOUT ME…

People like my attitude it takes a lot to get me down.
People admire that have the desire to help people.
People also like my inner strength.
I am an Entertainer and people like that.
People like that I am the spark of the party.

WHAT'S IMPORTANT TO ME…

What is important to me is learning the will of GOD.
Being Obedient to in life especially with the word of God.
My family is important to me.
Getting my GED is important.
It is important that I go to church.
Being able to have peace is very important to me.

RELATIONSHIPS IN MY LIFE…

Natural, Unpaid, and Community Supports:	Paid Supports:
Sister- [redacted] **Siblings** **IRC**	**Quality Care III** **Mr. Pratt (Probation officer)** **Sandhills- Kelvin McRae-Ashley Lucas**

Name: [redacted] Record Number: [redacted]

Medicaid ID: [redacted] **ISP Start Date:** **2/17/2018**

WHAT OTHERS NEED TO KNOW TO BEST SUPPORT ME…

Life Situation- [redacted] also suffered a TBI from a car accident when he was younger. As he has gotten older his dementia has increased. [redacted] can be very manipulative by nature. He also feels that there is nothing wrong with him. [redacted] also has charges of sexual assault on a minor therefor cannot be around children. Where ever he is located there can't be a playground in the area. He is also registered as a sex offender.

School/Vocational- [redacted] will be going to the IRC to complete his GED. [redacted] is also a hard worker and is very capable of working doing multiple types of jobs.

Social Network- [redacted] can be very sociable at times. He can also become overly friendly with females to the point where they may feel uncomfortable. [redacted] also is a friendly when it comes to most being and can be very helpful to others.

Medical/Behavioral: Medical: TBI- Dementia is increasing as I get older. [redacted] has high blood pressure. Behavioral: Can get angry or upset if I don't get my way. I can become aggressive towards others. When I become upset I will use vulgar language towards others.

WHAT'S WORKING AND NEEDS TO STAY THE SAME OR BE ENHANCED…

What is working is I'm out of jail and having a place to come to.
My family support that I have.
My faith. My belief in God.
Having a team that is supportive of my needs.
Current Placement
Going to school getting his GED

WHAT'S NOT WORKING AND NEEDS TO CHANGE…

What is not working for me at the current time is not having a job.
Not having 24 hours supervision in the community to keep him from violating his probation.

Name: [redacted] Record Number: [redacted]

Medicaid ID: [redacted] **ISP Start Date: 2/17/2018**

Crisis Prevention and Intervention

Significant Event(s) That May Cause Increased Stress / Trigger Crisis.

(Examples include: anniversaries, holidays, noise, change in routine, inability to express medical problems or to get needs met, etc. Describe what one may observe when the person goes into crisis. Include lessons learned from previous crisis events):

No changes: 1/30/2018

People cursing me.
Not being able to sleep because of loud noises.
If I can't have coffee in the morning.
People yelling at me.
People treating me like I am a child.
Being under Pressure.

Crisis Prevention and Early Intervention Strategies

(Describe what can be done to help this person AVOID a crisis. Include lessons learned from previous crisis events)

No changes: 1/30/2018

Walks away
Time alone Talk to mike about what is bothering him respectfully
Allow him to take deep breathes.
Allow him to watch his Tv shows.

Strategies for Crisis Response and Stabilization

(Focus first on natural and community supports. Begin with least restrictive steps, include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help this person to become stable)

No changes: 1/30/2018

Take a walk.
Get some fresh air
Give him his space
Call [redacted]
Call Sister-[redacted]
Call Parole officer-Mr. Pratt-336-803-7847
Call 911 in case he become a danger to himself or others.
Call Sandhills: Kelvin McRae- 336-3896369 or Ashley Lucas-336-389-6098

Name: [redacted]

Record Number: [redacted]

Medicaid ID: [redacted]

ISP Start Date: **2/17/2018**

Systems Prevention and Intervention Protocols To Support The Individual

(i.e. who should be called and when, how can they be reached? Include contact names, phone numbers, etc. Be as specific as possible)

Designated Crisis Services Provider

- ☐ In-Home Skill Building provider
- ☐ Personal Care Provider
- ☒ Residential Supports provider
- ☐ Back-Up Staffing Agency for Individual/Family Directed Services – Employer of Record

Name of Agency: Quality Care III

Contact Person: Erick Bradley

Day-Time Phone #: 336-558-1742 After-hours Phone #:

Other

Specific Recommendations For Interacting With The Person Receiving a Crisis Service

Talk calmly to Michael.
Bring up prayer.

Behavioral Supports Needed

Behavior Support Plan is required if • **Rating is ≥ 13 for children (ages 21 and under)** • **Rating is ≥ 10 for adults (ages 22 and over)** • **Any individual identified as a Community Safety Risk based on self injury or dangerousness to others**	**Supports Intensity Scale / Behavioral Rating**	
	Community Safety Risk based on self injury or dangerousness to others?	☐ Yes ☐ No

Name: [redacted] Record Number: [redacted]

Medicaid ID: [redacted] **ISP Start Date:** **2/17/2018**

Primary Care Physician

Name:	Phone:

Risk Summary

Area of Support on Risk/Support Needs Assessment	Risk/Support Identified		
	Yes	No	
Demographic Information	☒	☐	**All identified risks/supports must be included in/addressed within the plan.**
Material Supports	☐	☒	
Physician Supports	☐	☒	
Professional Supports	☐	☒	
Medication Supports	☐	☒	
Medical Treatment Supports	☐	☒	
Health and Wellness Supports	☐	☒	
Health Screenings /Preventative Care	☐	☒	
Nutrition Supports	☐	☒	
Vision Related Supports	☐	☒	
Hearing Related Supports	☐	☒	
Supports for Communicating Needs	☐	☒	
Positive Behavior Supports	☐	☒	
Safety Supports in Home and Community	☐	☒	

Back-Up Staffing Plan

Agency-Directed Services OR Individual/Family Direction / Agency With Choice (AWC) Model	Who	Contact #
Agency Back-Up (mandatory)	**Quality Care III**	**336-558-1742**
Non-Paid Back-Up (in the event of an emergency)	[redacted]	[redacted]

Individual/Family Direction / Employer of Record (EOR) Model*	Who	Contact #
Back-Up Staffing Agency (Back-Up Staffing Agency must be included, even if EOR does not anticipate needing to use this agency)		

*** Employer of Record will ensure that Back-Up Staffing Plan for Individual/Family Directed Services is reviewed at least quarterly and that this review is documented.**

Name: [redacted] Record Number: [redacted]

Medicaid ID: [redacted] **ISP Start Date: 2/17/2018**

Action Plan

* For short-range goals, see provider plan

Long Range Outcome : [redacted] wants to be continue to be happy. He wants to be able to get supported employment so he can get more income. He also want to become more independent and do things more for himself. [redacted] also wants to complete his GED through the IRC program. [redacted] also wants to improve his overall behaviors when he becomes upset and interacts with others.

Where am I now in Relationship to the Outcome? (Reason for outcome/Justification):
[redacted] needs assistance with coordinating and getting to doctor's appointment, ensuring that he takes his medications and with overall managing of his health and safety. [redacted] also is on Probation for sexual assault on a minor and needs to be supervised at all times while in the community. [redacted] recently left his day facility and went to a minor's home that he met at church but was met at the home by her parents. [redacted] went to jail for about a week for violating his probation. Due to recent events, [redacted] need 24 hours of supervision at all times. [redacted] also needs to seek outpatient therapy to help with his sexualized behaviors. Without those continued monitoring services and prompting [redacted] behaviors would decline.

Service / Support to Reach Outcome	Who will provide Support & Location(s)* (where service/support will be provided)	Estimated Frequency for Each Location (e.g. 75% of hours, 3 out of 5 days, 2 hours/day)	Target Date
Supervised Living Level II	**Quality Care III 1,4**	**365 day year/7 days a week**	**2/17/19**
Service / Support to Reach Outcome	Who will provide Support & Location(s)* (where service/support will be provided)	Estimated Frequency for Each Location (e.g. 75% of hours, 3 out of 5 days, 2 hours/day)	Target Date
Personal Assistance	**Quality Care III 3,4**	**32.5 Hours weekly**	**2/17/19**

* **Location Codes:** 1-Consumer's Home 2-Day Program 3-Residential Facility 4-Community 5-Place of Employment 6-Volunteer Site 7-Worker's Home 8-Other (Please specify)

Long Range Outcome :

Where am I now in Relationship to the Outcome? (Reason for outcome/Justification)

Service / Support to Reach Outcome	Who will provide Support & Location(s)* (where service/support will be provided)	Estimated Frequency for Each Location (e.g. 75% of hours, 3 out of 5 days, 2 hours/day)	Target Date
Service / Support to Reach Outcome	Who will provide Support & Location(s)* (where service/support will be provided)	Estimated Frequency for Each Location (e.g. 75% of hours, 3 out of 5 days, 2 hours/day)	Target Date

Name: [redacted] Record Number: [redacted]

Medicaid ID: [redacted] **ISP Start Date: 2/17/2018**

*** Location Codes:** 1-Consumer's Home 2-Day Program 3-Residential Facility 4-Community 5-Place of Employment 6-Volunteer Site 7-Community 8-Worker's Home 9-Other (Please specify)

Status of Individual and Family Direction

N/A ☒	Individual is not an Innovations participant
Yes ☐ No ☐	Currently involved with Individual/Family Direction (If yes, skip the next 3 questions)
Yes ☐ No ☐	Orientation to Individual/Family Direction Given
Yes ☐ No ☐	Individual/Family Chose Not To Receive Orientation
Yes ☐ No ☐	Interested in Individual/Family Direction

Care Coordination

Your Care Coordinator can assist you in the following ways:

- Assisting you with assessment and documentation of your support needs
- Assistance with development of your plan and Individual Budget.
- Monitoring services to ensure that you are receiving services to meet your needs and that you are happy with them.
- Monitoring to ensure that you are healthy and safe.
- Helping you receive information on directing your own services.
- Help you with problems or complaints about services, if necessary.

Monitoring Plan (√ all that apply)

☒ Minimum of monthly contact

☐ Minimum of monthly face-to-face contact

Required for the following:

- individuals living in residential placements, including alternative family living homes
- individuals new to the waiver for the first six months
- individuals who have service(s) provided by a guardian or relative living in the same home
- individuals participating in Individual and Family Directed Services

☐ Minimum of quarterly face-to-face contact with individual

☐ Other _____

Issues To Be Resolved

Issue	Discussion At Plan Meeting	Who needs to be involved?	Target Date

Name: [redacted] Record Number [redacted]

Medicaid ID: [redacted] **ISP Start Date: 2/17/2018**

Signature Pages

Innovations Waiver / Level of Care Re-Determination

☐ I certify that there has been no substantial change in the individual's condition and that the individual continues to require an ICF/MR Level of Care.

☐ There has been a change in the individual's condition and the individual needs an ICF/MR assessment.

Care Coordinator: _____ Date: _____

Innovations Waiver / Freedom of Choice

I understand that enrollment in the Innovations Waiver is strictly voluntary. I also understand that if enrolled I will be receiving Waiver services instead of services in an Intermediate Care Facility for the Mentally Retarded. I understand that in order to be determined to need waiver services, an individual must require the provision of at least one waiver service monthly and that failure to use a waiver service monthly will jeopardize my continued eligibility for the Innovations waiver.

☒ **I have chosen** Innovations Waiver Services

☐ **I have not chosen** Innovations Waiver Services

[redacted] 7-3-18

Signature of Individual or Legally Responsible Person Date

Name [redacted] Record Number: [redacted]

Medicaid ID: [redacted] **ISP Start Date:** 2/17/2018

Statement of Concern or Disagreement

I, the individual/Legally Responsible Person signing this plan have concerns or disagree with the following issues related to my Individual Support Plan:

Plan Signatures

By signing this plan, I am indicating agreement with the bulleted statements listed here unless crossed through. I understand that I can cross through any statement with which I disagree.

- My Care Coordinator helped me know what services are available.
- I was informed of the range of providers in my community qualified to provide the service(s) included in my plan and freely chose the providers who will be providing services/supports.
- This plan includes the services/supports I need.
- I participated in the development of this plan
- I understand that Sandhills Center will be coordinating my care with the Sandhills Center network providers listed in this plan

[redacted] 6-26-18
Signature of Individual Date

Signature of Legally Responsible Person Date

[redacted] 6-26-18
Signature/Credentials of Care Coordinator Date

[redacted] 6-26-18
Signature/Credentials of QP (if applicable) Date

[redacted] BS/QP 6-26-2018.
Other Signature Date

SANDHILLS CENTER

Certificate of Training

Granted to

[redacted]

Name

For Successful Completion of

Writing Effective Short Range Goals

Course Title

July 26, 2016

Date(s)

Lisa Bunting Bradley, MSW, LCSW

Instructor(s)

6 Contact Hours

Training Hours

these
goals were
revised after
mike violated her
probation

Revised

Name: [redacted] DOB: [redacted] Medicaid Number: [redacted] Record Number: [redacted]

ACTION PLAN

The Action Plan should be based on information and recommendations from: **the Comprehensive Clinical Assessment (CCA), the One Page Profile, Characteristics/Observations/Justifications for Goals, and any other supporting documentation.**

Long Range Outcome: (Ensure that this is an outcome desired by the individual, and not a goal belonging to others).

[redacted] wants to be able to continue to be happy. He wants to be able to get supported employment so he can get more income. He also wants to become more independent and don things more for himself. [redacted] also wants to complete his GED through IRC program. [redacted] also wants to improve his overall behaviors when he becomes upset and interacts with others.

Where am I now in the process of achieving this outcome? (Include progress on goals over the past years, as applicable).

[redacted] needs assistance with coordinating and getting to doctor appointments, ensuring that he takes his medication and with overall managing of his health and safety. In the past [redacted] has had some issues with eloping but due to the improvement of his behavior and with the direct care most of his behaviors have decreased. Without those continued monitoring services and prompting [redacted] behavior would decline.

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Daily Living Skills Residential- House Hold Chores

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
Goal (1 [redacted] will Independently keep his room clean and neat at all times	Quality Care III LLC Residential Staff	Daily for the next 6 months

Task: In the morning and throughout the day [redacted] will learn to keep his bed made, dresser clean, his clothes put away (either in the dirty clothes hamper or in the closet). Staff should check Michael room throughout the day to make sure that it is neat and clean.

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Code**	**Progress toward goal and justification for continuation or discontinuation of goal.**
11/01/2018	05/01/2018		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Daily Living Skills Residential-Personal Care

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
Goal (2) [redacted] will Independently to take a shower, and complete all of his personal care goals daily.	Quality Care III LLC Residential Staff	Daily for the next 6 months

Task: Daily in the morning [redacted] will be given an initial prompt to get up. Once [redacted] s up staff will prompt [redacted] when it's time for him to shower. [redacted] will independently turn on the water to the appropriate temperature. For safety reason and to prevent any accidents staff should check the water. [redacted] should be able to lather and wash his entire body without staff reminding him. After [redacted] has completed his shower [redacted] will dry himself off and complete all of his other personal care goals.

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Code**	**Progress toward goal and justification for continuation or discontinuation of goal.**
11/01/2018	05/01/2018		

Name: [redacted] DOB: [redacted] Medicaid Number: [redacted] Record Number: [redacted]

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Daily Living Skills Residential-House Hold Chores

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
Goal (3) [redacted] will Independently complete a list of household chores.	Quality Care III LLC Residential Staff	Daily for the next 6 months

HOW (Support/Intervention) Task: Daily [redacted] will Independently follow a list of chores that is splint up between him and his housemates. After receiving an initial prompt Michael will review the chore list and discuss with staff on what needs to be done. After receiving his directive [redacted] will be given whatever he needs to complete the task. [redacted] should be able to complete any task independently but if he does need assistance staff should document the task, and what assistance was given in the comment section of the grid. Staff should also document the appropriate prompt that was given to assist [redacted] with completing the task, if he did not complete the task independent.

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Code**	**Progress toward goal and justification for continuation or discontinuation of goal.**
11/01/2018	05/01/2018		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Daily Living Skills Residential- House Hold Chores

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
Goal (4) [redacted] will Independently do his own laundry.	Quality Care III LLC Residential Staff	7 Days a week for 365 days

HOW (Support/Intervention) Task: After initial prompt [redacted] will sort through his clothing separating the colored from the whites and place them in separate piles. Staff will monitor [redacted] while he choose which one to wash first. After selecting [redacted] will place all items in washing machine, set the appropriate water setting and place the appropriate amount of detergent in washer, and close the lid. When clothes have completed [redacted] will take clothes from washer and place them into the dryer. [redacted] will place clothes into the dryer, and will set the appropriate temperature. When clothes have completed [redacted] will learn to fold and place neatly in his room.

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Code**	**Progress toward goal and justification for continuation or discontinuation of goal.**
11/01/2018	05/01/2018		

Name: [redacted] DOB: [redacted] Medicaid Number: [redacted] Record Number: [redacted]

Status Codes:	R=Revised	O=Ongoing	A=Achieved	D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Daily Living Skills Residential-Personal Care-exercise

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
Goal (5) [redacted] will Independently learn how to properly communicate his feeling when he gets upset or agitated.	Quality Care III LLC Residential Staff	Daily for the next 6 months

HOW (Support/Intervention) Task: Staff should redirect any all negative behavior exhibited by [redacted] Staff should immediately redirect [redacted] behavior as soon as staff is aware or notice a change in him. Staff should remind [redacted] of his behavior and the consequences that can follow if he does not get himself together. Staff should allow [redacted] to calm himself down, but if at anytime staff have to redirect him staff should document on a behavior data sheet of the behavior and any triggers. After no more than 10 minutes staff will process will [redacted] to help him with solving any issues or concerns he might have. Staff will document the appropriate prompt that was given to him, if no prompt was given or if there were no behaviors staff should place an N/A in the appropriate space on the grid and write on the back of the grid no behaviors.

Target Date (Not to exceed 12 months)	Date Goal was reviewed	Status Code	Progress toward goal and justification for continuation or discontinuation of goal.
11/01/2018	05/01/2018		

Status Codes:	R=Revised	O=Ongoing	A=Achieved	D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Daily Living Skills Residential)

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
	Quality Care III LLC Residential Staff	7 Days a week for 365 days

HOW (Support/Intervention) Task:

Target Date (Not to exceed 12 months)	Date Goal was reviewed	Status Code	Progress toward goal and justification for continuation or discontinuation of goal.
11/01/2018	05/01/2018		

Status Codes:	R=Revised	O=Ongoing	A=Achieved	D=Discontinued

Name: [redacted] DOB: [redacted] Medicaid Number: [redacted] Record Number [redacted]

PLAN SIGNATURES

I. PERSON RECEIVING SERVICES:

- ☐ I confirm and agree with my involvement in the development of this PCP. My signature means that I agree with the services/supports to be provided.
- ☐ I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this PCP.
- ☐ For CAP-MR/DD services only, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with mental retardation instead of participating in the Community Alternatives Program for individuals with Mental Retardation/Developmental Disabilities (CAP-MR/DD).

Legally Responsible Person: Self: Yes ☐ No ☐

Person Receiving [redacted] ed when person is his/her own legally responsible person)

Signature: [redacted] [redacted] (Print Name) Date: 5/1/18

Legally Responsible Person (Required if other than person receiving Services)

Signature: _____ _____ (Print Name) Date: / /

Relationship to the Individual: _____

II. PERSON RESPONSIBLE FOR THE PCP: The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided.

Signature: [redacted] (Person responsible for the PCP) Qualivida Care LLC (Name of Case Management Agency) Date: 5/1/18

Child Mental Health Services Only:

For individuals who are less than 21 years of age (less than 18 for State funded services) **and who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the person responsible for the PCP must attest that he or she has completed the following requirements as specified below:**

- ☐ Met with the Child and Family Team - Date: / /
- ☐ OR Child and Family Team meeting scheduled for - Date: / /
- ☐ OR Assigned a TASC Care Manager - Date: / /
- ☐ AND conferred with the clinical staff of the applicable LME to conduct care coordination.

If the statements above do not apply, please check the box below and then sign as the Person Responsible for the PCP:

- ☐ This child is not actively involved with the Department of Juvenile Justice and Prevention or the adult criminal court system.

Signature: _____ _____ Date: / /
(Person responsible for the PCP) (Print Name)

III. SERVICE ORDERS: *REQUIRED for all Medicaid funded services; RECOMMENDED for State funded services.*

(SECTION A): For services ordered by one of the Medicaid approved licensed signatories (see Instruction Manual).

My signature below confirms the following: (Check all appropriate boxes.)

- Medical necessity for services requested is present, and constitutes the Service Order(s).
- The licensed professional who signs this service order has had direct contact with the individual. ☐ Yes ☐ No
- The licensed professional who signs this service order has reviewed the individual's assessment. ☐ Yes ☐ No

Signature: _____ _____ License #: _____ Date: / /
(Name/Title Required) (Print Name)

(SECTION B): For Qualified Professionals (QP) / Licensed Professionals (LP) ordering:

- CAP-MR/DD or
- Medicaid Targeted Case Management (TCM) services (if not ordered in Section A)
- **OR recommended** for any state-funded services not ordered in Section A.

My signature below confirms the following: (Check all appropriate boxes.) Signatory in this section must be a Qualified or Licensed Professional.

- ☐ Medical necessity for the CAP-MR/DD services requested is present, and constitutes the Service Order.
- ☐ Medical necessity for the Medicaid TCM service requested is present, and constitutes the Service Order.
- ☐ Medical necessity for the State-funded service(s) requested is present, and constitutes the Service Order

Signature: _____ _____ License #: _____ Date: / /
(Name/Title Required) (Print Name) (If Applicable)

IV. SIGNATURES OF OTHER TEAM MEMBERS PARTICIPATING IN DEVELOPMENT OF THE PLAN:

Other Team Member (Name/Relationship): _____ Date: / /

Other Team Member (Name/Relationship): _____ Date: / /

update 7-16-2018.

Short Range Goals

[redacted]

Effective 05/1/2018

Goal (1) [redacted] will Independently keep his room clean and neat at all times

Task: In the morning and throughout the day [redacted] will learn to keep his bed made, dresser clean, his clothes put away (either in the dirty clothes hamper or in the closet). Staff should check Michael room throughout the day to make sure that it is neat and clean.

Goal (2 [redacted] will Independently to take a shower, and complete all of his personal care goals daily.

Task: Daily in the morning [redacted] will be given an initial prompt to get up. Once [redacted] is up staff will prompt Michael when it's time for him to shower [redacted] will independently turn on the water to the appropriate temperature. For safety reason and to prevent any accidents staff should check the water. [redacted] should be able to lather and wash his entire body without staff reminding him. After [redacted] has completed his shower [redacted] will dry himself off and complete all of his other personal care goals.

Goal (3) [redacted] will Independently complete a list of household chores.

Task: Daily [redacted] will Independently follow a list of chores that is splint up between him and his housemates. After receiving an initial prompt [redacted] will review the chore list and discuss with staff on what needs to be done. After receiving his directive [redacted] will be given whatever he needs to complete the task [redacted] should be able to complete any task independently but if he does need assistance staff should document the task, and what assistance was given in the comment section of the grid. Staff should also document the appropriate prompt that was given to assist [redacted] with completing the task, if he did not complete the task independent. will Independently do his own laundry.

Goal (4) [redacted] will work towards his GED by completing basic worksheets to help with his math, reading, and social skills.

Task: [redacted] is currently not in a day program so while he is at home [redacted] needs to be working on some basic skills to help him with gaining the skills he needs to prepare him for when he does return. Staff will provide [redacted] with pencil and paper and any other needed material. Staff will support [redacted] by answering any question he might have and help him tackle any task. Staff should encourage [redacted] by praising him as he complete a step or a task. Staff should always right comment on [redacted] progress or lack of progress.

Goal (5) [redacted] will Independently learn what is appropriate conversation by being aware of what he say and how he say it.

Task: Staff should redirect any all negative behavior exhibited by [redacted] Staff should immediately redirect [redacted] behavior as soon as staff is aware or notice a change in him. When [redacted] is redirected staff should remind him the consequences that can follow if he does not get himself together. Staff should allow [redacted] time to process any negative behavior but if at anytime staff do

have to redirect him staff should document the behavior and any triggers. While [redacted]s processing staff should always keep [redacted] in their view. After no more than 10 minutes staff will process with [redacted] to help him with solving any issues. Staff will document the appropriate prompt that was given to him, if [redacted] did not exhibit any negative behavior for that day staff should place in N/A in the appropriate box.

Goal 6) [redacted] will learn how to distinguish between what's appropriate and what's not appropriate

Task: [redacted]s aware of the stipulations that is surrounded by his probation. by spending no more than15 minutes daily reviewing through his list of rules and regulations as it relates to the terms of his probation. Staff should assist [redacted] to write down some of the do's and don't"s that reflex what he can and can not do while on, probation. Staff will document the number of times [redacted] needed to be reminded of any of the rules by placing the number of prompts [redacted] should be able to complete the task with an initial prompt but after the initial prompt staff should document the appropriate prompt.

Goal 7) [redacted] will learn how to manage his health by taking his blood pressure daily

Task: Everyday [redacted] should be given an initial prompt on when its time for his morning medication. After taking his morning medication staff will monitor [redacted] as he takes his blood pressure. Staff will provide [redacted] with blood pressure monitor. Michael will place the cuff on his arm and push the appropriate button. When the machine has stopped. [redacted] will document what the pressure was on the appropriate form. Staff will document the appropriate assistance given in the comment section of the grid.

Name [redacted] DOB: [redacted] Medicaid Number: [redacted] Record Number: [redacted]

ACTION PLAN

The Action Plan should be based on information and recommendations from: **the Comprehensive Clinical Assessment (CCA), the One Page Profile, Characteristics/Observations/Justifications for Goals, and any other supporting documentation.**

Long Range Outcome: (Ensure that this is an outcome desired by the individual, and not a goal belonging to others).

[redacted] wants to be able to continue to be happy. He wants to be able to get supported employment so he can get more income. He also wants to become more independent and don things more for himself. [redacted] also wants to complete his GED through IRC program [redacted] lso wants to improve his overall behaviors when he becomes upset and interacts with others.

Where am I now in the process of achieving this outcome? (Include progress on goals over the past years, as applicable).

[redacted] needs assistance with coordinating and getting to doctor appointments, ensuring that he takes his medication and with overall managing of his health and safety. [redacted] is probation for sexual assault on a minor and needs to be supervised at all the time while in the community. [redacted] ecently left his day program and went to a minor home that he met in church but was met at the home by the girls parents. [redacted] went to jail for about a week for violating his probation. Due to recent events [redacted] needs 24 hour supervision at all times. [redacted] also needs to seek outpatient therapy to help with his sexualized behaviors. Without those continued monitoring services and prompting [redacted] behaviors would decline. In the past [redacted] has had some issues with eloping but due to the improvement of his behavior and with the direct care most of his behaviors have decreased. Without those continued monitoring services and prompting [redacted] behavior would decline.

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Daily Living Skills Residential- House Hold Chores

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
Goal (1) [redacted] will Independently keep his room clean and neat at all times	Quality Care III LLC Residential Staff	Daily for the next 6 months

Task: In the morning and throughout the day [redacted] ill learn to keep his bed made, dresser clean, his clothes put away (either in the dirty clothes hamper or in the closet). Staff should check [redacted] oom throughout the day to make sure that it is neat and clean.

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Code**	**Progress toward goal and justification for continuation or discontinuation of goal.**
11/01/2018	07/16/2018		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Daily Living Skills Residential-Personal Care

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
Goal (2) [redacted] will Independently to take a shower, and complete all of his personal care goals daily.	Quality Care III LLC Residential Staff	Daily for the next 6 months

Task: Daily in the morning [redacted] will be given an initial prompt to get up. Once [redacted] is up staff will prompt [redacted] when it's time for him to shower. [redacted] will independently turn on the water to the appropriate temperature. For safety reason and to prevent any accidents staff should check the water. [redacted] should be able to lather and wash his entire body without staff reminding him. After [redacted] has completed his shower [redacted] will dry himself off and complete all of his other personal care goals.

Target Date (Not to	**Date Goal was**	**Status Code**	**Progress toward goal and justification for continuation**

exceed 12 months)	reviewed		or discontinuation of goal.
11/01/2018	07/16/2018		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Daily Living Skills Residential-House Hold Chores

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
Goal (3) [redacted] will Independently complete a list of household chores.	Quality Care III LLC Residential Staff	Daily for the next 6 months

HOW (Support/Intervention) Task: Daily [redacted] will Independently follow a list of chores that is splint up between him and his housemates. After receiving an initial prompt [redacted] will review the chore list and discuss with staff on what needs to be done. After receiving his directive [redacted] will be given whatever he needs to complete the task. [redacted] should be able to complete any task independently but if he does need assistance staff should document the task, and what assistance was given in the comment section of the grid. Staff should also document the appropriate prompt that was given to assist [redacted] with completing the task, if he did not complete the task independent.

Target Date (Not to exceed 12 months)	Date Goal was reviewed	Status Code	Progress toward goal and justification for continuation or discontinuation of goal.
11/01/2018	07/16/2018		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Daily Living Skills Residential-

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
Goal (4) [redacted] will work towards his GED by completing basic worksheets to help with his math, reading, and social skills.	Quality Care III LLC Residential Staff	7 Days a week for 365 days

HOW (Support/Intervention) Task: [redacted] is currently not in a day program so while he is at home [redacted] eeds to be working on some basic skills to help him with gaining the skills he needs to prepare him for when he does return. Staff will provide [redacted] with pencil and paper and any other needed material. Staff will support [redacted] by answering any question he might have and help him tackle any task. Staff should encourage [redacted] by praising him as he complete a step or a task. Staff should always right comment on [redacted] progress or lack of progress.

Target Date (Not to exceed 12 months)	Date Goal was reviewed	Status Code	Progress toward goal and justification for continuation or discontinuation of goal.
11/01/2018	7/16/2018		

Name: [redacted] DOB: [redacted] Medicaid Number: [redacted] Record Number: [redacted]

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Daily Living Skills Residential-Personal Care-exercise

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
Goal (5) [redacted] will Independently learn what is appropriate conversation by being aware of what he say and how he say it.	Quality Care III LLC Residential Staff	Daily for the next 6 months

HOW (Support/Intervention) Task: Staff should redirect any all negative behavior exhibited by [redacted] Staff should immediately redirect [redacted] behavior as soon as staff is aware or notice a change in him. When [redacted] is redirected staff should remind him the consequences that can follow if he does not get himself together. Staff should allow [redacted] time to process any negative behavior but if at anytime staff do have to redirect him staff should document the behavior and any triggers. While [redacted] is processing staff should always keep [redacted] in their view. After no more than 10 minutes staff will process with [redacted] to help him with solving any issues. Staff will document the appropriate prompt that was given to him, if [redacted] did not exhibit any negative behavior for that day staff should place in N/A in the appropriate box.

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Code**	**Progress toward goal and justification for continuation or discontinuation of goal.**
11/01/2018	07/16/2018		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Daily Living Skills Residential)

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
6) [redacted] will learn how to distinguish between what's appropriate and what's not appropriate.	Quality Care III LLC Residential Staff	7 Days a week for 365 days

HOW (Support/Intervention) Task: [redacted] is aware of the stipulations that is surrounded by his probation. by spending no more than15 minutes daily reviewing through his list of rules and regulations as it relates to the terms of his probation. Staff should assist [redacted] to write down some of the do's and don't"s that reflex what he can and can not do while on, probation. Staff will document the number of times [redacted] needed to be reminded of any of the rules by placing the number of prompts [redacted] should be able to complete the task with an initial prompt but after the initial prompt staff should document the appropriate prompt.

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Code**	**Progress toward goal and justification for continuation or discontinuation of goal.**
11/01/2018	7/16/2018		

Name: [redacted] DOB: [redacted] Medicaid Number: [redacted] Record Number [redacted]

Status Codes:	R=Revised	O=Ongoing	A=Achieved	D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Daily Living Skills Residential)		
WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
6) [redacted] will learn how to cope with his sexual misconduct by researching	Quality Care III LLC Residential Staff	7 Days a week for 365 days

HOW (Support/Intervention) Task: [redacted] is aware of the stipulations that is surrounded by his probation. Staff should assist [redacted] to write down some of the do's and don't"s that reflex what he can and can not do while on, probation. Staff will document the number of times [redacted] needed to be reminded of any of the rules by placing the number of prompts. [redacted] should be able to complete the task with an initial prompt but after the initial prompt staff should document the appropriate prompt.

Target Date (Not to exceed 12 months)	Date Goal was reviewed	Status Code	Progress toward goal and justification for continuation or discontinuation of goal.
11/01/2018	7/16/2018		

Status Codes:	R=Revised	O=Ongoing	A=Achieved	D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Daily Living Skills Residential)		
WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
7) [redacted] will learn how to manage his health by taking his blood pressure daily	Quality Care III LLC Residential Staff	7 Days a week for 365 days

HOW (Support/Intervention) Task: Everyday [redacted] should be given an initial prompt on when its time for his morning medication. After taking his morning medication staff will monitor [redacted] as he takes his blood pressure. Staff will provide [redacted] with blood pressure monitor. [redacted] will place the cuff on his arm and push the appropriate button. When the machine has stopped. [redacted] will document what the pressure was on the appropriate form. Staff will document the appropriate assistance given in the comment section of the grid.

Target Date (Not to exceed 12 months)	Date Goal was reviewed	Status Code	Progress toward goal and justification for continuation or discontinuation of goal.
11/01/2018	7/16/2018		

Status Codes:	R=Revised	O=Ongoing	A=Achieved	D=Discontinued

Name: [redacted] DOB: [redacted] Medicaid Number: [redacted] Record Number: [redacted]

PLAN SIGNATURES

I. PERSON RECEIVING SERVICES:

- ☐ I confirm and agree with my involvement in the development of this PCP. My signature means that I agree with the services/supports to be provided.
- ☐ I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this PCP.
- ☐ For CAP-MR/DD services only, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with mental retardation instead of participating in the Community Alternatives Program for individuals with Mental Retardation/Developmental Disabilities (CAP-MR/DD).

Legally Responsible Person: Self: Yes ☑ **No** ☐

Person Receiving Services: (Required when person is his/her own legally responsible person)

Signature: [redacted] _____ _____ Date: 7/16/18

(Print Name)

Legally Responsible Person (Required if other than person receiving Services)

Signature: _____ _____ Date: / /

(Print Name)

Relationship to the Individual: _____

II. PERSON RESPONSIBLE FOR THE PCP: The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided.

Signature: [redacted] BSTP Quality Care TX LLC Date: 7,14 2018.

(Person responsible for the PCP) (Name of Case Management Agency)

Child Mental Health Services Only:

For individuals who are less than 21 years of age (less than 18 for State funded services) **and who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the person responsible for the PCP must attest that he or she has completed the following requirements as specified below:**

- ☐ Met with the Child and Family Team - Date: / /
- ☐ OR Child and Family Team meeting scheduled for - Date: / /
- ☐ OR Assigned a TASC Care Manager - Date: / /
- ☐ AND conferred with the clinical staff of the applicable LME to conduct care coordination.

If the statements above do not apply, please check the box below and then sign as the Person Responsible for the PCP:

- ☐ This child is not actively involved with the Department of Juvenile Justice and Prevention or the adult criminal court system.

Signature: _____ _____ Date: / /

(Person responsible for the PCP) (Print Name)

III. SERVICE ORDERS: REQUIRED for all Medicaid funded services; RECOMMENDED for State funded services.

(SECTION A): For services ordered by one of the Medicaid approved licensed signatories (see Instruction Manual).

My signature below confirms the following: (Check all appropriate boxes.)

- Medical necessity for services requested is present, and constitutes the Service Order(s).
- The licensed professional who signs this service order has had direct contact with the individual. ☐ Yes ☐ No
- The licensed professional who signs this service order has reviewed the individual's assessment. ☐ Yes ☐ No

Signature: _____ _____ License #: _____ Date: / /

(Name/Title Required) (Print Name)

(SECTION B): For Qualified Professionals (QP) / Licensed Professionals (LP) ordering:

- CAP-MR/DD or
- Medicaid Targeted Case Management (TCM) services (if not ordered in Section A)
- **OR recommended** for any state-funded services not ordered in Section A.

My signature below confirms the following: (Check all appropriate boxes.) Signatory in this section must be a Qualified or Licensed Professional.

- ☐ Medical necessity for the CAP-MR/DD services requested is present, and constitutes the Service Order.
- ☐ Medical necessity for the Medicaid TCM service requested is present, and constitutes the Service Order.
- ☐ Medical necessity for the State-funded service(s) requested is present, and constitutes the Service Order

Signature: _____ _____ License #: _____ Date: / /

(Name/Title Required) (Print Name) (If Applicable)

IV. SIGNATURES OF OTHER TEAM MEMBERS PARTICIPATING IN DEVELOPMENT OF THE PLAN:

North Carolina Division of Mental Health / Development Disabilities, Substance Abuse Services

Consumer Name : [redacted] Record Number: [redacted] Medicaid: [redacted] Month/ Year _____

Specify Service: Residential Supports Level 1-4 LME :SANDHILLS Service Provided/ Agency :Quality Care III,LLC

Goals	Key	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
Goal (1) [redacted] will Independently keep his room clean and neat at all times	I															
	A															
Goal (2) [redacted] will Independently to take a shower and complete all of his personal care goals daily.	I															
	A															
Goal (3) [redacted] will Independently complete a list of household chores.	I															
	A															
Goal (4) [redacted] will work towards his GED by completing basic worksheets to help with his math, reading, and social skills.	I															
	A															
Goal (5) [redacted] will Independently learn what is appropriate conversation by being aware of what he say and how he say it	I															
	A															
Goal (6) [redacted] will learn how to distinguish What's appropriate and what's not appropriate.	I															
	A															
Goal (7) [redacted] will learn to manage his health by taking his blood pressure daily	I															
	A															
Duration (when required)																
Date:																
Initials:																

Key I (Intervention): On back of page key A (Assessment): on back of page Page 1 of 1

EFFECTIVE DATE: Update 07/16//2018

North Carolina Division of Mental Health / Development Disabilities, Substance Abuse Services

Consumer Name : [redacted] Record Number: [redacted] Medicaid: [redacted] Month/ Year _____

Specify Service: Residential Supports Level 1-4 LME :SANDHILLS Service Provided/ Agency :Quality Care III,LLC

Goals	Key	1 6	17	18	19	20	21	22	23	24	25	26	27	28	29	30	30
Goal (1) [redacted] will Independently keep his room clean and neat at all times	I																
	A																
Goal (2) [redacted] will Independently to take a shower and complete all of his personal care goals daily.	I																
	A																
Goal (3) [redacted] will Independently complete a list of household chores.	I																
	A																
Goal (4) [redacted] will work towards his GED by completing basic worksheets to help with his math, reading, and social skills.	I																
	A																
Goal (5 [redacted] will Independently learn what is appropriate conversation by being aware of what he say and how he say it	I																
	A																
Goal (6) [redacted] will learn how to distinguish What's appropriate and what's not appropriate.	I																
	A																
Goal (7) [redacted] will learn to manage his health by taking his blood pressure daily	I																
	A																
Duration (when required)																	
Date:																	
Initials:																	

Key I (Intervention): On back of page key A (Assessment): on back of page Page__1__of _1_

EFFECTIVE DATE: Update 07/16//2018

North Carolina Department of Health and Human Services
Division of Facility Services * Adult Care Licensure Section
Tel 919-733-6650 * Fax 919-733-9379 * Courier 56-20-05
2708 Mail Service Center * Raleigh, North Carolina 27699-2708

Michael F. Easley, Governor
Carmen Hooker Buell, Secretary

James B. Upchurch, Jr., Chief

December 11, 2001

WOODROW E BRADLEY
1403 WOODBRIAR AVENUE
GREENSBORO, NC 27405

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Adult Care Licensure Section

This is to acknowledge that

[redacted]

has successfully passed the Medication Aide Written Exam.

Date of Exam: 12/10/2001

James B. Upchurch, Jr., Chief
Adult Care Licensure Section

This is proof of successfully meeting the written examination requirement for administering medications in adult care facilities in North Carolina. **You should keep this original document in the event of a need for verification.** A copy of this document should be maintained by the employer.

TRAINING CERTIFICATE

[redacted]

has completed the required

Employee Training

in

Medication Administration (6.0 hours)

and is hereby granted the rights and privileges belonging to that training and achievement.

(This training is good for 1 year.)

* * *

RN Industries	**Shaina N. Crudup, RN**	**4/16/2018**
Training by:	Trainer: Shaina N. Crudup, RN, BSN American Heart Association RN#: 152774	Date

TRAINING CERTIFICATE

[redacted]

has completed the required

Employee Training

in

Medication Administration (6.0 hours)

and is hereby granted the rights and privileges belonging to that training and achievement.

(This training is good for 1 year.)

* * *

RN Industries
Training by:

Shaina N. Crudup, RN 5/1/18
Trainer: Shaina N. Crudup, RN, BSN
American Heart Association
RN#: 152774
Date