Ohio Department of Mental Health and Addiction Services

Sample Personal Care Plan Class Two Facilities
5122-30-26

Date of Plan:

Resident Name or Agency Identifier

Date of Admission

Date of Birth:

Previous Placement

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

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

Declaration for mental health treatment? ◯ 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 AOD 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 ◯ Indicate Resident Independent	◯ Treatment Provider Staff ◯ RCF Staff Member ◯ Both
Comment:			
Assistance with Walking/Moving	◯ Yes ◯ No	◯ Prompting /Assistance Needed ◯ Indicate Resident Independent	◯ Treatment Provider Staff ◯ RCF Staff Member ◯ Both
Comment:			
Assistance with Dressing	◯ Yes ◯ No	◯ Prompting /Assistance Needed ◯ Indicate Resident Independent	◯ Treatment Provider Staff ◯ RCF Staff Member ◯ Both
Comment:			
Assistance with Grooming/Hair Care	◯ Yes ◯ No	◯ Prompting / Assistance Needed ◯ Indicate Resident Independent	◯ Treatment Provider Staff ◯ RCF Staff Member ◯ Both
Comment:			
Assistance with Toileting	◯ Yes ◯ No	◯ Prompting / Assistance Needed ◯ Indicate Resident Independent	◯ Treatment Provider Staff ◯ RCF Staff Member ◯ Both
Comment:			
Assistance with Eating	◯ Yes ◯ No	◯ Prompting /Assistance Needed ◯ Indicate Resident Independent	◯ Treatment Provider Staff ◯ RCF Staff Member ◯ Both
Comment:			
Assistance with Nail Care	◯ Yes ◯ No	◯ Prompting /Assistance Needed ◯ Indicate Resident Independent	◯ Treatment Provider Staff ◯ RCF Staff Member ◯ Both
Comment:			
Assistance with Budget/Money Management	◯ Yes ◯ No	◯ Prompting / Assistance Needed ◯ Indicate Resident Independent	◯ Treatment Provider Staff ◯ RCF Staff Member ◯ Both
Comment:			
Preparation of Special Diets	◯ Yes ◯ No	◯ Prompting / Assistance Needed ◯ Indicate Resident Independent	◯ Treatment Provider Staff ◯ RCF Staff Member ◯ Both
Comment:			
Self Administration of Medication	◯ Yes ◯ No	◯ Prompting / Assistance Needed ◯ Indicate Resident Independent	◯ Treatment Provider Staff ◯ RCF Staff Member ◯ Both
Comment:			
Other:	◯ Yes ◯ No ◯ Unknown	◯ Prompting /Assistance Needed ◯ Indicate Resident Independent	◯ Treatment Provider Staff ◯ RCF Staff Member ◯ Both

Resident Signature _____ Date _____ ◯ refused to sign

Residential Staff Signature _____ Date _____

Guardian/Family Signature _____ Date _____ ◯ not applicable

Casemanager/CPST Signature _____ Date _____ ◯ not applicable

Other Provider (if applicable) _____ Date _____