COMMUNITY OPTIONS
CARE PLAN SUMMARY

Agency Name: _____ Applicant Name: _____

Provider-Assessor # ☐☐☐☐☐☐☐☐–☐☐☐ Social Security # ☐☐☐–☐☐–☐☐☐☐

Assessment Date: ☐☐–☐☐–☐☐☐☐

SECTION S. SUPPORT SERVICES

1. EXTENT OF HELP (HOURS OF CARE ROUNDED)

For instrumental and personal activities of daily living received over the last 7 days, indicate extent of help from family, friends, and neighbors.

	HOURS
a. Sum of time across five weekdays	a. ☐☐☐
b. Sum of time across two weekend days	b. ☐☐☐

2. TWO KEY INFORMAL HELPERS

(Information on two family members, friends, or neighbors most relied on for help with ADLs or IADLs (or could be relied on, if no one now helps with these activities)

NAME OF PERSON 1 and PERSON 2

A. (Last/Family Name) (First) _____

B. (Last/Family Name) (First) _____

	(A) Pers 1	(B) Pers 2
a. Lives with client (0 - NO, 1 - YES, 2 - No such helper)		
b. Relationship to client (0 - Child or child-in-law, 1 - Spouse, 2 - Other Relative, 3 - Friend/Neighbor)		

3. CAREGIVER STATUS *(Check all that apply)*

- a. Primary caregiver receives help from family or friends in caring for client. ☐ a.
- b. A caregiver is unable to continue in caring activities *(e.g.,* decline in the health of the caregiver makes it difficult to continue) ☐ b.
- c. Primary caregiver is unable to identify other helpers or unable to provide additional care should the need arise *(e.g.,* cannot do more, other caregivers not available, or no funds to hire help) ☐ c.
- d. Primary caregiver is not satisfied with support received from family and friends *(e.g.,* other children of client) ☐ d.
- e. Primary caregiver expresses feelings of distress, anger or depression because of caring for client ☐ e.
- f. NONE OF ABOVE ☐ f.

Enter Number of Hours	4. Person A: A. Current # wkday hours	B. Current # wkend hours	C. Will increase # wkday hours	D. Will increase # wkend hours	E. Extent of knowledge 0=full 1=partial 2=none	5. Person B: A. Current # wkday hours	B. Current # wkend hours	C. Will increase # wkday hours	D. Will increase # wkend hours	E. Extent of knowledge 0=full 1=partial 2=none
a. Advice or emotional support										
b. ADL care										
c. IADL care										
d. Supervision only										

Refer to the coding sheet on previous page when filling out this care plan summary.

6. MEDICARE/3RD PARTY PAYORS:

1 Funding Source	2 Service Category	3 Reason Code/Need Met (*List all reasons for service*)	4. DURATION 4a Start Date	4b End Date	5 Unit Code	6 Avg # of Units per Month	7 Rate per Unit	8 TOTAL Cost per Month
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						MEDICARE/3RD PARTY TOTAL		

7. ALL OTHER SOURCES/SERVICES PROVIDED:

1 Funding Source	2 Service Category	3 Reason Code/Need Met (*List all reasons for service*)	4. DURATION 4a Start Date	4b End Date	5 Unit Code	6 Avg # of Units per Month	7 Rate per Unit	8 TOTAL Cost per Month
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						OTHER FUNDING SOURCES TOTAL		

1. FUNDING SOURCE: Enter the payment code for the funding source which will pay for the recommended service.
2. SERVICE CATEGORY: Enter the appropriate code to indicate the service category recommended to meet the need.
3. REASON CODES: Enter the reason code for recommended service/need being met.
4. DURATION: Enter the Start and End Dates for the proposed service.
5. UNIT CODE: Enter the unit of time which is used in calculating the cost of this service.
6. NUMBER OF UNITS: Enter the number of units needed per month to meet the person's needs.
7. RATE: Enter the current rate for this service based on the maximum allowable MaineCare rate for that specific unit of service in this program as found in the appropriate MaineCare manual.
8. TOTAL COST: Calculate the total cost per month for this service.