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| **Client Name: Joe Adams** | **Month/Year June 2018** |
| **Agency Name: XYZ Home Care** | |
| **Waiver Service**  ❑ Transitional CM ❑ ACT X CSP ❑ Supported Employment ❑ Peer Support | |
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| **Goal Number: 1- Hygiene** | **Objective Number: 1** |
| **(**Describe progress or continued stabilization, evidence of progress or stabilization from perspective of both provider and client.) | |
| Client does not require much assistance with hygiene and grooming. He is good with showering and Does not like wearing dirty clothes. Client does require minimal assistance due to his limited mobility, But is able to complete tasks. | |
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| **Average Level of Assistance Provided**  ❑ Maximum ❑ Moderate X Minimum ❑ Standby ❑ Independent | |

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| **Goal Number: 2 – Food Management** | **Objective Number: 1** |
| **(**Describe progress or continued stabilization, evidence of progress or stabilization from perspective of both provider and client.) | |
| Client chose not to work on this goal. Will revisit at a later time. | |
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| **Average Level of Assistance Provided**  ❑ Maximum ❑ Moderate ❑ Minimum ❑ Standby ❑ Independent | |

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| **Goal Number: 2** | **Objective Number: 3** |
| **(**Describe progress or continued stabilization, evidence of progress or stabilization from perspective of both provider and client.) | |
| Client chose not to work on this goal. Will revisit at a later time. | |
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| **Average Level of Assistance Provided**  ❑ Maximum ❑ Moderate ❑ Minimum ❑ Standby ❑ Independent | |
| **Client Name: Joe Adams** | |
| **Agency Name: XYZ Home Care** | |

**Summary of Client Progress**

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| Joe is in his 2nd month in his apartment and is steadily improving. He still worries that something might happen at night when no one is around but has felt better since no emergencies have happened overnight. The only emergency during the month was when Joe had foot pain due to his diabetes. RA took him to Hartford Hospital to get the foot checked out and it has been fine since then. Joe has limited mobility because of his wheelchair but has been able to assist the RA in doing laundry and other household tasks. |
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| **Stressors/Extraordinary Events During Past Month:** ❑None Reported❑Required Modification of Plan see below | | |
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| **Hospital Notification**  **N/A** | | |
| Facility Name: | | Date: |
| X Emergency Dept ❑Inpatient | X Medical ❑Psychiatric | ❑ Planned X Unplanned |

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| **Suggestions for changes or modification of Recovery Plan:** |
| None at this time. Joe has sown interest in engaging in the community but feels that he is not quite ready for that yet. CSP will bring this up to Joe in the future. |
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| **Signature of Primary WISE Service Staff/Credential:**  **Jane Staff** | **Date:**  **7/6/2018** |
| **Signature of Licensed Clinician/Date (if required)**  **John Supervisor, LCSW** | **Date:**  **7/8/2018** |
| **Signature and Date of Client (Optional):** | **Date:** |

***Level of Assistance (LOA) Definitions:***

**MAXIMUM ASSISTANCE – Unable to meet minimal standards of behavior or functioning in order to participate in daily living activities or performance of basic tasks approximately 75% of time.**

**MODERATE ASSISTANCE – Needs constant cognitive assistance such as 1:1 cueing, prompting/coaching or demonstrations to sustain or complete simple, repetitive activities or tasks safely and accurately approximately 50% of time. MINIMUM ASSISTANCE – Needs periodic cognitive assistance (cueing and/or prompting/coaching) to correct mistakes, check for safety and/or solve problems approximately 25% of time.**

**STANDBY ASSISTANCE – Supervision by one person is needed to enable the individual to perform new procedures for safe and effective performance.**

**INDEPENDENT – No physical or cognitive assistance needed to perform activities or tasks.**