Plan for Protective Oversight

Name: _____ Phone #: _____ (Home)

Address: _____ CIN #: _____

_____ Date Submitted: _____

[ ] Original Plan for Protective Oversight
[ ] Revision of Plan for Protective Oversight
[ ] No change since last submission

Information about Anyone Listed in this Plan for Oversight

Name: _____ Relationship: _____ Phone(home)_____ (work)_____

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I. Finances

a. Can waiver participant mange his/her own finances? [ ] Yes [ ] No

b. If the waiver participant needs assistance with his/her finances, who will provide the assistance?

1. ATM: _____

2. Banking: _____

3. Bill Paying: _____

4. Budgeting: _____

5. Checking: _____

c. Does the waiver participant request a Representative Payee? [ ]Yes [ ] No
If so, who will act in this capacity?
_____

II. Fire and Safety

a. Can the waiver participant use the various means of egress in his/her home?
[ ] Yes [ ] No

b. If not, have other arrangements been made to assure that the waiver participant can be as safe as possible in case of a fire?
[ ] Yes [ ] No [ ] Not applicable

Please list all of these extra precautions:

_____

_____

c. Does the waiver participant have a tendency to be unsteady in his/her balance?
[ ] Yes [ ] No

If yes, what measures have been taken to decrease the probability and/or sequlae of his/her falling within the home?

_____

d. Is the waiver participant safe within the kitchen? [ ] Yes [ ] No
If not, what activities may be unsafe for the waiver participant?

_____ ,

and what actions have been taken to increase the likelihood that the waiver participant will be as safe as possible in the kitchen?

_____

III. Emergency Plan for Usually Unstaffed Time

Although the waiver participant's need for supervision has been assessed and dealt with more fully in other sections of the Service Plan, there may be emergencies during the time when there is no immediate unpaid or paid support.

a. Is the waiver participant receiving 24-hour supervision? [ ] Yes [ ] No
This is provided by: [ ] Paid staff only
[ ] A combination of natural and paid staff
[ ] Natural supports only

b. If there is the need for 24-hour supervision, is a back-up plan for supports clearly defined and included in the Service Plan? [ ] Yes [ ] No

c. If the waiver participant does have time when he/she will be alone, who will be contacted in case of an emergency? (Please list in order of who will be called. This list should be prominently displayed by the telephone in the waiver participant's home).

Name	Telephone Number	Relationship

d. Does the waiver participant have a Personal Emergency Response System?
[ ] Yes [ ] No

e. Are there any other systems/devices/supports that have been provided to the waiver participants for safety purposes?

_____

IV. Medication Administration

a. Is the waiver participant presently taking prescribed medication?
[ ] Yes [ ] No

b. Is the waiver participant able to consistently take his/her medication independently? [ ] Yes [ ] No

c. If assistance is needed, what type of cueing is needed, including both visual and verbal cues?

_____

d. Does the waiver participant have assistance with pre-pouring of the medication?
[ ] Yes – Who provides this assistance: _____
[ ] No – If no, should this be considered? _____

e. Who will the natural or paid staff contact in case there is concern about the waiver participant's reaction to medication or if the waiver participant is not taking his/her medication as directed?

_____ _____ _____
Name **Relationship** **Phone**

f. Who will the natural or paid staff contact if the waiver participant's food intake decreases or increases noticeably?

Name	Relationship	Phone

Additional Comments:

This plan for Protective Oversight must be readily accessible to all staff and natural supports. This Plan must also be submitted to the Regional Resource Development Specialist with all Service Plans, and reviewed, at lease every six months by the Service Coordinator. If there are incidents or concerns that arise which are directly related to the areas covered by the Plan for Protective Oversight, then that Plan should be reviewed immediately.

Signatures of Individuals Participating in the Plan for Protective Oversight

Waiver Participant _____ **Date** _____

Advocate/Representative _____ **Date** _____
(When applicable)

Service Coordinator _____ **Date** _____

Service Coordinator Supervisor _____ **Date** _____

Natural Support _____ **Date** _____

Natural Support _____ **Date** _____

Regional Resource Development Specialist Comment

[ ] The information provided in this Plan for Protective Oversight documents that the Waiver Participant's health and welfare is being maintained and that he/she is not at risk for nursing home placement;

[ ] The information provided in this Plan for Protective Oversight raises serious concerns about the Waiver Participant's health and welfare. A Plan for Protective Oversight must be submitted to clarify concerns about the Waiver Participant's ability to remain in the community.

Signature: _____

Print Name: _____

Title: _____

Date: _____