OLDER ADULT DAILY LIVING CENTERS
CARE PLAN FORM
6 Pa. Code, §§ 11.104 – 11.107

An initial care plan shall be developed within 30 calendar days following admission to the center and be reviewed at least every 6 months thereafter. Centers shall also address each core service and modify care plans as necessary in light of changes in the client's status.

☐ **Initial** ☐ **Semiannual** ☐ **Significant Change**

1. **Client Name:** (First, MI, Last)	2. **Admission Date:** (mm/dd/yy)
3. **Date Care Plan Developed:** (mm/dd/yy)	4. **Date of Next Review:** (mm/dd/yy)

5. Personal Care Services					
Start Date	**Needs**	**Goals**	**Methods and Activities**	**Staff Persons Responsible**	**End Date**

6. Nursing Services					
Start Date	**Needs**	**Goals**	**Methods and Activities**	**Staff Persons Responsible**	**End Date**

7. Social Services					
Start Date	**Needs**	**Goals**	**Methods and Activities**	**Staff Persons Responsible**	**End Date**

8. Therapeutic Activities					
Start Date	**Needs**	**Goals**	**Methods and Activities**	**Staff Persons Responsible**	**End Date**

9. Nutrition and Therapeutic Diet					
Start Date	**Needs**	**Goals**	**Methods and Activities**	**Staff Persons Responsible**	**End Date**

10. Emergency Care Services					
Start Date	**Needs**	**Goals**	**Methods and Activities**	**Staff Persons Responsible**	**End Date**

11. Other Services					
Start Date	**Needs**	**Goals**	**Methods and Activities**	**Staff Persons Responsible**	**End Date**

12. Care Plan Development *Who participated in the development of the care plan? Check all that apply.*	
☐ Client	Signature: _____ Date: _____ ☐ Unable to sign* ☐ Refused to sign*
☐ Client's Responsible Party	Name: _____ Relationship: _____ Signature: _____ Date: _____ ☐ Unable to sign* ☐ Refused to sign* ☐ Discussed by Telephone* Date: _____
☐ Center Staff	Name and Title: _____ Signature: _____ Date: _____ Name and Title: _____ Signature: _____ Date: _____ Name and Title: _____ Signature: _____ Date: _____ Name and Title: _____ Signature: _____ Date: _____
☐ Other	Name: _____ Relationship: _____ Signature: _____ Date: _____ ☐ Unable to sign* ☐ Refused to sign* ☐ Discussed by Telephone* Date: _____

13. Care Plan Signature Comments
**Explain why the client, responsible party or other person was unable or refused to sign the plan.*

14. Care Plan Discussion Comments
**Explain why the parties were unable to be present at the center for a discussion of the plan.*

15. Care Plan Copy		
Did the client or responsible party request a copy of the care plan?	☐ Yes	☐No
Was a copy of the care plan provided to the client?	☐ Yes	☐No
Was a copy of the care plan provided to the responsible party?	☐ Yes	☐No