CARE PLAN/ANNUAL REVIEW FOR CLIENTS OF THE PUBLIC GUARDIAN AND TRUSTEE AS COMMITTEE

Client Name: _____ D.O.B.: _____

Current Address: _____

Delegated RHA or PCH: _____

Social Worker/Home Care Coordinator: _____

Date Supervision Delegated: _____ Date of Last Review: _____

Care Plan/Annual Review prepared by: _____

Date Client Seen: _____

Note: Please complete #'s 1,2, and 3 for all care plans/reviews.

1. Physical and Medical Functioning – describe the current level of functioning, including any significant medical or psychiatric conditions, and the type of care required.

2. Cognitive Functioning – describe the current level of functioning, including any special care required.

Careplan: _____
Name of Client

3-B-07-F01B Careplan MH

3. Social Functioning – include information about the support network and significant issues. Please also include, if applicable, information concerning paid companions, ie. Name of companion or agency, hours required, services required, and cost, if known.

Note: Complete #4, 5 and 6 only in the case of second or subsequent care plan/reviews.

4. Changes – please describe significant changes over the last year, including changes to the type of care or services provided.

5. What, if any, changes to the care plan are recommended or required for the next year?

6. General Comments:

7. Recommendation: _____ Continue Order of Committeeship

_____ Discontinue Order of Committeeship

8. _____ _____ _____
Name of Worker Signature Date

9. _____ _____ _____
RHA PT Contact/PCH Contact Signature Date

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