STATE OF HAWAII
QUEST Integration Service Plan (SP)
Initial SP Date: __/__/____

Member Name _____ **Member ID #** _____ **SP Date: __/__/____**
Lead Service Coordinator Name _____ **Phone Number** _____
☐ **Adult** ☐ **Child**
Long Term Services and Supports (LTSS) ☐
Special Health Care Needs (SHCN) ☐
At Risk ☐

SECTION A. AUTHORIZATION OF MY SUPPORT SERVICES		
A1. MEMBER/AUTHORIZED REPRESENTATIVE		
I have signed this document because I agree that: I/We have directed this service plan meeting as much as possible; Information about all my available choices was provided and I/We made my own choices and decisions in this meeting; and I/We reviewed and agree to the support services written in my plan.		
Print Member Name	Signature	Date
Print Authorized Representative Name	Signature	Date
Indicate who directed the meeting. If someone other than the member directed the service plan meeting, explain why. _____		
A2. SERVICE COORDINATOR(S)		
Print Lead Service Coordinator Name	Signature and Title	Date
Print Consulting Service Coordinator Name	Signature and Title	Date
A3. COPY OF PLAN GIVEN TO		
Primary Care Provider:		
Support Provider(s):		

	SECTION B. MY GOALS, AND ACTIONS

STATE OF HAWAII
QUEST Integration Service Plan (SP)

#	Start Date	Modified Date	My Needs, Risks, Issues	My Goals	My Outcomes (include timeframe)	Past Efforts to Meet Goal (include successful & unsuccessful efforts)	Next Review Date	Resolved Date
__	__/__/____	__/__/____					__/__/____	__/__/____

Priority	My Actions	Barriers	Who Will Help Me	Action Progress	Progress Note
				☐Not Started ☐In Progress ☐Completed	
				☐Not Started ☐In Progress ☐Completed	
				☐Not Started ☐In Progress ☐Completed	
				☐Not Started ☐In Progress ☐Completed	

SECTION C. MY SUPPORT PLAN

*Check appropriate service and complete information. Complete the Personal Assistance/Nursing Task section as indicated**

C1. SHCN Services ☐ N/A

SERVICES	START DATE	PROVIDER(S)	FREQUENCY/AMOUNT	DURATION
☐	/ /			
☐	/ /			

DHS 1147/1147e
Approved LOC: Click here to enter text. **Functional Points***:* Click here to enter text. **Expiration Date:** Click here to enter text.

C2. At Risk Services ☐ N/A

SERVICES	START DATE	PROVIDER(S)	FREQUENCY/AMOUNT	DURATION
☐ Adult Day Care (ADC)	/ /			
☐ Adult Day Health (ADH)	/ /			
☐ Home Delivered Meals	/ /			
☐ Personal Emergency Response Systems (PERS)	/ /			
Personal Assistance Level I (PA I Chore)* ☐ PA I Agency ☐ PA I	/ /			

Personal Assistance Level II (PA II Personal Care)* ☐ PA II Agency ☐ PA II CDPA	/ /			
Personal Assistance Level II Delegated (PA II Delegated)* ☐ PAII Agency ☐ PAII CDPA	/ /			
☐ Skilled (or private duty) Nursing*	/ /			
C3. Home and Community Based Services (HCBS)			☐ N/A	
SERVICES	**START DATE**	**PROVIDER(S)**	**FREQUENCY/AMOUNT**	**DURATION**
☐ Service Coordination	/ /	RN: SW:		
☐ Adult Day Care (ADC)	/ /			
☐ Adult Day Health (ADH)	/ /			
☐ Assisted Living Facility (ALF)	/ /			
☐ Community Care Management Agency (CCMA)	/ /	RN: SW:		
Counseling and Training ☐ Nutrition ☐ Coping/Support ☐ Crisis Intervention ☐ Family Training ☐ Caregiver Training ☐ **Other:**	/ /			
☐ Environmental Accessibility Adaptations (EAA)	/ /			
☐ Home Delivered Meals	/ /			
☐ Home Maintenance	/ /			
☐ Moving Assistance	/ /			
☐ Non-Medical Transportation	/ /			
Personal Assistance Level I (PA I Chore)* ☐ PA I Agency ☐ PA I CDPA	/ /			
Personal Assistance Level II (PA II Personal Care)* ☐ PA II Agency ☐ PA II CDPA	/ /			
Personal Assistance Level II Delegated (PA II Delegated)* ☐ PAII Agency ☐ PAII CDPA	/ /			
☐ Skilled (or private duty) Nursing*	/ /			
☐ Personal Emergency Response Systems (PERS) ☐ Basic Reassurance ☐ Enhanced Reassurance/Calls	/ /			
☐ Residential Care ☐ Expanded Adult Residential Care Home (E-ARCH) ☐ Community Care Foster Family Home (CCFFH)	/ /			
☐ Respite	/ /		☐ Hourly	

☐ In-home ☐ Community based ☐ Institutional			☐ Overnight	
☐ Specialized Medical Equipment/Supplies (SMES)	/ /			
☐ Other:	/ /			

C4. INSTITUTIONAL SERVICES ☐ N/A

TYPE OF FACILITY			**START DATE**
☐ ICF/ID ☐ Nursing Facility ☐ Hospital			/ /
Facility Name:	Name of Contact:	Phone:	

☐ Discharge Planning *(Must complete if pending discharge)*
Pre-Discharge Assessment Date: __/__/____
Anticipated Discharge Date: __/__/____
Discharge Location:
Anticipated Discharge Planning Meeting Date: __/__/____
Discharge Date: __/__/____

☐ Other:

C5. ADDITIONAL SUPPORT SERVICES

SERVICES	**START DATE**	**PROVIDER(S)**	**FREQUENCY/AMOUNT**	**DURATION**
☐ Dental	/ /			
☐ Home Health Agency ☐ HHA* ☐ LPN* ☐ RN* ☐ OT ☐ PT ☐ Speech	/ /			
☐ Hospice	/ /			
☐ Transportation, Medical	/ /			
Department of Education (DOE) School Based Services ☐ Home Schooling ☐ Skilled Nursing ☐ Behavioral Health ☐ Speech ☐ OT ☐ PT ☐ Special Education	/ /			
Department of Health (DOH) ☐ Early intervention (0-3) ☐ OT ☐ PT ☐ Speech ☐ Skilled Nursing ☐ PHN ☐ Audiology ☐ Healthy Start ☐ DD/ID Waiver ☐ WIC ☐ CAMHD ☐ AMHD (Legally Encumbered) ☐ ADAD ☐ Other	/ /			
Department of Human Services (DHS) ☐ CWS ☐ APS ☐ Foster care	/ /			

☐ LIHEAP ☐ SNAP ☐ VOC Rehab ☐ Financial Assistance ☐ Other				
☐ Community Care Services (CCS)	/ /			
☐ HIV/AIDS Services	/ /			
☐ Congregate Meals	/ /			
☐ Housing Assistance	/ /			
☐ Disabled Parking Permit	/ /			
☐ Homeless Shelter	/ /			
☐ Legal Assistance ☐ Guardianship ☐ POA for Healthcare ☐ Advance Directives	/ /			
☐ Volunteer ☐ Companion	/ /			
☐ Other State Agencies	/ /			
☐ Other:	/ /			

SECTION D. MY SUPPORT PLAN DETAILS *(Select all that apply) *Skilled Nursing RN/LPN only*

D1. VITAL SIGNS	**Frequency/Amount**	**Special Instructions**
☐ Temperature ☐ Pulse ☐ Respiration ☐ Blood Pressure ☐ Oxygen Saturation ☐ Height and Weight Other:		
D2. PERSONAL ASSISTANCE LEVEL I (PA I Chore)		
Routine House Cleaning ☐ Bathroom ☐ Kitchen ☐ Bedroom ☐ Changing linen ☐ Make bed ☐ Empty Trash		
Laundry ☐ Washing ☐ Drying ☐ Ironing ☐ Mending		
☐ Shopping/Errands		
☐ Transportation/Escort		
☐ Meal preparation		
Other:		
D3. PERSONAL ASSISTANCE LEVEL II (PA II Personal Care)		
☐ Eating/Feeding		☐ Prepare/Serve ☐ Assist/Feed ☐ Record Intake
☐ Bathing ☐ Bed ☐ Shower ☐ Shampoo		
☐ Dressing ☐ Upper Body ☐ Lower Body		
☐ Grooming		

☐ Oral care ☐ Shave		
☐ Hair and Skin care ☐ Brush ☐ Comb ☐ Nail Care ☐ Foot Care		
☐ Toileting (do not include transfer and ambulation)		
☐ Bed Mobility/Transfers		
☐ Manual Wheelchair mobility		
Medication Assistance ☐ Remind ☐ Assist		
Other:		
D4. PERSONAL ASSISTANCE LEVEL II DELEGATED (PA II Delegated)		
☐ Task:		
☐ Task:		
D5. MEALS/FEEDING		
☐ Record Feeding Intake		
☐ Tube Feeding*		Feeding Orders:
☐ G-Tube care		
☐ Monitor skin condition for adequate hydration		
Other:		
D6. CARDIAC/RESPIRATORY CARE		
☐ Oxygen* Oxygen Orders:		
☐ Oral Suctioning		
☐ Suctioning*		Every hour(s) or as needed to maintain clear airway
☐ Nebulizer/Aerosol Treatments*		
☐ Humidifier		
☐ Apnea Monitor		
☐ Pulse Oximeter		
☐ Tracheostomy Care*		
☐ Ventilator Type:		FIO2 _____ %, VT _____, Peep _____, Rate _____, PS _____ ☐ Check ventilator settings every shift
☐ O2 concentrator		_____ L/min
☐ Resuscitator/Ambu bag on hand		
☐ Chest physiotherapy		
☐ Cough stimulator		
☐ See manuals/information provided by equipment vendors for specific instructions about respiratory equipment		
Other:		
D7. WOUND CARE		
☐ Decubitus Care ☐ Dressing ☐ Clean ☐ Sterile*		

Other:		
D8. MEDICATIONS		
☐ See Medication Sheet and administer as ordered by physician*		
☐ Update medication list		
☐ All caregivers to know medication, purpose, effects and side effects		
☐ Blood glucose monitoring		
Other:		
D9. BOWEL AND BLADDER ELIMINATION		
☐ Brief/Diaper change and check site and skin daily		
☐ Bedpan ☐ Urinal ☐ Commode		
☐ Toilet		
☐ Catheter* ☐ Catheter Care ☐ Catheter Irrigation* ☐ Condom care		☐ Empty Drainage Bag ☐ Record Output ☐ Drain bag: Empty ½ full or more often
☐ Check for bowel movement (BM)		
☐ Digital Stimulation ☐ Suppository		
☐ Enema ☐ Fleet Enema*		
Other:		
D10. MOBILITY		
☐ Turning and Repositioning		
☐ Transfers		
☐ Chair		
☐ Manual Wheelchair		
☐ Front Wheeled Walker (FWW)		
☐ Patient Lift		
☐ Walk		
☐ Exercise		
☐ Safety Belt		
☐ Side Rails		
Other:		

SECTION E. DISEASE MANAGEMENT/EDUCATION

Learning Needs	Provider Name and Contact Information	Frequency/Amount and Duration	Comments
Asthma			
Diabetes			
Other:			

SECTION F. REFERRALS

Referral Service/Specialty	Provider Name and Contact Information	Frequency/Amount and Duration	Comments

SECTION G. SUPPORT PROVIDER RESPONSIBILITIES

G1. PRIMARY CARE PROVIDER (PCP)

Name: Phone: Fax:

- ☐ Review Service Plan annually and as needed
- ☐ Perform Health and Physical Exam as needed
- ☐ Complete DHS 1147/1147e annually and as needed
- ☐ Coordinate overall medical care of member
- ☐ Provide requested medical information, complete and return forms
- ☐ Other:

G2. LEAD (L) AND CONSULTING (C) SERVICE COORDINATORS

Lead Service Coordinator Name and Title: Phone: Fax:
Consulting Service Coordinator Name and Title : Phone: Fax:

L C

- ☐ ☐ Implement the Service Plan and coordinate services of the member with physician(s) and other providers
- ☐ ☐ Review and update Service Plan every _____ month(s), if not occurred earlier due to the occurrence of a significant event ☐ ☐ Review and update current medications during each home visit and as needed
- ☐ ☐ Monitor the member and the primary caregiver status through
  - ☐ Home Visits every _____ month(s) and as needed ☐ Phone Contacts every _____ and as needed
- ☐ ☐ Monitor the member within 48 hours after or next business day: hospitalization, acute medical or emotional crisis, adverse event report
- ☐ ☐ Review and update Individualized Emergency Back Up Plan annually and as needed
- ☐ ☐ Review and update Disaster Preparedness form annually and as needed
- ☐ ☐ Reviewed Infection Control Guidelines with member and caregiver
- ☐ ☐ Monitor operating status of smoke alarm at every home visit
- ☐ ☐ Identify fire hazard(s) and establish a Fire Safety Plan
- ☐ ☐ Provide referrals and supportive resources to the member and caregivers as needed
- ☐ ☐ Teach/provide health information based on members needs
- ☐ ☐ Assist with ordering equipment and supplies
- ☐ ☐ Complete DHS 1147/1147e annually and as needed
- ☐ ☐ Other:

G3. PRIMARY CAREGIVER (PC) AND MEMBER (M)

PC M

- ☐ ☐ Responsible for the members care and safety when a paid personnel are not present
- ☐ ☐ Maintain operating smoke alarm at all times
- ☐ ☐ Maintain operating telephone
- ☐ ☐ Maintain a clear pathway from member's bed to the closest exit
- ☐ ☐ Report all hospitalizations, health problems, injuries, falls, skin breakdown or other health or social problems to Lead SC within 24 hrs

☐ ☐ Report worker "no show" or problems with assigned worker to the service provider then to the Lead SC
☐ ☐ Report 2 hours in advance to service provider when canceling services
☐ ☐ Use 24 hour emergency number 911 for all emergencies
☐ ☐ Assure that all backup caregivers have been trained & are signed off on service plan by health professional i.e., PT, OT, RN, etc.
☐ Other:

G5. ALL CAREGIVERS

☐ Report any medical and/or social changes to the Lead SC and PCP.
☐ Maintain a clean environment and prevent the spread of disease with frequent hand washing. Use Infection Control barriers as needed.
☐ See home binder for detailed information and instructions on the member's care.
☐ Communication: Communicate with the member regularly with dignity and respect, listen to what's important to the member, face the member when speaking, talk clearly, and pronounce words.
☐ Verbally interact with the member during meaningful activities.
☐ Give verbal cues to the member prior to touching member due to _____ impairment.
☐ Check equipment and supplies regularly. Notify Vendor and Lead SC if equipment needs repair and if supplies are low quantity on hand.
☐ Provide a safe environment and review the Individualized Emergency Backup Plan annually and as needed.
☐ Other:

SECTION H. ADDITIONAL COMMENTS