ADULT FAMILY HOME RESIDENT NEGOTIATED CARE PLAN (NCP)

NOTE: Place an X in the bracket [] - [x] - to indicate/select your choice. *Form Version: 3.12.2024*

Provider's Name:	**Date NCP Started:**	**Moved In Date:**	**Date Completed:**	**Date Discharged:**
Resident's Name: **Pronouns:**	**Date of Birth/Age:**	**Primary Language:** **Speaks English?** **Interpreter needed?**	**ALLERGIES:**	

Legal Documents: [] None
[] Advanced Directives
[ ] POLST Form
[ ] Other:

Specialty Needs: [ ] No
[ ] Dementia
[ ] Mental Health
[ ] Developmental Disability
[ ] Other:

EMERGENCY EVACUATION

EVACUATION ASSISTANCE REQUIRED:

[] NONE – RESIDENT IS INDEPENDENT: Resident is physically and mentally capable of independently evacuating the home without the assistance of another individual or the use of mobility aids. The department will consider a resident independent if capable of getting out of the home after one cue.

[] ASSISTANCE REQUIRED: Resident is not physically or mentally capable of evacuating the home without assistance from another individual, mobility aids, or multiple cues.
Caregiver will keep walkways clear and ensure there are no barriers to evacuation routes.

RESIDENT'S EVACUATION and SAFETY INSTRUCTIONS:
Caregiver will

MENTAL/PHYSICAL HEALTH – CURRENT MEDICAL STATUS/DIAGNOSIS

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RESPONSIBLE PARTIES – CONTACTS Add those involved in care planning for your resident: Case Manager, DPOA, Guardian, Medical/Mental Health Providers, Pharmacy, Hospice, etc. – Indicate which contact method is preferred .				
Name	**Relationship**	**Home/Business Phone**	**Cell Phone/FAX**	**Address/Email**
1.				
2.				
3.				
4.				
5.				
6.				

(Place your cursor in the last box and hit your tab key to add another row)

COMMUNICATION		
SPEECH/HEARING/VISION	**Resident Strengths And Abilities** **Prefers To Do Independently** **Preferences and Personal Goals**	**Assistance Required** **Caregiver Instructions** **Who, How, When/How Often**
Modes of Expression: **Problems with Mode of Expression - [ ]** Yes **[ ]** No Describe: Equipment:	**How resident makes self-understood:** **How resident understands others:** **Strength and Abilities**	**Assistance Required** Caregiver will
Problems with Hearing - [ ] Yes **[ ]** No Describe: Equipment:		
Problems with Vision - [ ] Yes **[ ]** No Describe: Equipment:		
Ability to Use the Phone **[ ]** Independent **[ ]** Assistance Needed **[ ]** Dependent **[ ]** Resident has own phone, number:		
Preferred Language:		

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COMMUNICATION		
SPEECH/HEARING/VISION	**Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals**	**Assistance Required Caregiver Instructions Who, How, When/How Often**
Comments:		

MEDICATION MANAGEMENT - Overview	
[ ] MEDICATION ALLERGIES: **[ ]** Resident needs more than one kind of medication assistance need **[ ]** Resident is prescribed psychopharmacologic medications – *see behavior section for strategies and modification to address symptoms addressed by this/these medications*	**[ ]** See **MAR** for current medications, dosage, frequency, and route Meds are ordered by: Meds are delivered by: **[ ]** Meds are Pharmacy Packed: Note:

MEDICATION MANAGEMENT		
The amount of assistance required to receive prescription medications, over the counter medications, or herbal supplements.	**Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals**	**Assistance Required Caregiver Instruction Who, How, When/How Often**
[ ] SELF-ADMINISTRATION **[ ] SELF-ADMINISTRATION W/ ASSISTANCE** **[ ] MEDICATION ADMINISTRATION** Equipment: Type of Medication Management is Needed: **[ ]** Oral **[ ]** Topical **[ ]** Eye drops/ointment **[ ]** Inhalers **[ ]** Sprays	**Strengths and Abilities**	**Describe the reason the resident needs this amount of medication assistance:** **Assistance Required** Caregiver will CG will follow the 5 rights of medication administration + 2 **every time**: • Right resident • Right medication • Right dose

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MEDICATION MANAGEMENT		
The amount of assistance required to receive prescription medications, over the counter medications, or herbal supplements.	**Resident Strengths And Abilities** **Prefers To Do Independently** **Preferences and Personal Goals**	**Assistance Required** **Caregiver Instruction** **Who, How, When/How Often**
[ ] Injections: **[ ]** Resident **[ ]** Surrogate **[ ]** By Family **[ ]** Licensed Professional **[ ]** Qualified CG under Nurse Delegation (insulin Only) **[ ]** Allergy Kits **[ ]** Suppositories **[ ]** Other: **[ ]** Requires Nurse Delegation **RN Delegator** • **Name:** • **Phone:** • **FAX:** • **Email:**		• Right route • Right time + Right documentation + Follow strategy for resident's right to refuse CG is to follow Dr. orders, follow RND instructions; document in MAR and report significant changes, concerns/adverse reactions to Dr. immediately.
Medication Plan When Resident is not in the AFH	**Strengths and Abilities**	**Assistance Required** Caregiver will
Medication Refusal Plan	**Strengths and Abilities**	**Assistance Required** Caregiver will

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HEALTH INDICATORS		
Health Indicator Monitoring and Support	**Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals**	**Assistance Required Who Will Provide, When, And How**
[ ] Pain Pain Impact: **[ ]** Weight Loss/Gain Current Weight: Current Height: **[ ]** Vital Signs **[ ]** Hospitalization or Emergency Visits **[ ]** Other:	**Strengths and Abilities**	**Assistance Required** **Monitoring/Reporting significant changes and/or concerns:** Caregiver is to report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.).
Allergies	**Substance:**	**Reaction:**

TREATMENTS/PROGRAMS/THERAPIES		
Treatment/Program Therapy/Interventions	**Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals**	**Assistance Required Who Will Provide, When, And How**
Type of Treatment: **[ ]** Oxygen Use – Vendor: **[ ]** Dialysis – Health Provider: **[ ]** Blood Thinners **[ ]** INR/LAB – Health Provider: **[ ]** Easily bruised/Anti coagulation therapy **[ ]** Blood Glucose Monitoring **[ ]** Injection **[ ]** CPAP/BIPAP **[ ]** Nebulizer	**Strengths and Abilities**	**Assistance Required** Caregiver will

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TREATMENTS/PROGRAMS/THERAPIES		
Treatment/Program Therapy/Interventions	**Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals**	**Assistance Required Who Will Provide, When, And How**
[ ] Range of Motion **[ ]** PT/OT/ST **[ ]** **Nurse Delegation** for Treatments/Therapies – Tasks: **[ ]** Other:		
Programs Resident Requires/Attends: **[ ]** Home Health **[ ]** Adult Day Health **[ ]** Hospice – Agency: **[ ]** Hospice Plan **[ ]** Other:		
Interventions **[ ]** Meaningful Day		
Physical Enablers	**Strengths and Abilities**	**Assistance Required** Caregiver will
TREATMENT/PROGRAM/THERAPY REFUSAL PLAN	**Strengths and Abilities**	**Assistance Required** Caregiver will

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PSYCH/SOCIAL/COGNITIVE STATUS	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When, And How
Sleep [ ] Sleep disturbance [ ] Nighttime assistance needed	**Resident Strengths And Abilities** **Prefers To Do Independently** **Preferences and Personal Goals**	**Assistance Required** **Who Will Provide, When And How**
Memory Impairment [ ] Short-term [ ] Long-term [ ] Orientated to Person		
If any behavior is checked, describe in the column to the right. [ ] Impaired decision making		
[ ] Disruptive behavior		
[ ] Assaultive		
[ ] Resistive to care		
[ ] Depression		
[ ] Anxiety		
[ ] Irritability		
[ ] Disorientation		
[ ] Wandering in home/Pacing		
[ ] Exit seeking		
[ ] Hallucinations		
[ ] Delusions		
[ ] Verbally agitated/aggressive		
[ ] Physically agitated/aggressive		
[ ] Inappropriate or unsafe behavior		
[ ] Suicidal Ideation		

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PSYCH/SOCIAL/COGNITIVE STATUS	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When, And How
[ ] Difficulty in new or unfamiliar situations		
[ ] Disrobing		
[ ] Weeping/Crying		
[ ] Unaware of Consequences		
[ ] Unrealistic fears and suspicions		
[ ] Inappropriate spitting		
[ ] Breaks/throws things		
[ ] Other		
[ ] Requires psychopharmacological medications. If checked, describe symptoms each medication is addressing) See Current MAR WAC 388-76-10463 (link) **[ ]** Behavioral Health Support Crisis Plan (See attached crisis plan) **[ ]** Counseling Mental Health Provider (MHP): Past Behaviors:		
DSHS Specialized Behavioral Programs: ☒ Meaningful Day ☐ Expanded Community Services (HCS ONLY) ☐ Specialized Behavior Services (HCS ONLY) ☐ Mental Health Provider/Program		

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PSYCH/SOCIAL/COGNITIVE STATUS	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When, And How
Contact info:		
Interventions **[ ]** Meaningful Day **[ ]** Other:		
Narrative (optional) – What does a typical day look like?		

Left Alone	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When, And How
Ability of Resident to Be Left Unattended	**Strengths and Abilities**	**Assistance Required** Caregiver will

UNIVERSAL PRECAUTIONS	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When, And How
[ ] Always **[ ]** Special Precautions: **[ ]** Alternative method for visitation	**Strengths and Abilities**	Caregiver will always use latex/plastic gloves when in contact with any secretions to prevent spread of infection. Thorough hand washing with soap will be done before and after gloving. Gloves will be put on and discarded at the

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UNIVERSAL PRECAUTIONS	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When, And How
Mask – Resident is: **[ ]** Able to wear a mask **[ ]** Not able to wear a mask **[ ]** Resident is safe to have sanitizer or disinfectant wipes left out for caregiver and client use. **[ ]** Resident has been/or is up to date on vaccinations: **[ ]** Resident shares the following medical equipment: **[ ]** Other:		end of each task. If the AFH provider orders these gloves they can be paid for through the medical coupon. **Assistance Required**

ACTIVITIES OF DAILY LIVING	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When, And How
Resident functional limitations that impact ADL functioning:		

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ACTIVITIES OF DAILY LIVING	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When, And How
AMBULATION/MOBILITY **Locomotion in room and immediate living environment:** **[ ]** Independent **[ ]** Supervision/Cueing **[ ]** Assistance Needed **[ ]** Totally Dependent **Locomotion outside of immediate living environment (including outdoors):** **[ ]** Independent **[ ]** Supervision/Cueing **[ ]** Assistance Needed **[ ]** Totally Dependent **[ ] Risks for falls** **[ ] Fall prevention plan:** **[ ]** Resident chooses bedroom door lock **Equipment/Supplies:** Vendor: **Limitations:**	**Strengths and Abilities** **Evacuation addressed under Evacuation Plan**	**Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.) **Assistance Required** Caregiver will
BED MOBILITY/TRANSFER *Transfer includes moving between bed, chair, wheelchair, standing position – excludes to/from bath/toilet. Bed mobility includes the ability to move in bed.* **[ ]** Independent **[ ]** Supervision/Cueing **[ ]** Assistance Needed **[ ]** Totally Dependent	**Strengths and Abilities**	**Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.) **Assistance Required** Caregiver will

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ACTIVITIES OF DAILY LIVING	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When, And How
[ ] Skin care required due to inability to position self: Equipment/Supplies: **[ ]** Turning and Repositioning needed - Frequency: **[ ]** Safety assessment, alternatives explored; how to keep resident safe: **[ ]** Risks for falls: **[ ]** Fall prevention plan **[ ]** Safety plan **[ ]** Medical Device(s): **[ ]** Enablers: **[ ] Hoyer Lift** **[ ] Transfer Pole** **[ ]** Medical Device/Enabler Risk Assessment: **[ ]** Nighttime care needs Equipment/supplies:		
EATING *How the Resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)* **[ ]** Independent **[ ]** Supervision/Cueing **[ ]** Assistance Needed **[ ]** Totally Dependent **[ ] Special Diet/Supplements**:	**Strengths and Abilities**	**Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.) **Assistance Required** Caregiver will

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ACTIVITIES OF DAILY LIVING	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When, And How
[ ] Eating Habits: **[ ] Food Allergies:** **[ ] Equipment/Supplies/Procedures:** **Limitations:**		
TOILETING/CONTINENCE ISSUES *How individual uses the toilet room (or commode, bed pan, urinal); transfers on/off toilet, cleanses, changes incontinence pads, manages ostomy or catheter, adjusts clothes* **[ ]** Independent **[ ]** Supervision/Cueing **[ ]** Assistance Needed **[ ]** Totally Dependent **Frequency/How Often:** Continence Issues: **[ ] Bladder Incontinence** **[ ] Bowel Incontinence** **[ ] Skin care due to bowel/bladder incontinence** **Equipment/Supplies/Procedures:** **Limitations:**	**Strengths and Abilities**	**Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.) **Assistance Required** Caregiver will
DRESSING *How individual puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis* **[ ]** Independent **[ ]** Supervision/Cueing **[ ]** Assistance Needed **[ ]** Totally Dependent	**Strengths and Abilities**	**Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.) **Assistance Required** Caregiver will

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ACTIVITIES OF DAILY LIVING	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When, And How
Equipment/Supplies/Procedures: **Limitations:**		
PERSONAL HYGIENE– *How individual maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum* **[ ]** Independent **[ ]** Supervision/Cueing **[ ]** Assistance Needed **[ ]** Totally Dependent **[ ]** Own teeth **[ ]** Partials **[ ]** Dentures **[ ] Oral Hygiene** (including dentures): **[ ]** Flossing **[ ]** Brushing **[ ]** Soaking **[ ] Hair Care:** **[ ] Menses Care:** **When/how often:** **Equipment/Supplies/Procedures:** **Limitations:**	**Strengths and Abilities**	**Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.) **Assistance Required** Caregiver will
BATHING *How individual takes full-body shower, sponge bath, and transfer in/out of tub/shower* **[ ]** Independent **[ ]** Supervision/Cueing **[ ]** Assistance Needed **[ ]** Totally Dependent	**Strengths and Abilities**	**Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.) **Assistance Required** Caregiver will

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ACTIVITIES OF DAILY LIVING	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When, And How
When/how often: **Equipment/Supplies/Procedures:** **Limitations:**		
FOOT CARE **[ ]** Independent **[ ]** Supervision/Cueing **[ ]** Assistance Needed **[ ]** Totally Dependent **[ ]** Foot Care: How Often: **[ ]** Diabetic Foot Care **[ ]** Nail Care **When/how often:** **[ ]** Home Health Agency: **Equipment/Supplies/Procedures:** **Limitations:**	**Strengths and Abilities**	**Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.) **Assistance Required** Caregiver will
SKIN CARE **[ ]** Independent **[ ]** Supervision/Cueing **[ ]** Assistance Needed **[ ]** Totally Dependent **[ ] Skin Care -** How Often: **[ ]** Status: **[ ] Skin Problems -** Describe: **[ ]** Status: **[ ] Pressure Injuries -** Describe: **[ ] Dressing Changes -** How Often:		Caregiver will

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ACTIVITIES OF DAILY LIVING	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When, And How
[ ] Nurse Delegated **When/how often:** **[ ]** Home Health Agency: **Equipment/Supplies/Procedures:** **Limitations:**		

INSTRUMENTAL ACTIVITIES OF DAILY LIVING	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When And How
MANAGING FINANCES **[ ]** Independent **[ ]** Assistance Needed **[ ]** Dependent **[ ] Who Manages Finances:** **[ ] Who Manages Financial Records:** **[ ]** Payee Name and Contact information:	**Strengths and Abilities** **Prefers to do independently:**	**Assistance Required** Caregiver will
SHOPPING **[ ]** Independent **[ ]** Assistance Needed **[ ]** Dependent **[ ] Special transportation needs:** **How often/when:**	**Strengths and Abilities**	**Assistance Required** Caregiver will

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INSTRUMENTAL ACTIVITIES OF DAILY LIVING	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When And How
Equipment/Supplies/Procedures: **Limitations:**		
TRANSPORTATION **[ ]** Independent **[ ]** Assistance Needed **[ ]** Dependent **[ ] Medical services:** **[ ] Special transportation needs:** **[ ] Escort Required** **How often/when:** **Equipment/Supplies/Procedures:** **Limitations:**	**Strengths and Abilities**	**Assistance Required** Caregiver will
ACTIVITIES/SOCIAL *Social/Cultural considerations, traditions, or preferences* **[ ]** Independent **[ ]** Assistance Needed **[ ]** Dependent **[ ]** Interests/Activities/Religious Activities: **[ ]** Social/Cultural Traditions/Preferences: **[ ]** Family/Friends/Relationships: **[ ]** Employment Support: **[ ]** Clubs/Groups/Day Health: **[ ]** Special Arrangements: **[ ]** Participation Issues: Emergency Numbers: ***See face sheet in resident binder***	**Strengths and Abilities**	**Assistance Required** Caregiver will **Special Arrangements**: **Participation Assistance**:

ACTIVITY PREFERENCES AT A GLANCE		
[ ] Reading book and/or magazines	**[ ]** Gardening	**[ ]** Parties and social gatherings
[ ] Listening to audio books and/or podcasts	**[ ]** Outings with family or provider	**[ ]** Arts and crafts
[ ] Storytelling		**[ ]** Table games, Bingo, cards, puzzles

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INSTRUMENTAL ACTIVITIES OF DAILY LIVING	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When And How
[ ] Phone conversation/visiting **[ ]** Reminiscing **[ ]** Current events **[ ]** Discussion group **[ ]** Bible study or church **[ ]** Visitors	**[ ]** Visiting zoos and/ or spending time with pets and animals **[ ]** Exercises/range of motion **[ ]** Therapeutic Walking **[ ]** Cooking or baking **[ ]** House chore activities **[ ]** Watching TV, movies, or favorite shows	**[ ]** Beauty time, beautician visit **[ ]** Music appreciation/therapy/singing **[ ]** Employment support **[ ]** Community Integration **[ ]** Other: **[ ]** Other:
ACTIVITY NARRATIVE:		
SMOKING [ ] Resident Smokes [ ] Safety Concerns: [ ] Smoking Policy reviewed with resident. Signed by resident and placed in their record. Storage of Cigarettes/lighter:	**Strengths and Abilities**	**Assistance Required** Caregiver will
CASE MANAGEMENT **[ ]** Resident receives Case Management Name: Agency: Phone: Email: FAX:		CM will be contacted when: • The resident needs assistive device or other services to meet their needs • When the provider need help with the care plan • Significant changes with the condition/needs that necessitate changes with the care plan
OTHER ISSUES/CONCERNS/PROBLEMS		

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INSTRUMENTAL ACTIVITIES OF DAILY LIVING	Resident Strengths And Abilities Prefers To Do Independently Preferences and Personal Goals	Assistance Required Who Will Provide, When And How
NEGOTIATED CARE PLAN REVIEW	The resident will participate in their NCP development/reviews to the extent they are able.	This NCP will be reviewed/revised: • After an assessment for a significant change in the resident's physical or mental condition; • When the plan, or parts of the plan, no longer address the resident's needs and preferences; • At the request of the resident or the resident representative; or • At least every twelve months.

Abbreviations used in this NCP:

ADL= Activities of Daily Living
AFH = Adult Family Home
CG = Caregiver
Dr. = Doctor
DPOA = Durable Power of Attorney
D/t = due to
Hx = history
MAR = medication assistance record
MD = medical doctor
PCP = primary care physician
PRN = As needed
RND = Register Nurse Delegator
W/c= Wheelchair

Negotiated Care Plan Review and Approval

DATE OF ORIGINAL PLAN:

Dates of Review/Revision:

INVOLVED IN NCP DEVELOPMENT	PERSON APPROVING PLAN	SIGNATURE DATE*	SIGNATURE DATE*
[ ] Resident [ ] Resident Representative [ ] Parent [ ] Health Professional [ ] Other: [ ] Other:	PROVIDER		

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INVOLVED IN NCP DEVELOPMENT	PERSON APPROVING PLAN	SIGNATURE DATE*	SIGNATURE DATE*
[ ] Other:	RESIDENT		
	RESIDENT REPRESENTATIVE		
[ ] Resident verbally agreed to NCP – Date:		[] NCP sent to DSHS CM on:	
Resident Recommendations:			

*The person signing writes the date they actually read and agreed to the plan. If the participant has verbally agreed to the plan, the provider should note below: (a) the name and role of the participant; (b) the date the participant had the plan to read to them; and (c) what if any changes the participant recommended for the plan.