# Plan for Protective Oversight

**Name:** _____ **Phone #:** _____

**Address:** _____ **CIN #:** _____

_____ **Date Submitted:** _____

**Identify cross streets of address:**_____ _____

☐ **Plan for Protective Oversight for the period:** _____ **to** _____
☐ **Revision of Plan for Protective Oversight effective:** _____ **to** _____

**Contact Information for Supports Identified in this Plan for Oversight**

**Legal Guardian**:

_____

**Name:** _____ **Relationship:** _____ **Phone:** _____**(Work)** _____**(cell)**

**Name:** _____ **Relationship:** _____ **Phone:** _____**(Work)** _____**(cell)**

**Name:** _____ **Relationship:** _____ **Phone:** _____**(Work)** _____**(cell)**

**Name:** _____ **Relationship:** _____ **Phone:** _____**(Work)** _____**(cell)**

## I. Finances

a. Can waiver participant manage 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/have a Representative Payee? ☐ Yes ☐ No
   If so, who (will) act(s) 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. Can the waiver participant safely evacuate from the home.

☐ Yes ☐ No

If no, identify type of assistance required: _____

Identify the closest fire/ambulance station to the home:_____

_____

c. 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:

_____

d. Is the waiver participant unsteady while standing or present balance issues?

☐ Yes ☐ No

If yes, what measures have been taken to decrease/prevent falls within the home or community?

_____

e. Is the waiver participant safe within the kitchen? ☐ Yes ☐ No

If not, what activities may be unsafe for the waiver participant?

_____

What actions have been taken to ensure that the waiver participant is protected while in the kitchen?

_____.

f. Does the participant have any food or medication precautions/allergies?

☐ Yes ☐ No

If yes, describe:

_____
_____
_____

g. Is there a fire extinguisher, CO detector and a flashlight in the home? If yes, where are they located?

☐ Yes ☐ No: When will they be put in place? Date:_____

If yes, describe:

_____
_____
_____

h. Who has a key to the residence and is able to access the home on a routine basis or in an emergency?

_____
_____
_____

## III. Emergency Plan for Scheduled Unstaffed Time

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

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. Does the participant have a phone and is s/he able to call 911?

☐ Yes ☐ No

☐ Land-line ☐ Cell

If none: PERS should be utilized

c. 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

List the name(s) and phone number of back-up support(s)

| Name | Telephone Number | Relationship |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Describe the back-up plan. This is a step-by-step plan to be followed by staff or natural supports to ensure the safety of the participant when a change in staff coverage unexpectedly occurs due to emergency, natural disaster, crisis or break down in the service system. E.g. staff fails to report to work, natural or informal supports are not available as planned etc.

d. 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 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

e. Does the waiver participant have a Personal Emergency Response System?

☐ Yes ☐ No

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

Explain:

_____

_____

## 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

## V. Environment

a. Does the waiver participant have specialized or adaptive equipment they must use in order to complete activities of daily living?

☐ Yes ☐ No

What is this equipment and where is it located in the home?

_____
_____
_____

b. Can the waiver participant access and/or utilize community resources independently? If no, explain the type of assistance and/or supervision and oversight required

☐ Yes ☐ No

_____
_____
_____

c. Are there other individuals or family members residing in the home on a full time basis or who visit frequently? Identify name and relationship

_____
_____
_____
_____

d. Where is the waiver contact list located: _____

e. Does the participant know how to file a complaint?

☐ Yes ☐ No

_____
_____

## VI. Behavior

a. Does the participant present any challenging behavior that presents a risk to him/herself or a threat to others?

☐ Yes ☐ No

If yes, describe:

_____
_____
_____

b. Does the participant have a behavior plan and have staff been trained in its implementation

☐ Yes ☐ No

**Additional Comments:**

_____
_____
_____
_____

***This plan for Protective Oversight (PPO) must be readily accessible to all staff and natural supports and reviewed on a routine basis. This Plan must also be submitted to the Regional Resource Development Center with all Service Plans, and reviewed by the Service Coordinator with the participant, at least every six months or when conditions change. If there are incidents or concerns that arise which are directly related to the information presented in the Plan, the Plan must be reviewed and or amended immediately. Staff are responsible to know the contents and precautions established within the document. The PPO must be signed by at least one representative of each service agency and natural supports identified in the service plan.***

**Signatures of Individuals, Including Natural and Paid Supports, Participating in the development and utilization of the Plan for Protective Oversight**

Waiver Participant_____ Date _____

Advocate/Representative _____ Date_____
(When applicable)

Service Coordinator _____ Date _____

Service Coordinator Supervisor _____ Date _____

Service Provider _____ Date _____

Service Provider _____ Date _____

Service Provider _____ Date_____

Service Provider _____ Date _____

Service Provider _____ Date _____

Service Provider _____ Date_____

Natural Support _____ 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 sufficient supports are identified to safely maintain him/her in the community.**

**[ ] The Plan of Protective Oversight is not approved. It does not sufficiently address the health and welfare needs of the waiver participant. A revised Plan for Protective Oversight must be submitted to address the following concerns:**

_____
_____
_____

Signature: _____

Print Name: _____

Title: _____

Date: _____