Blue Plus SecureBlue[SM] (HMO SNP), **(651) 662-6013** or toll free **1-888-740-6013**,

8 a.m. to 8 p.m. seven days a week.

Blue Plus Blue Advantage and MinnesotaCare, **(651) 662-5545** or toll free **1-800-711-9862**,

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Attention. If you need free help interpreting this document, call the above number.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

ចំណាត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, nazovite gore naveden broj.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ໂປຣດຊາບ. ຖ້າທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງໂທຣໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bibili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

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LBS-0001 (1-15)

SecureBlue[SM] (HMO SNP) is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in SecureBlue (HMO SNP) depends on contract renewal.

This information is available in other forms to people with disabilities by calling Blue Plus Member Service at **(651) 662-5545** (voice), or **1-800-711-9862** (toll free), or **7 1 1**, or through the Minnesota Relay direct access numbers at **1-800-627-3529** (TTY, Voice, ASCII, Hearing Carry Over), or **1-877- 627-3848** (Speech-to-Speech)

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For enrollees age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your health plan primary care provider prior to the referral.

My Care Plan and Community Support Plan

I. Information About Me

Name: Kathy L. Doe	**My Health Plan ID Number:** 80123456	**My Health Plan Name:** Secure Blue-MSHO	**Today's Date:** 8/29/16
Phone #: 763-555-5555	**My DOB:** 4/01/1947 69 years young	**Product Enrollment Date:** 8/1/16	
My Address: Thousand Lakes Assisted Living 999 Metro BLVD #99 Twin Cities, MN 55055 *Moved in May 2015	**Rate Cell:** B	**Diagnosis:** Diabetes type 2 (E11.65), Hyperlipidemia (E78.5), HTN, Bilateral primary osteoarthritis of knee, IFG, Major depressive d/o, Generalized anxiety d/o, Borderline intellectual functioning, Allergies: Lisinopril	
	Date of My Assessment Visit: 8/26/16 **Assessment Type:** ☒ **Initial Health Risk Assessment** ☐ **Annual Reassessment** ☐ **Change in My Needs** ☐ **Other**		
Is there an Advance Directive or Health Care Directive in place? ☒ **Yes** ☐ **No** **Was Advance Directive/Health Care Directive discussed:** ☒ **Yes** ☐ **No** **If no, reason:** *POLST on file-Full code	**My primary language is:** ☒ **English** ☐ **Hmong** ☐ **Spanish** ☐ **Somali** ☐ **Vietnamese** ☐ **Russian** ☐ **Other (*Type in the "other" language*)** **I need an interpreter:** ☐ **Yes** ☒ **No** **Name and number of Interpreter (*If applicable*):** NA		

My Care Team (Interdisciplinary Care Team-ICT)

Care Coordinator/Case Manager: **Name:** Sally Care Coordinator ,LSW **Phone #:** 320-555-5555	**Primary Physician:** Dr. Richard **Phone #:** 651-555-5555 **Fax #:** 651-555-9999	**Clinic:** Doctor Richard Clinic 999 N. Main St. Twin Cities, MN 55055
Emergency Contact Name & Phone: Sandy Sisterhood #763-555-5555 Email: sandy@sisterhood.com	**My Representative is:** Sandy is POA for financial Sandy address: 110 Main, Twin Cities, MN 55055 *Mail all things to Sandy **They can be contacted for:** Updates- financial or medical, mail	
I have a Mental Health Targeted Case Manager: ☐ **Yes** ☒ **No** **Name of MHTCM:** NA **Phone Number of MHTCM:** NA		

Other Care Team Members Name	Relationship to me	Give Copy of Care plan?	Notes
Thousand Lakes Assisted Living Staff	24 hour paid caregivers	Yes	Discuss care F2F or

			via phone as needed

II. What's Important to Me? *(e.g. living close to my family, visiting friends)*

Initial/Annual: The most important things to Kathy are her family and spending time with them. Kathy identifies as Catholic and her faith is important to her. She enjoys participating in the activities a local Pastor offers often when he visits facility. Some of these activities are Catholic Rosary on Fridays, bible study, and prayer team. Kathy enjoys living at Lake Ridge and would like to remain living there. Kathy has a close relationship with her brother Tom, her sister Sandy, and her sister Mary.
Update: 02/12/17- Remains the same. No changes or concerns at this time.

III. My Strengths: *(e.g. skills, talents, interests, information about me)*

Initial/Annual: Kathy is a very kind and friendly 69 years young female who resides at Thousand Lakes Assisted Living. Kathy described herself as "a good and kind person, and a Bingo person". Kathy has a very strong relationship with her sister Sandy who lives close and visits frequently and also her two other siblings that live out of state. Kathy enjoys participating in many of the activities and outings offered at the facility including exercise programs, music entertainment, crafts, singing, bingo, having her nails painted, water painting, and going out to eat with the facility. Kathy used to work for XXXXXX Hospital in different areas over these years (housekeeping, laundry, aide, transportation aide, etc.). Kathy graduated from school in XXXXX, MN and started her at XXXX Hospital only 3 days after graduation. Kathy was raised in XXXXX, MN and her family later moved to XXXXX. She had 2 sisters and 2 brothers, one brother has passed away.
Update: 02/12/17- Strengths remain the same. No changes or concerns at this time.

IV. My Supports and Services: *(What do I want help with? Service and support I requested? From whom?*

Initial/Annual: Kathy and family would like continued assistance from sister Sandy as her POA with management of finances and MA renewals as needed. Current services Kathy is receiving are Care Coordination from XXX, wears a CPAP at night, and 24 hours Customized Living Services from Thousand Lakes. 24 hour CL provider supports Kathy with bathing supervision, medication admin supervision, medication set up, medical coordination,

diabetic management, housekeeping, laundry, meal prep, reminders, and socialization activities.
Update: 02/12/17- Supports and services remain the same. No changes at this time.

V. Caregiver

Informal Caregiver listed on HRA/LTCC: ***(Caregivers are unpaid person(s) providing services)***
☐ **Yes** ☒ **No**
If yes, the Caregiver Assessment Form was completed by:
☐ **Face-to-Face** ☐ **Telephone** ☐ **Mail** ☐ **Declined**
Date Completed: NA

VI. Managing and Improving My Health

Screening for my health				
	Check if educational conversation took place with me	**Goal is needed**	**Check if N/A, contraindicated, declined**	**Notes**
Annual Preventive Health Exam	☒	☐	☐	Kathy is seen on-site by PCP team 1x/month.
Mammogram (Within past 2 years ages 65-75)	☒	☐	☐	Per POA Kathy had a mammogram in April 2016.
Continence needs (Evaluated by a physician?)	☒	☐	☐	Kathy reports minor incontinence concerns but manages independently and does not wear or need incontinence supplies.
Colorectal Screening (Up to age 75)	☒	☐	☐	Per POA Kathy is up to date. She last had an exam 3 years ago and no concerns were noted.
At Risk for Falls (Afraid of falling, has fallen in the past).	☒	☒	☐	Kathy is a fall risk. See goal below.
Pneumovax (*Immunize at age 65 if not done previously. Re-immunize once if 1st pneumovax was received more than 5 years ago & before age 65)*	☒	☐	☐	Received 7/6/15
Flu shot *(Annually ages 50+ and persons at high risk.)*	☒	☐	☐	Kathy receives annually. Received 10/29/15
Tetanus Booster *(Once every 10 years)*	☒	☐	☐	Received 6/30/15
Hearing Exam	☒	☐	☐	Kathy denies any hearing concerns and reported recent hearing exams with no concerns expressed.
Vision Exam	☒	☐	☐	Kathy is farsighted and reads large print. She wears glasses daily. Kathy has a

				vision exam on-site.
Dental Exam	☒	☐	☐	Kathy has her own teeth and has a dental exam 1x/yr. Last dental exam was offered on-site. Kathy denies any current pain.
Calcium Vitamin D **Rx for Ca Vitamin D?** **(as directed by physician)**	☒	☐	☐	Kathy has an order for Calcium Carbonate tablet daily.
Aspirin **Rx for Aspirin?** **(as directed by physician)**	☒	☐	☐	Kathy has an order for 81mg tablet daily.
Blood Pressure: **(Blood Pressure Goal is <140/80 to age 75. After 75 based on individual)**	☒	☐	☐	Kathy has a DX of HTN and has orders for Norvasc and Hydrochlorothiazide daily. PCP and nursing staff continue to monitor. Currently stable.
Cholesterol check	☒	☐	☐	Kathy has a DX of hyperlipidemia. Has an order for Simvastatin daily. PCP and nursing staff continue to monitor. Currently stable.
Diabetic routine checks as recommended by physician (Discuss with my care team: Hypertension, Neuropathy, Eye exam, Cholesterol, A1C)	☒	☐	☒	Kathy has a DX of DM Type 2 and takes oral medications daily with B/S checks 1x/day. Kathy is currently stable. PCP and staff continue to monitor. Declined need for goal. She is up to date on labs (cholesterol, A1C) and eye exams related to her Diabetic DX.
Other:	☒	☒	☐	Kathy reports having pain in her knees and rated the pain "8 out of 10". See goal below.
Mental Health Diagnosis (If applicable):	**Managed by Other Health Professionals?** ☒ **Yes** ☐ **No** **(Psychiatrist, Psychologist, Primary Care Physician)**			

Depression (F33.9) and Anxiety (F41.1) ☐ **N/A**	**Need Goal?** ☒ **Yes** ☐ **No** ☐ **Declined**
My Medications	**I need help with my medications?** ☒ **Yes** ☐ **No** ☐ **N/A (no medications used)** **If yes, create a goal**
List of Medications ***(If not on LTCC)***	Robitussin DM(Dextromethorphan-Guaifenesin) 100-10 MG/5ML Syrup, Sig: 5 ml as needed Orally every 4 hrs for cough Mintox(Alum & Mag Hydroxide-Simeth) Suspension, Sig: 15 ml as needed Orally q 4 hrs for indigestion Milk of Magnesia(Magnesium Hydroxide) 400 MG/5ML Suspension, Sig: 30 mL Orally once daily PRN Senna S(Senna) 8.6-50 MG Tablet, Sig: 1 tablet Orally BID PRN Start Date: 02/29/2016 Bacitracin Zinc 500 UNIT/GM Ointment, Sig: 1 application to affected area Externally Once a day Loperamide A-D(Loperamide HCl) 2 MG Tablet, Sig: 1 Tablet Orally 8 time(s) a day Simvastatin 20 MG Tablet, Sig: 1 tablet in the evening Orally Once a day Zoloft(Sertraline HCl) 100 MG Tablet, Sig: 2 tablets Orally Once a day Toprol XL(Metoprolol Succinate ER) 50 mg Tablet Extended Release 24 Hour, Sig: 1 tablet Orally Once a day Start Date: 12/23/2015 Metformin HCl 1000 MG Tablet, Sig: 1 tablet with meals Orally Twice a day Acetaminophen 325 MG Tablet, Sig: 2 tablets Orally daily and q 4 hours PRN Losartan Potassium 25 MG Tablet, Sig: 1 tablet Orally Once a day Loratadine 10 MG Tablet, Sig: 1 tab PO daily Synthroid(L-Thyroxine Sodium) 75 MCG Tablet, Sig: 1 tablet Orally Once a day Tofranil(Imipramine HCl) 50 MG Tablet, Sig: 3 tablets Orally Once a day Hydrochlorothiazide 25 MG Tablet, Sig: 1 tablet Orally Once a day GlipiZIDE XL(Glipizide) 5 MG Tablet Extended Release 24 Hour, Sig: 1 tablet Orally Once a day Start Date: 12/23/2015 Cerovite Senior Tablet, Sig: 1 Tablet Orally daily at HS Calcium Carbonate 500 MG Tablet Chewable, Sig: 1 tablet Orally Once a day Aspirin 81 MG Tablet, Sig: 1 tablet Orally Once a day Norvasc(AmLODIPine Besylate) 5 MG Tablet, Sig: 1 tablet Orally Once a day
Health Improvement Referral	☐ **Yes** ☐ **Declined** ☒ **N/A** **Diagnosis:** NA
Hospitalizations ***(In past year number and reason, date(s) if available)***	0 **02/12/17- 0**
ER visits (In past year number and reason for visit; ***dates, if available)***	July 2015- Fall that resulted in a FX foot. D/c same day **02/12/17- 0**

VII. My Goals

Discuss with Care Coordinator goals for: my everyday life (taking care of myself or my home); my relationships and community connections; my future plans, my health, my safety; my choices.

Rank by Priority	My Goals	Support(s) Needed	Target Date	Monitoring Progress/Goal Revision date	Date Goal Achieved/ Not Achieved (Month/Year)
☐ Low ☐ Medium ☒ High	Kathy and family would like to have her health and safety needs met and monitored and receive medication management support in a 24/7 assisted living environment to help to maintain her independence and to reduce ER or hospital admissions.	Kathy will continue to live at 24 hour Assisted Living for her physical, cognitive, and mental health needs. Kathy will continue to have assistance from staff with housekeeping, laundry, meal prep, med set up, med admin supervision and monitoring, bathing supervision, socialization, and medical coordination.	8/31/17	02/12/17: Continues to have her health, safety, and mental health needs met in 24 hour AL. Kathy wants to continue living at Thousand Lakes Assisted Living and chooses to continue this goal for her health and safety.	
☐ Low ☐ Medium ☒ High	Kathy and family would like support in management of her mental health needs. Kathy has a DX of Anxiety and Depression.	Kathy will continue to take meds as prescribed by PCP and continue to participate in activities at Lake Ridge. Kathy will continue to meet with PCP 1x/month to discuss and monitor mental health concerns. Kathy will continue to meet with Psychiatrist Dr. Davis at XXXX. 24 hour staff will continue to monitor for any symptoms and report to PCP	08/31/17	02/12/17: Continues to take meds as prescribed and continues to participate in activities at Lake Ridge. Continues to meet with Dr. Davis. Kathy chooses to continue this goal for quality of life needs.	

		team.			
☐ **Low** ☐ **Medium** ☒ **High**	Kathryn would like to avoid any falls in the next year.	Kathryn reported some concerns with walking and fear of falling. She denied need for PT or a 4WW at this time, but will think about it and knows to contact CC or PCP team if decides otherwise. Staff will continue to monitor bathing for supervision needs. Staff will ensure her room and community areas are clear of clutter or possible fall hazards. Kathy chooses to continue to wear her wireless pendant.	8/31/17	02/12/17: No reported falls recently. Continues to use 4WW and receive staff supervision with bathing. Kathy wishes to continue this goal as she remains a fall risk.	
☐ **Low** ☐ **Medium** ☒ **High**	Kathy would like support in management of her pain symptoms in her knees due to arthritis.	Kathy will continue to have injections in her knees as recommended (3 set up). Kathy will continue to follow PCP orders and treatments. Kathy will express pain symptoms to staff, PCP team, or family.	8/31/17	02/12/17: She reports NO pain since starting the injections in her knees. She would like to continue this goal despite rating her pain 8/10 a few months ago. Staff and PCP team will continue to monitor.	
☐ **Low** ☐ **Medium** ☐ **High**					

☐ **Low** ☐ **Medium** ☐ **High**					
☐ **Low** ☐ **Medium** ☐ **High**					

VIII. Barriers to meeting my goals

Initial/Annual: An obstacle that may occur for Kathy to meeting her discussed goals in the next year are her physical limitations that debilitates her from being as independent as she was in the past.
Update: 02/12/17- Barriers remain the same at this time. No changes or new concerns at this time.
☐ **No barriers identified**

IX. My follow up plan:

Care Coordinator/Case Manager follow-up will occur:

☐ **Once a month for 3 months**
☐ **Every 3 months**
☒ **Every 6 months**
☒ **Other** As needed/Change of Condition

Purpose of Care Coordinator contact: Monitor care plan, evaluate goals, finding resources.

I can contact my Care Coordinator to help me with my medical, social or everyday needs. I should contact my Care Coordinator when:

- **Changes happen with my health**
- **I have a scheduled procedure or surgery or I am hospitalized**
- **I have experienced falls in my home or community**
- **I can no longer do some things that I had been able to do by myself (such as meal preparation, bathing, bill paying)**
- **If I need additional community services such as: equipment for bathroom safety or home safety; assistance with finding a new living situation (senior apartment); information about topics such as staying healthy, preventing falls, and immunizations.**
- **I need help finding a specialist**
- **I need help learning about my medications**
- **I would like information to help myself and my family make health care decisions**
- **I would like changes to my care plan or my services and supports**
- **I would like to talk about other service options that can meet my needs**
- **I am dissatisfied with one or more of my providers**

My Safety Plan

My safety concerns were discussed with my Care Coordinator: ☒ **Yes**
All services in place are meeting Kathy's health, safety, emotional, and mental health needs.

My plan for managing risks that I have discussed with my Care Coordinator is: NA

Emergency Plan:
In the event of an emergency, I will (check all that apply):

☒ **Call 911** ☐ **Use Emergency Response Monitoring System**
☒ **Call Emergency Contact**
☐ **Call Other Person Name: Phone:**
☒ **Other (describe)** 24 hour Assisted Living will follow emergency procedures.

Self Preservation/Evacuation Plan:
If I am unable to evacuate on my own in an emergency, my plan is to: following staff instruction and assistance with evacuation in the event of an emergency.

If other concerns or plans, describe: Assisted living staff will provide assistance during an emergency.

Essential Services Backup Plan: (*when providers of essential services are unavailable; essential services are services that if not received, health and safety would be at risk)*
I am receiving essential services ☒ **Yes** ☐ **No**
Essential services I am receiving: 24 hour customized living services
If Yes, describe provider's backup plan, as agreed to by me: If 24 hour Assisted Living becomes unavailable, Care Coordinator will work with PCP team, Kathy, and family to find alternative 24 hour placement.

Community-Wide Disaster Plan:
In the event of a community-wide disaster, (e.g., flood, tornado, blizzard), I will (describe plan): Follow the Assisted Living's disaster plan in the event of an emergency with staff assistance and direction.

Additional Case Notes: NA

XI. Choosing Community Long Term Care

☒ **Yes** ☐ **No** **I have been offered a choice between receiving services in the community or in the Nursing Home.**

☒ **Yes** ☐ **No** **I have been given a choice of different types of services that can meet my needs, as seen on my plan.**

☒ **Yes** ☐ **No** **I have been offered a choice of providers from available providers.**

☒ **Yes** ☐ **No** **I have annually received my appeal rights.**

☒ **Yes** ☐ **No** **I am aware that healthcare information about me will be kept private. (Data Privacy rights)**

☒ **Yes** ☐ **No** **I have discussed my plan of care with my Care Coordinator/Case Manager and have chosen the services I want.**

☒ **Yes** ☐ **No** **I agree with the plan of care as discussed with my Care Coordinator/Case Manager.**

MY/MY REPRESENTATIVE SIGNATURE: *Kathy Doe*	**DATE:** 8/29/16
CARE COORDINATOR/CASE MANAGER SIGNATURE: *Care Coordinator*	**DATE:** 8/29/16
CARE PLAN MAILED/GIVEN TO ME ON:	**DATE:** **8/29/16**
CARE PLAN OR SUMMARY MAILED/GIVEN TO MY DOCTOR (verbal, phone, fax, EMR): Information sent by fax.	**DATE:** 8/29/16

Member Name: Kathy Doe **ID#** 80123456

XII. Home and Community Based Service and Support Plan/Budget Worksheet

Please include ALL formal and informal services, e.g., skilled home care, home care, home-and-community-based services, medical supplies, etc.

Support/Service	Services Offered, if appropriate (mark "X" if service was offered; if accepted, fill in remaining boxes on support plan)	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider	Payment Type (Medicare, Medicaid, Waiver or Other)	Schedule/ Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Adult Day Care Bath	☐							
Adult Day Services	☐							
Customized Living Verification code: _ _____	☐							
24-Hour Customized Living Verification code: __123456789111___ _____	☒	Purchased	Thousand Lakes AL	EW-BCBS	Daily	8/1/16-3/31/17	$76.00/day	$2,323.00 /month
Care Coordination/Case Management	☒	Purchased	Delegate Agency	BCBS	As needed/Monthly	8/1/16-3/31/17	$180/mo	$180/mo

Support/Service	Services Offered, if appropriate (mark "X" if service was offered; if accepted, fill in remaining boxes on support plan)	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider	Payment Type (Medicare, Medicaid, Waiver or Other)	Schedule/ Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Care Coordination-Para-Professional	☐							
Caregiver Support	☐							
Companion Services	☐							
Foster Care	☐							
Help w/MA, Finances, Other	☒	Volunteer	Sister/POA-Sandy	NA	As needed	Ongoing	NA	NA
Homemaking	☐							
Home Modification	☐							
Home Delivered Meals	☐							
Nurse Visits	☐							
Home Health Aide	☐							

Support/Service	Services Offered, if appropriate (mark "X" if service was offered; if accepted, fill in remaining boxes on support plan)	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider	Payment Type (Medicare, Medicaid, Waiver or Other)	Schedule/ Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Personal Care Assistant (PCA)	☐							
PCA Supervision	☐							
Personal Emergency Response System (PERS)	☐							
Respite	☐							
Therapies at Home: PT, OT, ST	☐							
Transportation	☐							
Yard Work/Chores	☐							
CDCS Services	☐	FSE:	Support Planner:					
List of Equipment								

Support/Service	Services Offered, if appropriate (mark "X" if service was offered; if accepted, fill in remaining boxes on support plan)	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider	Payment Type (Medicare, Medicaid, Waiver or Other)	Schedule/ Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
Member Has								
Cane	☐	Purchased	Unknown	MA	1x/purchase	NA	NA	NA
4WW	☐	Purchased	Unknown	MA	1x/purchase	NA	NA	NA
	☐							
	☐							
	☐							
	☐							
List of Supplies								
	☐							
	☐							
	☐							
	☐							
	☐							
Other: (supports, resources)								
	☐							
	☐							
Case Mix Level: B		**CAP amount** $3,341/mo $40,092/yr. 24 hour CL cap: $92.58/day	**Member Waiver Obligation if Known:**	BCBS	**Total Cost of Authorized Services:** $2,503/mo.	**Notes:** Total cost of monthly authorized services includes 24 hour customized living services and Care Coordination.		

Support/Service	Services Offered, if appropriate (mark "X" if service was offered; if accepted, fill in remaining boxes on support plan)	How is Service Provided? (e.g. Source: caregiver, purchased service, neighbor, volunteer)	Provider	Payment Type (Medicare, Medicaid, Waiver or Other)	Schedule/ Frequency	Service Start Date and End Date (if applicable)	Estimated Cost per Unit	Cost Per Week or Month
			Unknown					