

AGED AND DISABLED WAIVER INTERIM SERVICE PLAN

(Initial Service Plan must be completed in 21 days)

Last Name	First Name	Medicaid #	Service Level Range of HRs
Case Manager Provider:		Phone:	
PA/ Homemaker Provider:		Phone:	

I Prefer These Activities, on These Days, During These Times: : In box indicate if Informal Support (I) or Formal Support (F) or Both (B)

Activity	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Time Am/PM
Special Directions:								
Bath:								
Skin Care:								
Hair:								
Nails:								
Mouth Care:								
Dressing:								
Ambulation:								
Transfer:								
Toileting:								
Positioning: Turn Every Hr(s) Up in Chair								
Bed making:								
Assist with Medication: (Prompt only)								

**AGED AND DISABLED WAIVER
INTERIM SERVICE PLAN**

Activity	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Time Am/PM
Meals: B L D Snacks Diet: Special Directions:								
Laundry								
Vacuum/Sweep								
Mop								
Dust								
Straighten								
Transportation for:								
Essential Errands: Describe								
Community Activities: (not to exceed 30 hours/month)								

WHAT SERVICES AND RESOURCES DO I NEED?

Service Type or Resource	Provider	Amount/Frequency

Service Type or Resource	Provider	Amount/Frequency

Document any current identified risk to health and safety?

Date copy of interim service plan send to Personal Assistance/Homemaker agency _____