

AGED AND DISABLED WAIVER SERVICE PLAN

Member Name:

Date:

Initial	Six Month	Annual	
(If change in need occurs mark appropriate box and a Service Plan Addendum must be attached.)			Begin Date: End Date:
Last Name	First Name		Medicaid #
			Service Level Range of HRs
Case Manager Provider:			Phone:
Primary PA/ Homemaker Provider			Phone:
Secondary PA/Homemaker Provider			Phone:
Informal Support			Phone:
Informal Support			Phone:

***If needed add another sheet with Informal Support information.**

What do you expect from this program?

PERSONAL PREFERENCES

1. What would you like your personal assistant/homemaker to do for you?

2. Are there any things you prefer the personal assistant/homemaker not do for you?

3. Do you need assistance with scheduling appointments? Yes No

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I Prefer These Activities, on These Days, During These Times: In box indicate if AM or PM and also 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)								
Meals: B L D Snacks								
Diet:								
Special Directions:								
Laundry:								
Vacuum/Sweep:								
Mop:								

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Activity	Sun	Mon	Tues	Wed	Thurs	Fri	Sat	Time Am/PM
Dust:								
Straighten:								
Transportation for:								
Essential Errands: Describe								
Community Activities: (not to exceed 30 hours/month) Describe:								
Other Service(s)/Activities:								

Risk Mitigation

Identified Problems/Risks as Noted on Member Assessment	Service(s) to Address Problems/Risks	Provider	Phone Number	Date Completed	Comments

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SERVICE PLAN**

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Other Issues to be Addressed (Refer to Member Assessment #9 Member Needs):

Identified Member Need(s)	Service(s) to Address Member Need(s)	Provider	Phone Number	Date Completed	Comments

Additional Comments:

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Signature Page

In order to be a valid Service Plan all involved persons are to sign and date this document.

By signing, I certify that the reported information is complete and accurate. I understand that payment for the services certified on this form will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under Medicaid Fraud.

Required Signatures:

Member/Legal Representative Signature	Date
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Case Manager Signature	Date
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RN Signature (on six month and annual)	Date
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Signatures requested by member:

Name	Date
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Name	Date
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Name	Date
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Name	Date
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Name	Date
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Copy of Service Plan was provided to the member on _____
Copy of Service Plan was provided to Personal Assistance/Homemaker Agency on _____