AGED AND DISABLED WAIVER – INTERIM SERVICE PLAN

ADW Participant's Name:_____ Plan Date:_____

Last Name:	**First Name:**
Medicaid ID:	**Service Level/Hours:**
Case Manager Provider:	**Plan Begin Date:** **Plan End Date:**
Primary Personal Attendant Provider Name/Phone (or Personal Options):	**Informal Support/Phone:** **Informal Support/Phone:**
What would you like the Personal Attendant to do/not do for you?	
Describe Any Immediate Risks:	**Describe How the Risks will be Addressed:**

SERVICE PLAN

Personal Attendant Provider Name	**Amount** ***How Much?***	**Frequency** ***How Often?***	**Duration of Plan**

Service(s) Needed	**Provider**	**Describe the Service Amount, Frequency and Duration** *(How much, how often and when)*
Case Management		
Transportation Services		
Other:		

Describe Any Immediate Resource Needs:	**Who/Where Will You Refer:**

Where I live: *I choose to live in a home that is in the community (not an institution) where I have a choice of who lives with me, what I do in my home, who I talk with on the phone, visitors coming into my home, my meals, how I manage my resources and who I interact with outside my home.* Yes No

CHOICE: ***I have a right to choose program models, types of services and agencies***. **Date: _____**
Initials: _____

_____ _____
ADW Participant/Legal Representative Signature Date

_____ _____
Case Manager Signature Date

_____ _____
RN or Resource Consultant Signature Date

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PERSONAL ATTENDANT LOG

ADW Participant's First and Last Name:		PA Agency/Personal Options:	**PAL UPDATE** **Date Updated by RN/RC:**	
RN/RC Signature: Date: RN Time In: RN Time Out:		Plan Period: Service Level/Hours:	**CM/RC Receipt Date:** **CM/RC Initials:**	
Hours/Day:	**Days/Week:**	Was this a change in hours, days or activities?	**Service Time In:**	**Service Time Out:**

Date: *PA Circle correct day*	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	
	16	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
Time Arrived:																
Time Left:																
Total Hours:																
PA Initial: 1 staff per recipient																
ADW Participant's Initials:																

DESCRIPTION OF SERVICES – RN or RC *Describe activities, circle type of assist, list days of week.* ***PA –*** *Initial on day activity provided.*

Describe Activities **S= Supervised; P = Partial; T =Total**	**DAYS**																
Bath: S P T																	
Skin Care: S P T																	
Hair: S P T																	
Nails: S P T																	
Mouth Care: S P T																	
Dressing: S P T																	
Ambulation: S P T																	
Transfer: S P T																	
Toileting: S P T																	
Positioning: Turn Every ____Hrs. Up in Chair																	
Bed Making:																	
Medication Prompt:																	
Meals: Diet/Special Directions B ____ L ____ D ____ Snack																	
Laundry:																	
Vacuum/Sweep:																	
Mop:																	
Dust:																	
Straighten:																	

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Essential Errands *(include purpose, destination, frequency and day of week):*

Community Activities: *(include purpose, destination, frequency and day of week):*

Other:

Special Instructions for Transportation:

Date/Start Time **	Total Miles Traveled	How much time did you spend driving? **	Destination and Purpose of Travel **Complete these sections for medical appointments ONLY and do NOT bill for miles for medical	Essential Errand Time Spent**	Community Activities Time Spent	**Was Person with You? Yes No	ADW Person's Initials **

I have reviewed this PA Service Log and to the best of my knowledge, the reported information is complete and accurate. **No RN for Personal Options.**

RN Printed Name: _____

RN Signature: _____Date:_____

(If needed, attach additional documentation).

Comments:_____

_____

_____

_____

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 material fact, may be prosecuted under Medicaid fraud.

*Participant/Legal Representative*_____*Date:*_____

(Program Representative for Personal Options)

Personal Attendant Printed Name: _____

Personal Attendant Signature: _____*Date:* _____

Unless prior approved, services must follow Plan. For Personal Options, follow participant's budget.

PAL Updates: Change in days, times, activities.
Date:
RN/RC Initials:

RN/RC spoke to person by phone____
Face to Face____ regarding changes.

Must send updated PAL to CM or RC.

Date	Wellness Scale	Comments *Wellness Scale 1-10 (1=poor; 10 =great)*	Date	Wellness Scale	Comments *Wellness Scale 1-10 (1=poor; 10 =great)*