AGED AND DISABLED WAIVER – SERVICE PLAN

ADW Participant's Name: _____ Plan Month/Year: _____

Date	Initial	Six Month	Annual	Change in Need/Service Level	Dual Services
	☐	☐	☐	☐	☐

I. DEMOGRAPHICS:

Last Name:	**First Name:**
Medicaid ID (and PPL ID):	**Service Level/Hours:** **Anchor Date:**
Case Management Agency or Personal Options Resource Consultant(Name/Phone):	**Plan Begin Date:** **Plan End Date:**
Primary Personal Attendant Agency Name/Number:	**Secondary Personal Attendant Agency Name/Phone:**
Legal Representative Name/Phone:	**Informal Support Name(s)/Phone:**
Personal Options Budget:	**Take Me Home WV:**

II. GOAL(S) AND PREFERENCES:

What are my goals? *(In own words, what I expect from the program):*	***How can my program support my goals?***
Describe your personal strengths.	***List specific things you do or do not want your worker to do for you.***

III. RISK PLAN: (For Service Plan Updates, CM/RC add date/initials with new risk)

RISK(S) *Describe the identified risks on the assessment needing addressed.*	RISK PLAN(S) *Describe how the risk(s) will be addressed.*

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IV. SERVICE PLAN *(For Service Plan Updates: CM/RC add date/initials for new service)*

ADW Service Do not list worker name	**Amount** ***Number Hours Per Day***	**Frequency** ***Days of the Week***	**Service Plan Duration**
Personal Attendant Services or Personal Options:			

Other Service(s) Other ADW Services, Home Health, PT, etc.	**Provider (or Personal Options)** Do not list worker name	**Service Amount, Frequency and Duration**
Case Management		
Skilled Nursing Services		
Transportation Services		
Other:		
Other:		
Other:		
Other:		

V. RESOURCE PLAN *(For Service Plan Updates, CM/RC add date/initials for new risk)*

Resource(s) Needed *(Food stamps, HUD, etc.)*	**Provider/Referral Source/Physicians**

NOTE: MAY ATTACH ADDITIONAL PAGES WHEN NECESSARY.

VI. HOME AND COMMUNITY BASED SETTING

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

ADW Participant's Name: _____ Plan Month/Year: _____

VII. 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:																	

ADW Participant's Name: _____ Plan Month/Year: _____

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 Stop 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 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 person'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)*

ADW Participant's Name: _____ Plan Month/Year: _____

VII. MY EMERGENCY BACK UP PLAN

INFORMAL SUPPORT: *What activities are to be completed by the informal support?*	*What Days/Times are activities completed?*	*Who provides the informal support?*

Personal Attendant Availability

For Traditional Services, I will accept a substitute Personal Attendant if my assigned PA is not available. ☐ Yes ☐ No

I will use my informal supports when a Personal Attendant is not available. ☐ Yes ☐ No

I understand that no services within 180 days may result in my ADW case being closed. ☐ Yes ☐ No

For Traditional Services when no Personal Attendant is available, I prefer that you contact:
Me or **Name:** **Phone:**

As a back-up, I need the following things to occur. Describe what will happen if no one is available, who to call for informal support, the person's urgent needs and any actions that need to take place.

Access to Emergency Assistance

If I'm unable to answer the door when the worker arrives, please contact the individual(s) below for access to my home:

Name: **Home Phone:** **Cell Phone:** **Work Phone:**

Name: **Home Phone:** **Cell Phone:** **Work Phone:**

Other Directions:

I can access emergency assistance by dialing 911. ☐ **Yes** ☐ **No**
I need additional assistance such as Life Alert, Safe Link, etc.
I have a hospital preference: ☐ **Yes** ☐ **No Name of hospital: _____ Comment:**

Disaster Emergency Plan

I have a plan in place for: floods, extended power outage, snow, fire, etc. Described the person's urgent needs and any actions that need to take place.

ADW Participant's Name: _____ Plan Month/Year: _____

Other *(Please indicate the status of available resources such as family, friends, or other community resources):*
Directions to my home:
How to report abuse/neglect/exploitation: I understand how to report abuse/neglect/exploitation because it was explained me at the time of my service planning meeting. _____Yes _____No
Choice: I understand that I have the right to choose program models, types of services and agencies. ___Yes ___ No

SERVICE PLAN SIGNATURES AND PLAN AGREEMENT

_____	_____	_____	_____
ADW Participant/Legal Representative Signature	Agree	Disagree	Date
_____			_____
Case Manager Signature			Date
_____			_____
RN or Resource Consultant Signature			Date
_____			_____
Other			Date
_____			_____
Other			Date

ADW Service Plan Disagreement *Only complete this section if "disagree" was marked above by the ADW person. <u>This does not apply to issues related to ADW policy compliance (Example: Transportation Services).</u>*
If disagree was marked above, state the reason for the disagreement with the plan. **Describe the resolution.** **If unresolved, I have been referred to the ADW Grievance Process.** **Yes No** **ADW Person's Initials** _____

Service Plan was provided to the ADW Participant and the Personal Attendant Agency. **Date:** _____

*Note: If you are accessing this document on Word, any alterations of the original form will result in improper documentation and disallowance