

## 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
<b>I. DEMOGRAPHICS:</b>					
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:		
<b>II. GOAL(S) AND PREFERENCES:</b>					
<p><i>What are my goals? (In own words, what I expect from the program):</i></p>    <p><i>Describe your personal strengths.</i></p>			<p><i>How can my program support my goals?</i></p>    <p><i>List specific things you do or do not want your worker to do for you.</i></p>		
<b>III. RISK PLAN: (For Service Plan Updates, CM/RC add date/initials with new risk)</b>					
<b>RISK(S)</b>			<b>RISK PLAN(S)</b>		
<i>Describe the identified risks on the assessment needing addressed.</i>			<i>Describe how the risk(s) will be addressed.</i>		

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<b>IV. SERVICE PLAN</b> <i>(For Service Plan Updates: CM/RC add date/initials for new service)</i>			
<b>ADW Service</b> Do not list worker name	<b>Amount</b> <i>Number Hours Per Day</i>	<b>Frequency</b> <i>Days of the Week</i>	<b>Service Plan</b> <b>Duration</b>
<b>Personal Attendant Services or Personal Options:</b>			
<b>Other Service(s)</b> Other ADW Services, Home Health, PT, etc.	<b>Provider (or Personal Options)</b> Do not list worker name	<b>Service Amount, Frequency and Duration</b>	
Case Management			
Skilled Nursing Services			
Transportation Services			
Other:			
<b>V. RESOURCE PLAN</b> <i>(For Service Plan Updates, CM/RC add date/initials for new risk)</i>			
<b>Resource(s) Needed</b> <i>(Food stamps, HUD, etc.)</i>		<b>Provider/Referral Source/Physicians</b>	

**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*

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**VII. PERSONAL ATTENDANT LOG**

ADW Participant's First and Last Name:			PA Agency/Personal Options:													<b>PAL UPDATE</b>								
RN/RC Signature:			Plan Period:													Date Updated by RN/RC:								
Date:      RN Time In:      RN Time Out:			Service Level/Hours:													CM/RC Receipt Date:								
<b>Hours/Day:</b>		<b>Days/Week:</b>		Was this a change in hours, days or activities?													<b>Service Time In:</b>		<b>Service Time Out:</b>					
<i>Date: PA Circle correct day</i>				<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>	<b>12</b>	<b>13</b>	<b>14</b>	<b>15</b>						
				<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>25</b>	<b>26</b>	<b>27</b>	<b>28</b>	<b>29</b>	<b>30</b>	<b>31</b>					
<b>Time Arrived:</b>																								
<b>Time Left:</b>																								
<b>Total Hours:</b>																								
PA Initial: 1 staff per recipient																								
<b>ADW Participant's Initials:</b>																								
<b>DESCRIPTION OF SERVICES – RN or RC Describe activities, circle type of assist, list days of week. PA – Initial on day activity provided.</b>																								
<b>Describe Activities</b>			<b>DAYS</b>																					
S= Supervised; P = Partial; T =Total																								
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																								
<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px;">B</td> <td style="width: 20px;">L</td> <td style="width: 20px;">D</td> <td style="width: 20px;">Snack</td> </tr> </table>			B	L	D	Snack																		
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 Stop Time **	Total Miles Traveled	How much time did you spend driving? **	Destination and Purpose of Travel <b>** Complete these sections for medical appointments ONLY and do NOT bill for miles for medical.</b>	Essential Errand Time Spent **	Community Activities Time Spent	**Was Person with You? Yes No	ADW Person Initials **
						<input type="checkbox"/> <input type="checkbox"/>	
						<input type="checkbox"/> <input type="checkbox"/>	
						<input type="checkbox"/> <input type="checkbox"/>	
						<input type="checkbox"/> <input type="checkbox"/>	
						<input type="checkbox"/> <input type="checkbox"/>	
						<input type="checkbox"/> <input type="checkbox"/>	
						<input type="checkbox"/> <input type="checkbox"/>	

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: \_\_\_\_\_

**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.

Personal Attendant Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
**Unless prior approved, services must follow Plan. For Personal Options, follow person's budget.**

Date	Wellness Scale	Comments <i>Wellness Scale 1-10 (1=poor; 10 =great)</i>	Date	Wellness Scale	Comments <i>Wellness Scale 1-10 (1=poor; 10 =great)</i>



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**VIII. MY EMERGENCY BACK UP PLAN**

<b>INFORMAL SUPPORT:</b> <i>What activities are to be completed by the informal support?</i>	<i>What Days/Times are activities completed?</i>	<i>Who provides the informal support?</i>	
<b>Personal Attendant Availability</b>			
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.			
<b>Access to Emergency Assistance</b>			
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:			
<b>Disaster Emergency Plan</b>			
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.			

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**Other** (Please indicate the status of available resources such as family, friends, or other community resources):

**Directions to my home:**

**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. This does not apply to issues related to ADW policy compliance (Example: Transportation Services).*

**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