Aged and Disabled Waiver- Service Plan Additional Pages

Last Name:		**First Name:**
Date	**Medicaid ID (Personal Options, PPL ID)**	**Case Manager or Resource Consultant**
		Name:

Risk Plan: (For Service Plan Updates, CM 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.*

Service Plan: Other Service(s)	**Provider**	**Service Amount, Frequency and Duration**

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**