HCBS SERVICE PLAN

Member Name:		Enrollment Date: Update:	Discharge	Readmits
Level of Care Evaluation Date:		Met LOC: YES☐ NO☐	Screened by: MPQH ☐ CMT ☐	
Social Security Number:	Medicaid ID#:	Phone Number:		
Physical Address:		Mailing address:		
Care Category ☐ Basic ☐ AR ☐ CC3		Email Address:		
Date of Birth:	Height:	Weight:	Sex:	Marital Status:
☐ _____ ☐ ☐ ☐ _____				
OPA:				
Pharmacy:			Phone:	
Residential Status: ☐ Lives Alone ☐ Lives with family/significant other ☐ Live in attendant	☐ Residential Habilitation; Type:_____ ☐ Other:			
Medicare ☐ Yes ☐ No	Medicare #	Effective Date (if Known):		
Medicare D:	Other Insurance:	Veteran or spouse of Veteran ☐ Yes ☐ No		
Primary Diagnosis:		ICD 10:		

☐ ☐ ☐ ☐ ☐	
☐ ☐	

MEDICAL INFORMATION

NUTRITIONAL STATUS

Diet:	☐ General ☐ Diabetic ☐ Low salt ☐ Other (Specify):
Supplements	

MEDICAL DIAGNOSIS

Date	Medical Diagnoses	ICD-9/10 Code	Date	Medical Diagnoses	ICD-10 Code

MEDICATION LIST

Date	Medications	Dosage	Frequency	Date	Medications	Dosage	Frequency

Medication Allergies: Other Allergies:

Medication Dispensing System:	Pharmacy:

Comments:

PSYCHOSOCIAL INDICATORS

List indicators that currently affect member and/or service delivery:

Mental status/orientation :

FUNCTIONAL OVERVIEW

Task	Independent	Needs Assistance	Dependent	Task	Independent	Needs Assistance	Dependent
Bathing				Laundry			
Dressing				Shopping			
Exercise				Socialization			
Grooming				Telephone			
Toileting				Vision			
Continence				Hearing			
Transfer				Speech			
Mobility				Banking			
Assistive Devices				Money Mgmt			
Meal Preparation				Orientation			
Eating				Transportation			
Medications				Time Mgmt			
Escort				Other			
Household				Other			

ASSISTIVE DEVICE INFORMATION

Needs	Has	Device	Needs	Has	Device
		Bath Chair/Bench			Environmental Control Unit
		Cane			Non-Skid tub mat
		Commode Chair			Communication Device
		Commode seat, raised rails			Scooter
		Grab Bars			Personal Alert/Safety/Response System
		Handheld shower			Trapeze Bar
		Specialized Bed			Walker
		Positioning Bar			Wheelchair
		Lift System/Lift Chair			Wheelchair Ramp
		Service Animals			Other:

DME Provider(s):

SERVICE OPTIONS

SERVICE	SUPPORT REQUIRED	PROVIDER	FREQUENCY

OTHER SERVICES AND INFORMAL SUPPORT SYSTEMS

Service	Need	Provider	Frequency

PLAN ASSESSMENT SUMMARY

Physical Summary:

Long-Term Goals:

Short-Term Objectives:

Psychosocial Summary**:**

Long-Term Goals:

Short-Term Objectives:

Discharge Plan:

Emergency Backup Plan:

Emergency Evacuation Plan:

Emergency Contact: Phone:

Location of Medications & Important Documents:

SAFETY INFORMATION

Please check the following safety concerns as they apply:

☐	Access to phone in emergency is limited	☐	Entrance/exit to home not accessible	☐	Concern for safety in community

Comments/Issues:

Need for formal risk assessment Yes ☐ No ☐ Date assessment will be completed:

SIGNATURE SECTION

My plan addresses my needs and personal goals, including health and safety.	☐
I have made a free choice of services and qualified providers for each service included in my Service Plan.	☐
I have received a choice between institutional care or HCBS.	☐
I have received information on Abuse/Neglect and Exploitation and know how to report.	☐
I understand there is a service plan cost limit and a limit on the type of services available through the HCBS Program.	☐
I have participated in the development of this service plan and agree with it.	☐
The case management team has verified that HCBS services in this plan cannot be reimbursed by state plan Medicaid, Medicare or private insurance.	☐

Member Signature:	Date:
Legal Representative:	Date:
Primary Care Provider Signature:	Date:
CMT Nurse:	Date:
CMT: Social Worker:	Date:
Other:	Date:

ANY OTHER COMMENTS / NOTES