Department of Mental Health, Mental Retardation and Substance Abuse Services

PLAN OF CARE SUMMARY

Check type of Waiver: ☐ **MR WAIVER** ☐ **DAY SUPPORT WAIVER**

Individual's Name: _____ (FIRST) _____ (LAST) ____ (M.I.) CSP Start Date: _____

Medicaid Number: _____ Date of last medical exam: _____ CSP End Date: _____

CSB: _____ Case Manager: _____ Phone: _____

Primary goals of the individual:

_____

_____

_____

_____

Living Arrangements (while in the MR Waiver)
Check any that apply:

- ☐ Lives alone
- ☐ In home/apartment shared with relatives or other
- ☐ DMHMRSAS-Licensed Supportive Residential
- ☐ DMHMRSAS-Licensed Group Home (2-4 persons)
- ☐ DMHMRSAS-Licensed Group Home (5-7 persons)
- ☐ DMHMRSAS-Licensed Group Home (8 or more)
- ☐ DMHMRSAS-Licensed Sponsored Res Home
- ☐ DSS-Approved Adult Foster Care Home
- ☐ DSS-Licensed Asst Living Facility-Not waiver provider
- ☐ DSS-Approved Child Foster Care Home
- ☐ Core-Licensed Children's Family Care Home
- ☐ Core-Licensed Children's Group Home

ICF/MR Level of Functioning ☐ Date completed

Check the following categories in which dependency level is met (must be met in 2 or more within 6 months of start date)

- ☐ 1. Health Status
- ☐ 2. Communication
- ☐ 3. Task Learning Skills
- ☐ 4. Personal/Self Care
- ☐ 5. Mobility
- ☐ 6. Behavior
- ☐ 7. Community Living Skills

Functional Assessment Date Completed: _____

Title _____ If SIS used Support Needs Index: ☐

Check if format approved by OMR: ☐ If ICAP used Service Score: ☐

List the full range of services/supports that this individual receives/will receive:

Service Type	Services/Supports	Provider Name	Amt / Frequency	Start Date
	WAIVER SERVICES			
Case Management				
Residential Support	In-Home			
	Group Home			
	Group Home for Children			
	AFC			
If more than one provider, enter 2nd here →	Sponsored Residential			
Day Support [**MR or DS Waiver**]	Regular Intensity, Center-Based			
	Regular Intensity, Community-Based			
	High Intensity, Center-Based			
If more than one provider, enter 2nd here →	High Intensity, Community-Based			
Prevocational [**MR or DS Waiver**]	Regular Intensity, Center-Based			
	Regular Intensity, Community-Based			
	High Intensity, Center-Based			
If more than one provider, enter 2nd here →	High Intensity, Community-Based			

Individual's Name: _____ (LAST) _____ (FIRST) _____ (M.I.) Medicaid #: _____

Service Type	Services/Supports	Provider Name	Amt / Frequency	Start Date
WAIVER SERVICES (continued)				
Supported Employment If more than one provider enter 2nd here →	Individual Placement			
	Group			
Personal Assistance	Agency Directed			
	Consumer Directed			
Skilled Nursing If more than one provider enter 2nd here →	LPN			
	RN			
Respite If more than one provider enter 2nd here →	In-Home			
	Out-of-Home			
	Residential			
	Center-Based			
	Consumer Directed			
Companion	Agency Directed			
	Consumer Directed			
Therapeutic Consultation	Behavioral			
	Psychological			
	Physical			
	Speech			
	Occupational			
	Recreational			
	Rehabilitation Engineering			
Crisis Stabilization	Clinical / Behavioral Intervention			
	Crisis Supervision			
Environmental Modification				
Assistive Technology				
PERS (Personal Emergency Response System)	PERS			
	PERS and Medication Monitoring			
NON-WAIVER SERVICES				
School				
Medical				
Mental Health				
OT/PT/SP Therapy				
Other				

ATTACH ADDITIONAL PAGES IF FURTHER EXPLANATION IS NEEDED.

_____ Case Manager Signature

_____ Date

Instructions for the Completion of the Plan of Care Summary Form (DMAS-438)

For initial authorizations, the Plan of Care Summary must accompany the Social Assessment and ISARs. The Plan of Care Summary must also be updated and submitted to DMHMRSAS at the annual review.

Check the box beside the type of Waiver.

1. *Identifying information*

   - ***Individual's Name***: in the appropriate boxes enter last name, first name and middle initial

   - ***CSP Start Date***: enter the start date (month-day-year) of the Case Manager's plan for this year. This may be earlier than the actual start date of ***Waiver*** services, but must be used to determine the quarterly review dates and annual reassessment date for the individual's CSP. All Waiver services that begin during the CSP year will follow this review/assessment cycle.

   - ***Medicaid Number***: enter the consumer's **12 digit** number

   - ***Date of Last Medical Exam***: Enter the date the individual last had a comprehensive physical exam, in the order "month-day-year." A medical exam must be completed within one year prior to the actual start of Waiver services. The individual may be approved for enrollment without a current medical, but actual services will not be authorized if it has been more than one year since a physical exam was conducted.

   - ***CSP End Date***: enter the end date (month-day-year) for the CSP (no more than 365 days [366 in leap years] from the CSP start date). This should be the annual end date of the case management plan.

   - ***CSB***: enter the name of the CSB/BHA providing (or contracting for) case management services

   - ***Case Manager***: enter the name of the individual's case manager

   - ***Phone***: enter the phone number of the individual's case manager, including the area code.

   NOTE: The individual name and Medicaid number must be entered on the top of page 2 as well.

2. Primary goals of the individual

Enter the goals set by the individual and his/her support team for this CSP year. These are **not** the objectives stated in Individual Service Plans, but the individual's desired long-term outcomes, which are to be accomplished through the completion of all ISP objectives.

3. Living Arrangements

Check what the individual's living situation will be while receiving Waiver services. Please be careful with the response. Critical pre-authorization decisions will be made based on this information.

4. ***ICF/MR Level of Functioning***

- Enter the most recent date of completion of the LOF. It must be completed no earlier than 6 months prior to the start of Waiver services and annually thereafter.

- Check the LOF categories met by the consumer. The consumer must meet at least 2 in order to qualify and remain eligible for Waiver services.

5. Functional Assessment

- If a DMHMRSAS-approved assessment was completed for the individual, include the date and title and note if it's been through the mandatory review by OMR.

- If the Supports Intensity Scale was completed, enter the Support Needs Index. If the ICAP was completed for the individual, enter the Service Score and the date it was completed.

6. Range of services/supports that this individual receives or will receive

- For each service requested by the individual and family for Waiver funding, as well as each regularly provided or other necessary non-Waiver service or support received by the individual through other funding mechanisms, enter the p***rovider name***, ***amount/frequency*** to be provided and requested ***start date*** on the appropriate line.

  NOTE: All Waiver services other than Therapeutic Consultation services, Environmental Modifications and Assistive Technology include an extra line in the event of two providers of the same service. In the unusual event of more than 2 providers (or two providers of TC, EM or AT) attach additional pages.

7. ***Case Manager Signature***

The case manager must sign and date the form.