

**Department of Medical Assistance Services
Individual and Family with Developmental Disabilities Support Waiver (IFDDS) Waiver
Plan of Care**

Initial/Wait list Enrollment Annual Revision Interruption Transfer Termination

POC Start Date:

Last Name First Name M. POC End Date:

Medicaid Number Social Security Number DOB (mm/dd/yyyy)

Provider Name

Provider NPI/API Number

Provider Phone Number

Provider Fax Number

Current Living Arrangement:

- Resident of State Training Center
- Applicant to state or community ICR/MR
- Resident of state MH hospital
- Resident of community ICF/MR
- Living in community at risk of ICF/MR placement
- Living in Sponsored or Congregate Home
- Currently lives with

Name

Relationship

Waiver Services Requested	Annual Hrs Requested (Enter total number of hours requested for plan of care year)	<u>DMAS Function Only:</u> Status of Requested Services
<input type="checkbox"/> Adult Companion Care		
<input type="checkbox"/> CD – Attendant Care		
<input type="checkbox"/> CD – Companion Care		
<input type="checkbox"/> CD - Respite		
Crisis Stabilization		
<input type="checkbox"/> Intervention		
<input type="checkbox"/> Supervision		
Day support		
<input type="checkbox"/> Regular Intensity, Center Based		
<input type="checkbox"/> Regular Intensity, Community Based		
<input type="checkbox"/> High Intensity, Center Based		
<input type="checkbox"/> High Intensity, Community Based		
Prevocational Services		
<input type="checkbox"/> Regular Intensity		
<input type="checkbox"/> High Intensity		
<input type="checkbox"/> Family Caregiver Training		
<input type="checkbox"/> Personal Care		

Individual's Name _____ Medicaid ID _____

Personal Emergency Response System		
<input type="checkbox"/> PERS Installation		
<input type="checkbox"/> PERS and Med Monitoring Installation		
<input type="checkbox"/> PERS Monitoring		
<input type="checkbox"/> PERS and Med Monitoring		
<input type="checkbox"/> PERS Nursing Service RN		
<input type="checkbox"/> PERS Nursing Service LPN		
<input type="checkbox"/> Respite Care		
<input type="checkbox"/> In-Home Residential Supports		
Skilled Nursing		
<input type="checkbox"/> RN		
<input type="checkbox"/> LPN		
Supported Employment		
<input type="checkbox"/> Enclave		
<input type="checkbox"/> Individual		
Therapeutic Consultation		
<input type="checkbox"/> Social Work		
<input type="checkbox"/> Psychological		
<input type="checkbox"/> Physical		
<input type="checkbox"/> Speech		
<input type="checkbox"/> Occupational		
<input type="checkbox"/> Therapeutic Recreation		
<input type="checkbox"/> Rehabilitation		
<input type="checkbox"/> Psychiatry		
<input type="checkbox"/> Psychiatry Clinical Nursing		
<input type="checkbox"/> Behavioral		
MFP		
<input type="checkbox"/> MFP Transition Service		
AT/EM	Enter items requested and total cost from quote	
<input type="checkbox"/> Assistive Technology		
<input type="checkbox"/> Environmental Modifications		

Individual's Name _____ Medicaid ID _____

The individual or parent/guardian has been given the choice between institutional care and DD Waiver services, has signed the "Documentation of Individual Choice" form, and has selected DD waiver. Signing this form, I certify that the above information is accurate, complete and maintained in the individual's record.

Individual/Guardian Signature

Case Manager Signature

Date

Date

FOR CASE MANAGEMENT TRANSFERS ONLY

Case Manager has reviewed current Plan of Care with individual/guardian and individual/guardian agrees that services and goals will continue as originally implemented.

Individual/Guardian Signature

Case Manager Signature

Date

Date

When a denial and/ or reduction of services is issued on the Plan of Care, the case manager must provide the waiver individual/ primary caregiver at the time of denial/reduction with written notification of 30 days of appeal rights.