AGENCY OR CONSUMER DIRECTION PROVIDER PLAN OF CARE

☐ Agency-Directed Services ☐ Consumer-Directed Services Current DMAS-99 Date: _____

Participant: _____ Medicaid ID#: _____

Provider: _____ Provider ID#: _____

Categories/Tasks	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1. ADL's							
Bathing							
Dressing							
Toileting							
Transfer							
Assist Eating							
Assist Ambulate							
Turn/Change Position							
Grooming							
Total ADL Time:							
2. Special Maintenance							
Vital Signs							
Supervise Meds							
*Range of Motion							
*Wound Care							
*Bowel/Bladder Program							
***MD order required**							
Total Maint. Time:							
3. Supervision Time							
4. IADLS							
Meal Preparation							
Clean Kitchen							
Make/Change Beds							
Clean Areas Used by Participant							
Shop/List Supplies							
Laundry							
(CD only) Money Management							
Medical Appointments							
Work/School/Social							
Total IADLS Time:							
TOTAL DAILY TIME:							

This Section Must Be Completed in its Entirety for Agency & Consumer-Directed Services

Composite ADL Score = (The sum of the ADL ratings that describe this participant)

BATHING SCORE		TRANSFERRING SCORE	
Bathes without help or with MH only	0	Transfers without help or with MH only	0
Bathes with HH or with HH & MH	1	Transfers w/ HH or w/HH & MH	1
Is bathed	2	Is transferred or does not transfer	2
DRESSING SCORE		**EATING SCORE**	
Dress without help or with MH only	0	Eats without help or with MH only	0
Dresses with HH or with HH & MH	1	Eats with HH or HH & MH	1
Is dressed or does not dress	2	Is fed: spoon/tube/etc.	2
AMBULATION SCORE		**CONTINENCY SCORE**	
Walks/Wheels without help w/MH only	0	Continent/incontinent < wkly self care of internal	
Walks/Wheels w/ HH or HH & MH	1	/external devices	0
Totally dependent for mobility	2	Incontinent weekly or > Not self care	2

LEVEL OF CARE (LOC)	☐ **A** (Score 0 - 6)	☐ **B** (Score 7 - 12)	☐ **C** (Score 9 + wounds, tube feedings, etc.)
	Maximum Hours of 25/Week	Maximum Hours 30/Week	Maximum Hours 35/Week

Participant _____ Medicaid ID#: _____

Provider: _____ Provider ID#: _____

Initial Plan of Care hours must be pre-authorized & should not exceed the maximum for the specified LOC category. Documentation must support the amount of hours provided to the participant.

Reason Plan of Care Submitted: ☐ New Admission ☐ ↑ In Hours ☐ ↓ In Hours ☐ Transfer

Reason for change/additional instructions for the aide: _____

_____

Required Backup Plan (Person's name, relation and phone #) for Services: _____

Plan of Care Effective Date: _____ Total Weekly Hours: _____

Participant / Primary Caregiver Signature: _____ Date: _____

RN, LPN or SF Signature _____ Date: _____

Instructions for the DMAS-97A/B

Provider Notification to Participant

This Plan of Care has been revised based on your current needs and available support. If you agree with the changes, no action is required on your part. If you do not agree with the changes, please contact the RN Supervisor who has signed the plan of care to discuss the reason that you disagree with the change.

If the provider agency is unwilling or unable to change the information, and you still disagree, you have the right to an appeal by notifying, in writing, The Client Appeals Division, The Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. The request for an appeal must be filed within thirty (30) days of the time you receive this notification. If you file a request for an appeal before the effective date of this action, _____ (enter effective date), services may continue unchanged during the appeal process.

Category/Tasks

Place a check mark for each task and put the total time for each category, for each day. Writing the amount of time for each task to the nearest 15 minutes is not necessary, but it greatly assists in the review of authorization requests.

Level of Care Determination for Maximum Weekly Hours

Enter a score for each activity of daily living (ADL) based on the participant's current functioning. Sum each ADL rating & enter the composite score under the appropriate category: A, B, or C. The amount of time allocated under **TOTAL DAILY TIME** to complete all tasks **MUST NOT EXCEED** the maximum weekly hours for the specified LOC of A, B, or C. Service Authorization (SA) must be obtained prior to initiating a change outside the authorized LOC category.

Provider Notification to Participant

Any time the RN Supervisor or Services Facilitator (SF) changes the plan of care that results in a change in the total number of weekly hours, the RN or SF must complete the entire front section of this form. If the change the agency is making does not require SA approval, the RN Supervisor or SF is required to enter the effective date on the Provider Agency Participant Notification Section which gives the participant their right to appeal. The participant should get a copy of both the front and back of the form.

SA Contractor Notification to Participant

If the changes to the Plan of Care require SA approval, the entire front portion of this form and the DMAS-98 must be completed and forwarded to the SA contractor for approval. If supervision is requested, attach the Request for Supervision form (DMAS-100). Once received by the SA contractor, the SA analyst will review the care plan and indicate whether the request is pended, approved, or denied. The participant will receive by mail the decision letter from the SA Contractor.

Participant / Caregiver Signature

The participant's signature is necessary on the original plan of care and decreases to the hours of care. It is not needed if the hours increase in a new plan of care. The provider may substitute the signature with documentation in the participant's record that shows acceptance of the plan of care.