

# DMAS 97 A/B 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 |
|---------------------------------------------|--------|---------|-----------|----------|--------|----------|--------|
| <b>1. ADL's</b>                             |        |         |           |          |        |          |        |
| Bathing                                     |        |         |           |          |        |          |        |
| Dressing                                    |        |         |           |          |        |          |        |
| Toileting                                   |        |         |           |          |        |          |        |
| Transfer                                    |        |         |           |          |        |          |        |
| Assist Eating                               |        |         |           |          |        |          |        |
| Assist Ambulate                             |        |         |           |          |        |          |        |
| Turn/Change Position                        |        |         |           |          |        |          |        |
| Grooming                                    |        |         |           |          |        |          |        |
| <b>Total ADL Time:</b>                      |        |         |           |          |        |          |        |
| <b>2. Special Maintenance</b>               |        |         |           |          |        |          |        |
| Vital Signs                                 |        |         |           |          |        |          |        |
| Supervise Meds                              |        |         |           |          |        |          |        |
| *Range of Motion                            |        |         |           |          |        |          |        |
| *Wound Care                                 |        |         |           |          |        |          |        |
| *Bowel/Bladder Program                      |        |         |           |          |        |          |        |
| <b>*MD order required</b>                   |        |         |           |          |        |          |        |
| <b>Total Maint. Time:</b>                   |        |         |           |          |        |          |        |
| <b>3. Supervision Time-LRI NOT ELIGIBLE</b> |        |         |           |          |        |          |        |
| <b>4. IADLS-LRI NOT ELIGIBLE</b>            |        |         |           |          |        |          |        |
| Meal Preparation                            |        |         |           |          |        |          |        |
| Clean Kitchen                               |        |         |           |          |        |          |        |
| Make/Change Beds                            |        |         |           |          |        |          |        |
| Clean Areas Used by Participant             |        |         |           |          |        |          |        |
| Shop/List Supplies                          |        |         |           |          |        |          |        |
| Laundry                                     |        |         |           |          |        |          |        |
| Money Management (CD only)                  |        |         |           |          |        |          |        |
| Medical Appointments                        |        |         |           |          |        |          |        |
| Work/School/Social                          |        |         |           |          |        |          |        |
| <b>Total IADLS Time:</b>                    |        |         |           |          |        |          |        |
| <b>TOTAL DAILY TIME:</b>                    |        |         |           |          |        |          |        |

## 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)

|                                     |                                                 |                                                  |                                                                           |
|-------------------------------------|-------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------|
| <u>BATHING SCORE</u>                |                                                 | <u>TRANSFERRING SCORE</u>                        |                                                                           |
| 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                                                                         |
| <u>DRESSING SCORE</u>               |                                                 | <u>EATING SCORE</u>                              |                                                                           |
| 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                                                                         |
| <u>AMBULATION SCORE</u>             |                                                 | <u>CONTINENCY SCORE</u>                          |                                                                           |
| Walks/Wheels without help w/MH only | 0                                               | Continent/incontinent < weekly self-care of      | 0                                                                         |
| Walks/Wheels w/ HH or HH & MH       | 1                                               | internal /external devices                       |                                                                           |
| Totally dependent for mobility      | 2                                               | Incontinent weekly or > Not self-care            | 2                                                                         |
| <b>LEVEL OF CARE (LOC)</b>          | <input type="checkbox"/> <b>A</b> (Score 0 - 6) | <input type="checkbox"/> <b>B</b> (Score 7 - 12) | <input type="checkbox"/> <b>C</b> (Score 9 + wounds, tube feedings, etc.) |
|                                     | ~25 Hours/Week                                  | ~30 Hours/Week                                   | ~35 Hours/Week                                                            |

Participant: \_\_\_\_\_ Medicaid ID#: \_\_\_\_\_  
Provider: \_\_\_\_\_ Provider ID#: \_\_\_\_\_

Service Plan of Care  
(Select only one per  
97A/B): ☐ Personal ☐ LRI Personal ☐ Respite  
Care/Assistance Care/Assistance  
Reason Plan of Care  
Submitted: ☐ New Admission ☐ ↑ In Hours ☐ ↓ In Hours ☐ Transfer

Reason for change and additional instructions for the aide/attendant:

Required Backup Plan (Describe the plan details and how it is carried out, person's name, and phone #) for Services:

Plan of Care Effective Date: \_\_\_\_\_ Total Weekly Hours: \_\_\_\_\_

For LRI Plans of Care: The State must assure the Centers for Medicare and Medicaid Services (CMS) that when a legally responsible individual has decision-making authority over the selection of waiver service providers that substituted judgment on behalf of the participant has been adequately applied. As the Nurse Supervisor/Services Facilitator, explain the process in which substituted judgment was used, the extent of the involvement of the participant, and how this arrangement was reached. Include if the individual indicated any preferences and how. Use additional sheets as necessary.

Participant / Primary  
Caregiver Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Participant/Primary  
Caregiver Printed Name: \_\_\_\_\_

RN, LPN or SF Signature: \_\_\_\_\_ Date: \_\_\_\_\_

RN, LPN, or SF Printed  
Name: \_\_\_\_\_

## **Instructions for the DMAS-97A/B**

### **Category/Tasks**

Personal Care: Place the total time for each task, for each day. Write the amount of time for each task to the nearest 15 minutes.  
Respite Care: Place a check mark for each task.

### **Level of Care Determination for 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. Service Authorization (SA) must be obtained prior to initiating a change outside the authorized LOC category. The LOC score is a framework for the number of hours and is not a hard cap or guarantee. All hours requested must be supported by the participant's person-centered needs and assessment. The LOC score is not required for respite plans of care. Please refer to Chapter IV of the CCC Plus Waiver Manual.

### **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 a new form. 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 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. Refer to Chapter IV of the CCC Plus Waiver Manual regarding plans of care.

### **Participant / Caregiver Signature**

The participant's signature is required on all plans of care.

### **Instructions Specific to LRI Plans of Care**

Legally responsible individuals (LRI) are defined as parents or legal guardians of minors (under the age of 18) or the participant's spouse.

The Centers for Medicare and Medicaid Services requires that any personal care/assistance provided by a LRI is extraordinary care. Extraordinary care is care that exceeds the ordinary care that would be provided to a person without a disability or chronic illness of the same age and is not a natural or normal responsibility of the LRI.

Only Activities of Daily Living are reimbursable to a LRI when extraordinary care is met. Instrumental Activities of Daily Living and general supervision are not considered extraordinary care. To assist in completing the Plan of Care when there is a LRI, use Chapter IV and the Extraordinary Care Guide (Appendix E) of the CCC Plus Waiver Manual. Tasks identified as "not extraordinary" on the guide may be approved if there is sufficient documentation that details how the task is extraordinary in care. Attach additional sheets as necessary for all tasks.

Reimbursement may be made to LRIs for up to 40 hours per week. When the LRI is reimbursed for providing assistance to multiple children, they may be reimbursed for up to 40 hours per week for each child.

If the participant is assessed to need, or has requested, more hours or additional tasks than a LRI is permitted to provide, a second DMAS-97A/B for the non-LRI aide/attendant is required to be completed documenting the separate tasks, assessed time, and expected shift start and end times along with the LRI-specific DMAS-97A/B. Both Plans of Care must be submitted to the service authorization entity as one request.

If the participant has an LRI providing personal care/assistance, respite is an incompatible service.

The participant's signature is required on all plans of care. The LRI aide/attendant may sign on behalf of the participant.