CHILDREN'S HOSPICE SERVICE PLAN

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 53 (6-2016)

Clear Fields

SERVICE PLAN

Hospice Agency	Provider Number
Quarter Period From: To:	☐ Quarterly Review ☐ Other

PERSONNEL

Name			
Address	City	State	ZIP Code
Date of Birth	Medicaid ID Number	Level of Care	
Mother's Name		Telephone Number	
Father's Name		Telephone Number	

Service(s) being authorized this quarter: (check services that are appropriate)

☐ Case Management (Hospice Case Manager) Code: G9012

☐ Expressive Therapy Counseling: Code: G0176 ☐ HSC ☐ Hospice Agency ☐ Independent - 39 per year

	Daily	Weekly	Monthly	Total	
☐ Grief Counseling					
☐ Pre-counseling: Code: S0255					Total hours for Pre-counseling and Post-counseling cannot exceed 96 hours per year
☐ Post-counseling: Code: S0257					
☐ Respite: Code: G0156					76 hours per year
☐ Skilled Nursing: Code: G0154					194.5 hours per year
☐ Hospice: Code Q5001					74 days per year
☐ Palliative Care: Code: G9054					54 hours per year

☐ Specialized Equipment/Supplies: Code: T2028 Cost: _____

GOALS - address Family/Falls/Health Care/Fire Safety/Nutrition/Financial/Legal/Community/Social/Mental Health/Education/Behaviors/Medication/Decision Making/Cognition/Employment

Goal 1
Responsible Person
Goal 2
Responsible Person

Initial the following if you are in agreement:

_____ I have received a copy of my rights and I/We understand them.

_____ I have been given the right to select institutional care verses waiver services.

_____ I am choosing waiver services.

_____ I have received information regarding my right to appeal.

_____ I am in agreement with the services listed on this Service Plan.

_____ I have been given information on Prevention of Child Abuse and Neglect.

CLIENT SIGNATURES (if age appropriate and able)

Legal Guardian Signature
Hospice Case Manager Signature
Program Manager Signature

EMERGENCY BACK-UP PLAN

Name of Contact Person (other than Legal Guardian)	Telephone Number
Primary Physician	Telephone Number
Hospice Back-Up Staff	Telephone Number
Name of Hospital	Telephone Number
Local Ambulance Telephone Number	

RESTRICTIONS - any restriction that is preventing the client from having the same access to home and community activity as other same-age members of the family

Identified Restrictions
Plan

Attach Hospice Agency Care Plan and send to department