PERSONAL CARE SERVICES PLAN

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 662 (9-2009)

Clear Fields

Entered
Reviewed
Follow-Up

Section I - Client Information

Name			Medicaid Number
Address			County of Residence
City	State	Zip Code	Date of Comprehensive Assessment

Section II - Personal Care Services Eligibility

ADL Scoring (An impairment is 2 or 3)
0 = Completely able
1 = Able with aids/difficulty
2 = Able with help
3 = Unable

☐ Bathing ☐ Eating ☐ Toileting
☐ Continence B/B ☐ Dressing ☐ Mobility Inside
☐ Transfers/Bed/Chair

IADL Scoring (An impairment is 1 or 2)
0 = Without help
1 = With help
2 = Can't do at all

☐ Meal Preparation ☐ Laundry
☐ Housework ☐ Taking Medication

Qualifies for: ☐ PCS - A ☐ PCS - B	LOC Determination Date	☐ Daily ☐ PCS - Basic Care ☐ None

Section III - Approved Services

PCS Provider	Provider Number	Authorized Units	Procedure Code	Billable Units/days
	Total Authorized Units		**Total Billable Units/Days**	

Targeted Case Management Services is Provided ☐ Yes ☐ No	Client and Provider reside in the same household ☐ Yes ☐ No

Section IV - Other Services

Section V - Signatures

Service Reduced ☐ Yes ☐ No	Services are reduced in accordance with 42 CFR 440.230 and N.D. Admin.Code 75-02-02-09.5 for the following reason(s).

☐ I am aware of the reduction in service, that the reduction will be effective on _____ and have been given a copy of my appeal rights (printed on the back of this form). The effective date of the reduction must be no less than 11 days after client signs the Personal Care Service Plan.

Reason for Completion of Plan or Change in Existing Care Plan:
☐ Initial Assessment
☐ Annual Assessment
☐ Six-Month Assessment
☐ Other Assessment (Describe)
☐ New Provider Added-Date: _____
☐ Care Plan Terminated-Date: _____
☐ Other Change (Describe)
Describe: _____

☐ I selected the service providers listed above.
☐ I am aware that I may have recipient liability.
☐ I am aware that if my Medical Eligibility terminates, I will no longer be eligible for the services listed above.
☐ I am not in agreement with this plan.

Effective Date of Plan From To	Client Signature	Date
	Case Manager Signature ☐ HCBS ☐ DDCM	Date

Section VI - Six-Month Review and Continuation of Plan with no Change

Effective Date of Plan Continuation From To	Client Signature	Date
	Case Manager Signature	Date

Distribution: **Original** - Client's case file **Copy** - Client or Legal Representative **Copy** - State Office

RIGHT TO HEARING

The North Dakota Department of Human Services (department) provides an opportunity for a fair hearing to any person whose claim for assistance is rejected or not acted upon promptly or if action is taken to suspend, terminate, or reduce services. You may request a hearing if you believe the department made an error in rejecting a request for services. The request for a hearing must be made within 30 days from the date of receipt of HCBS notice of Reduction notice on page one of this form (SFN662).

If the department's decision reduces, suspends, or terminates a service you were already receiving and you request a hearing within 10 days of the date of the notice of Reduction Denial or Termination form (SFN 1647), the action will not be taken until after the hearing decision unless:

1. A notice is not required;
2. You withdraw your request for a hearing;
3. You do not appear at a scheduled hearing, or
4. It is decided at the hearing that the only issue in the appeal is one of federal or sate law or department policy.

If you withdraw your request for a hearing or the hearing decision is not in your favor, the total additional cost of those services provided after the termination date will be considered an overpayment and you will be responsible to pay those costs.

The purpose of a hearing is to give you an opportunity to show that the action you dispute was due to an error on the part of the department. Established program limits are a matter of federal law or state law or department policy and are not errors.

You may have an attorney, relative, friend or other person assist you on your hearing. If you do not have money to pay for an attorney, you may contact a free legal service organization. The department has available a listing of legal aid organizations.

You may request a list of legal aid organizations or instructions on how to request a hearing by telephoning 1-800-755-2604, extension 2342 or Sending a letter to:

Appeals Supervisor
600 E Boulevard Ave.
Dept 325
Bismarck, ND 58505-0250