MEDICAID WAIVER PERSON CENTERED PLAN OF CARE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AGING SERVICES/HOME AND COMMUNITY BASED SERVICES (HCBS)
SFN 404 (8-2018)

Clear Fields

SECTION I. CLIENT INFORMATION

Name: Last	First	Middle	Client Identification Number (ND Number)
Physical Address		County of Residence	
City	State / ZIP Code	Level of Care (LOC) Screening Effective Date	

SECTION II. SERVICES (formal)

☐ HCBS Waiver ☐ RD 1 ☐ RD 2 ☐ RD 3 ☐ RD Removed

Does plan overlap dates of previous plan? ☐ Yes ☐ No

SERVICE	PROVIDER	PROVIDER NUMBER	UNIT RATE	UNITS PER MONTH	COST/MONTH
C.M. Annual/Initial Assessment			328.06	1	Costs when the service is provided
C.M. Reassessment			125.70	1	Costs when the service is provided
Contingency Plan			**Total Cost**		

SECTION III. ADLs AND IADLs SCORES (scores from functional assessment)

Bathing	Eating	Mobility Inside	Transfer/Bed Chair	Dressing
Toileting	Continence	Meal Prep	Communication	Laundry

Taking Medication	Shopping	Mobility Outside	Transportation	Housework	Management of Money

SECTION IV. SIGNATURES

☐ I am aware that I may have a recipient liability/ service fee.

☐ I am aware that the services and estimated cost is subject to change based on legislative action.

☐ I have been made aware of services, funding caps, and limits.

☐ I selected the services listed above.

☐ I selected the providers listed above.

☐ I am aware that if my Medicaid eligibility terminates, I will no longer be eligible for Waiver services listed above.

☐ I understand I can change this plan by contacting my case manager any time.

☐ I am aware of my right to appeal by writing to:
Appeals Supervisor
600 E. Boulevard Ave - Dept. 325
Bismarck, ND 58505-0250

Effective Date of Plan From: To:		Effective Date of Plan at Six Month Review. No change in plan, services will continue as agreed upon. From: To:	
Client/Legal Representative Signature	Date	Client/Legal Representative Signature	Date
Case Manager Signature	Date	Case Manager Signature	Date

Distribution: Original - Client's Case File **Copy** - Client or Legal Representative **Copy** - Aging Services/HCBS

Client Name	Client ID

SECTION V. RESTRICTIONS

Date	Reviewed - No restrictions required ☐
Behavior	
Identified Restriction	
Current Restrictive Plan	
Plans Tried in the Past	

Client/Legal Representative Signature	Date
Case Manager Signature	Date

☐ The team agrees this plan will not cause harm to the client.

Six Month Review of Restrictive Plan

Is the plan developed working? ☐ Yes ☐ No	
If not working, explain current reason plan not working	
New Restrictive Plan	
Date Plan Begins	

Client/Legal Representative Signature	Date
Case Manager Signature	Date

Client Name	Client ID

SECTION VI. WAIVER RISK ASSESSMENT

Date of Annual Assessment	Date of 6-Month Assessment	For the 3 month and 9 month assessments enter a note in SAMS

Every category under the risk assessment must include at least one strength. If no need, indicate n/a. If there is a need identified, must list a goal and tasks to meet the goal

WHAT IS IMPORTANT TO THE CLIENT (values, beliefs, how does the client want to live, activities, hobbies, routines, etc.)

Strength	Need

Goal (What/Why/How)

Task (how is goal going to be reached)

Six Month Review. Note changes/additions here. If no changes, note n/a.

COMMUNITY INTEGRATION AND SOCIAL SUPPORT (involved in activities, able to go out, volunteer, socializing outside of the home, friendships, informal supports, church)

Strength	Need

Goal (What/Why/How)

Task (how is goal going to be reached)

Six Month Review. Note changes/additions here. If no changes, note n/a.

Client Name	Client ID

FAMILY (level of family support, involvement)

Strength	Need
Goal (What/Why/How)	
Task (how is goal going to be reached)	
Six Month Review. Note changes/additions here. If no changes, note n/a.	

DECISION MAKING/LEGAL ISSUES (able to self-direct, pending legal issues, able to make decisions)

Power of attorney/guardianship copy on file? ☐ Yes ☐ No	
Strength	Need
Goal (What/Why/How)	
Task (how is goal going to be reached)	
Six Month Review. Note changes/additions here. If no changes, note n/a.	

Client Name	Client ID

FINANCIAL (able to meet financial needs, pay bills, rep payee, budgeting)

Strength	Need
Goal (What/Why/How)	
Task (how is goal going to be reached)	
Six Month Review. Note changes/additions here. If no changes, note n/a.	

EDUCATION/EMPLOYMENT/LIFE-LONG LEARNING (improve self, involved in, want to be involved in, do they want to work, retired, need help getting to work)

Strength	Need
Goal (What/Why/How)	
Task (how is goal going to be reached)	
Six Month Review. Note changes/additions here. If no changes, note n/a.	

Client Name	Client ID

HEALTH CARE (medical needs)

Strength	Need
Goal (What/Why/How)	
Task (how is goal going to be reached)	
Six Month Review. Note changes/additions here. If no changes, note n/a.	

MEDICATION (able to afford, understand schedule to take, need assistance with reminders equipment)

Strength	Need
Goal (What/Why/How)	
Task (how is goal going to be reached)	
Six Month Review. Note changes/additions here. If no changes, note n/a.	

Client Name	Client ID

NUTRITION (able to make simple meals, chew food, special diets, eating issues, weight issues)

Strength	Need
Goal (What/Why/How)	
Task (how is goal going to be reached)	
Six Month Review. Note changes/additions here. If no changes, note n/a.	

MENTAL HEALTH (Memory concerns, depressions, anxiety, addictions)

Strength	Need
Goal (What/Why/How)	
Task (how is goal going to be reached)	
Six Month Review. Note changes/additions here. If no changes, note n/a.	

Client Name	Client ID

COGNITIVE (memory issues (long/short) able to follow conversations, problem solving)

Strength	Need

Goal (What/Why/How)

Task (how is goal going to be reached)

Six Month Review. Note changes/additions here. If no changes, note n/a.

BEHAVIOR (aggressive, irritated, sleep patterns, wandering)

Strength	Need

Goal (What/Why/How)

Task (how is goal going to be reached)

Six Month Review. Note changes/additions here. If no changes, note n/a.

Client Name	Client ID

SAFETY (falls, how often has client fallen, history, fire safety, evacuation plan, detectors)

Strength	Need
Goal (What/Why/How)	
Task (how is goal going to be reached)	
Six Month Review. Note changes/additions here. If no changes, note n/a.	

OTHER (other services client is receiving, anything additional)

Strength	Need
Goal (What/Why/How)	
Task (how is goal going to be reached)	
Six Month Review. Note changes/additions here. If no changes, note n/a.	