MEDICAID WAIVER PERSON CENTERED PLAN OF CARE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AGING SERVICES/HOME AND COMMUNITY BASED SERVICES (HCBS)
SFN 404 (11-2021)

Clear Fields

SECTION I. INDIVIDUAL INFORMATION

Name: Last	First	Middle	Individual 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			349.85	1	Costs when the service is provided
C.M. Reassessment			134.05	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:	
Individual/Legal Representative Signature	Date	Individual/Legal Representative Signature	Date
Case Manager Signature	Date	Case Manager Signature	Date

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

Individual Name	ND Number

SECTION V. RESTRICTIONS

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

Individual/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	

Individual/Legal Representative Signature	Date
Case Manager Signature	Date