# PERSON CENTERED PLAN OF CARE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AGING SERVICES-HOME AND COMMUNITY BASED SERVICES
SFN 404 (10-2016)

Clear Fields

## SECTION I. CLIENT IDENTIFICATION

| Name: Last | First | Middle | ND Identification Number |
|---|---|---|---|
| Physical Address | | County of Residence | |
| City | State / ZIP Code | Effective Date of Screening | |

## SECTION II. SERVICES (formal):

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

| 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 |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Formal Supports: | | | | COST: M. W. | |
| Informal Supports: | | | | 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. CONTINGENCY PLAN (how will the member receive service if QSP cannot assist?)

List of Important People to Member to Complete Contingency Plan (list name and telephone number)

## SECTION V. 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 Dates
From: To:

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

| Member Signature | Date | Case Manager Signature | Date |
|---|---|---|---|
| Legal Rep Signature | Date | Other Signature | Date |

| Member Name | Member ID |
|---|---|
| | |

## SECTION VI. RESTRICTIONS

| Date |
|---|
| |

| Behavior |
|---|
| |

| Identified Restriction |
|---|
| |

| Current Restrictive Plan |
|---|
| |

| Plans Tried in the Past |
|---|
| |

| Member Signature | Date |
|---|---|
| | |
| Case Manager Signature | Date |
| | |

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

### 6 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 |
|---|
| |

| Member Signature | Date |
|---|---|
| | |
| Case Manager Signature | Date |
| | |

| Member Name | Member ID |
|---|---|
| | |

## SECTION VII. AUTHORIZATION OF WAIVER SERVICES

By accepting this Authorization to Provide Services the Provider agrees to provide the services in accordance with standards and conditions agreed to in signing the Medical Assistance Program Provider Agreement as a designated Qualified Service Provider. If an authorization is for multiple providers the monthly total authorized dollar(s)/units for a client may not be exceeded by the combined providers. **This authorization is not a guarantee of payment for service. Providers can verify client eligibility for Medicaid by contacting VERIFY at 1-800-428-4140 or 701-328-2891. Clients may be responsible for a recipient liability or service fee that is payable to the Qualified Service Provider.**

| Qualified Service Provider(s) Name (Last, First) | QSP Number | | Client Name (Last) | First Name | |
|---|---|---|---|---|---|
| Physical Address of QSP Providing Service | | | Recipient ID Number | | |
| City | State | ZIP Code | Address | Telephone Number | |
| Rural Differential Tier (choose one)<br>☐ 1 ☐ 2 ☐ 3 ☐ RD Removed Date: | | | City | State | ZIP Code |

| **Authorization Period**<br>**From:**<br>**To:** | Authorization Not to Exceed Intermittent Unit Rate<br>$ _____ Per/month | Authorization Not to Exceed Daily Rate of<br>$<br>For the Service of: |
|---|---|---|

## SECTION VIII.

Service(s) Authorized: Please [X] service, enter the procedure code, units authorized, and record dollar amount for the service.

| Service | Procedure Code | Units | Dollar Amount | Service | Procedure Code | Units | Dollar Amount |
|---|---|---|---|---|---|---|---|
| ☐ Adult Day Care | | | $ | ☐ Family Personal Care | | | $ |
| ☐ Adult Foster Care | | | $ | ☐ Homemaker | | | $ |
| ☐ Adult Residential Service | | | $ | ☐ Home Delivered Meals | | | $ |
| ☐ Attendant Care | | | $ | ☐ Supervision | | | $ |
| ☐ Chore Costs - Total | | | $ | ☐ Respite Care Service | | | $ |
| ERS | | | $ | ☐ Specialized Equipment | | | $ |
| Chore Task (Describe Below) | | | $ | ☐ Transitional | | | $ |
| | | | | ☐ Non-Medical Transportation | | | $ |
| ☐ Environmental Modification (Attach Approved Estimate) | | | $ | Driver/Vehicle | | | $ |
| | | | | Mileage | | | $ |
| ☐ Extended Personal Care | | | $ | Escort | | | $ |
| | | | | ☐ Other (Describe Below) | | | $ |

## SECTION IX.

Task(s) Authorized: Please [X] all authorized tasks. (An explanation of the tasks is printed on the back of this form.)

| | | | | |
|---|---|---|---|---|
| ☐ Bathing | ☐ Feeding | ☐ Meal Preparation | ☐ Nail (Finger) Care | ☐ Toileting |
| ☐ Communication | ☐ Hair Care/Shaving | ☐ Medication Assistance | ☐ Shopping | ☐ Transferring/Turning/Positioning |
| ☐ Community Integration | ☐ Housework | ☐ Mobility - Inside | ☐ Skin Care | ☐ Transportation |
| ☐ Dress/Undress | ☐ Incontinence | ☐ Mobility - Outside | ☐ Social Appropriateness | |
| ☐ Eye Care | ☐ Laundry | ☐ Money Management | ☐ Teeth, Mouth, Denture Care | |

GLOBAL ENDORSEMENTS: Only a provider who carries a global endorsement may provide these activities and tasks. Refer to the QSP list to determine which global endorsements the provider is approved to provide.

| | | | | |
|---|---|---|---|---|
| ☐ Cognitive/Supervision | ☐ Hoyer Lift | ☐ Medical Gases | ☐ Suppository | ☐ Temp/Pulse/Respiration/ Blood Pressure (Individual to be contacted for readings) _____ |
| ☐ Exercises | ☐ Indwelling Bladder Catheter | ☐ Prosthesis/Orthotics | ☐ Ted Socks | |

CLIENT SPECIFIC ENDORSEMENTS: Documentation by a health care provider required verifying client specific instructions.

| | | | | |
|---|---|---|---|---|
| ☐ Apnea Monitor | ☐ Jobst Stockings | ☐ Ostomy Care | ☐ Postural/Bronchial Drainage | ☐ Rik Bed Care |

| Annual/Initial Authorization (Case Manager's Signature/Date) | Provider Signature |
|---|---|
| Authorization Canceled (Case Manager's Signature/Date) | |

Send to Department

## AUTHORIZED SERVICE ACTIVITIES

**BATHING** assisting a client with tub/shower/bed bath, dressing after the bath, and bathroom cleanup.
**COMMUNICATION** limited to assisting the client in using the telephone, and client directed reading of mail and sending mail related to obtaining and managing essential services.
**COMMUNITY INTEGRATION** support and training provided to promote community involvement and access to services (limited to Adult Residential and Transitional Care Services.)
**DRESS/UNDRESS** assisting a client in getting dressed and undressed.
**EYE CARE** limited to routine regimen of eye drops, ointment, eye pad. **Does not include prescription eye drops or prescription ointment.**
**FEEDING** assisting a client to eat who is unable to eat without assistance. **Does not include tube feedings.**
**HAIR CARE** assisting a client with wash/comb hair and shaving.
**HOUSEWORK** routine light cleaning that includes dusting, vacuuming, floor care, garbage removal, changing linens, dishwashing, and other similar tasks in rooms occupied or used by the client. **Must be done when the client is at home**.
**INCONTINENCE** assisting the client with routine care associated with incontinence.
**LAUNDRY** includes washing, drying, folding, putting away, ironing, mending and other similar tasks. **Must be done in the client home or a laundromat. Client must be home when the service is provided.**
**MEAL PREPARATION** includes planning, preparing and serving the meal(s). **Does not include canning of produce or baking of such items as cookies, cakes, bread. Meals must be prepared in the client's home.**
**MEDICATION ASSISTANCE** limited to assisting with client self administration of routine oral medications by doing the following opening container, assisting the client with proper position for taking medication; assist with giving client drinking fluid to swallow medication; recap the container.
**MOBILITY** assisting the client to walk, use wheelchair, walker, crutches or cane for essential services, not walks or socialization.
**MONEY MANAGEMENT** limited to assistance with monthly budgeting or bill paying.
**NAIL CARE** limited to routine fingernail care to persons who do **NOT** have diabetes, heart disease, fungus, or circulatory disease problems. **Cutting of toenails is not allowed.**
**SHOPPING** limited to purchasing items for clients.
**SKIN CARE** limited to prophylactic (preventative) and palliative (relief or relieving) skin care, including application of creams or lotions for minor skin problems. **Does not include prescription ointment, prescription lotion or other prescription topicals, or wound care or care of skin lesions.**
**SOCIAL APPROPRIATENESS** support and training provided to promote and develop relationships, and participate in the social life of the community (Adult Residential and Transitional Care Service.)
**TEETH, MOUTH, DENTURE CARE** assisting a client with oral hygiene, brushing teeth, and cleaning dentures.
**TOILETING** assisting the client with all aspects of routine regime for toileting.
**TRANSFERRING/TURNING/POSITIONING** assisting the client with routine sitting up or positioning on back while in bed, transferring needs, using transfer belt, standard sit, bed to wheelchair, etc.
**TRANSPORTATION** limited to AFFC, Adult residential and clients receiving non-medical transportation service.

**GLOBAL ENDORSEMENTS (Only a provider who carries a global endorsement may provide these activities and tasks.)**
**COGNITIVE/SUPERVISION** assisting a client who needs supervision continuously, except for brief periods of time, for health/safety, cognitive and/or behavioral reasons. (Not applicable to Personal Care - Medicaid State Plan.)
**EXERCISES** limited to assisting with routine exercises, which have been recommended in writing by a therapist for a client, to maintain or improve physical functioning that was lost or decreased due to an injury or a chronic disabling condition (i.e., multiple sclerosis, Parkinson's, stroke, etc.). Exercise does not include physical activity that generally should be an aspect of a wellness program for any individual (i.e., walking for weight control, general wellness, etc.)
**HOYER LIFT/MECHANIZED BATH CHAIRS** assistance with routine use of mechanized bath chair or hoyer lift used by client.
**INDWELLING BLADDER CATHETER** limited to general maintenance care after a well-established routine of care has been established for the client. **No catheterization of client allowed.**
**MEDICAL GASES** limited to routine assistance with medical gases after a regimen of therapy has been established. Limited to oxygen use only.
**PROSTHESIS/ORTHOTICS/ADAPTIVE DEVICES** assist to apply and remove.
**SUPPOSITORY** limited to assisting with suppository only to maintain bowel program. **Does not include prescription suppositories.**
**TED SOCKS** apply ted socks according to manufacturer instructions. Limited to routine care for chronic conditions, ted socks only.
**TEMPERATURE/BLOOD PRESSURE/PULSE/RESPIRATION RATE** limited to taking the routine measurements. Vital signs, including temp/ pulse/respiration/blood pressure, can be authorized upon the written recommendation of a health care provider which outlines the requirements for monitoring, reason vital signs should be monitored, and the frequency. When the tasks of temp/pulse/ respiration/blood pressure are authorized, the individual to be contacted for readings must be listed on the SFN 1699.

**CLIENT SPECIFIC ENDORSEMENTS (These activities and tasks may be provided only by a personal, respite, AFFC, or transitional care service provider who has demonstrated competency.)**
**APNEA MONITOR** limited to routine assistance with apnea monitoring. Evidence of having training equivalent to what a primary caregiver has received for this specific client.
**JOBST STOCKINGS** routine care for chronic conditions. Evidence of having training equivalent to what a primary caregiver has received for this specific client.
**OSTOMY CARE** limited to general maintenance care after a well established routine of care has been set forth for the client. Evidence of having training equivalent to what a primary caregiver has received for this specific client.
**POSTURAL/BRONCHIAL DRAINAGE** limited to routine procedure established for client. Must have received specific training from a therapist who specializes in this procedure.
**RIK/SPECIALTY BED CARE** limited to client specific requirements. Evidence of having training equivalent to what a primary caregiver has received for this specific client.

| Member Name | Member ID |
|---|---|
| | |

## SECTION X. WAIVER RISK ASSESSMENT

| Date of Annual Assessment | Date of 6-Month Assessment |
|---|---|
| | |

For the 3 Month and 9 Month Assessments enter a note in Sam's

### FAMILY (Family Support, Involvement - Level of)

| Strength | Need |
|---|---|
| Strength | Need |
| Strength | Need |
| Goal (What/Why/How) | |
| Task (how is goal going to be reached) | |

### FALLS (how often has client fallen-history/frequency)

| Strength | Need |
|---|---|
| Strength | Need |
| Strength | Need |
| Goal (What/Why/How) | |
| Task (how is goal going to be reached) | |

### HEALTH CARE (medical needs)

| Strength | Need |
|---|---|
| Strength | Need |
| Strength | Need |
| Goal (What/Why/How) | |
| Task (how is goal going to be reached) | |

| Member Name | Member ID |
|---|---|
| | |

## FIRE SAFETY (evacuation plan, detectors)

| Strength | Need |
|---|---|
| Strength | Need |
| Strength | Need |
| Goal (What/Why/How) | |
| Task (how is goal going to be reached) | |

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

| Strength | Need |
|---|---|
| Strength | Need |
| Strength | Need |
| Goal (What/Why/How) | |
| Task (how is goal going to be reached) | |

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

| Strength | Need |
|---|---|
| Strength | Need |
| Strength | Need |
| Goal (What/Why/How) | |
| Task (how is goal going to be reached) | |

| Member Name | Member ID |
|---|---|
| | |

## LEGAL ISSUES (able to self-direct, pending legal issues)

| Strength | Need |
|---|---|
| Strength | Need |
| Strength | Need |
| Goal (What/Why/How) | |
| Task (how is goal going to be reached) | |

## COMMUNITY (are they involved in activities, able to go out, volunteer, socializing outside of the home)

| Strength | Need |
|---|---|
| Strength | Need |
| Strength | Need |
| Goal (What/Why/How) | |
| Task (how is goal going to be reached) | |

## SOCIAL SUPPORT (friendships, informal supports, church, someone checking in on them)

| Strength | Need |
|---|---|
| Strength | Need |
| Strength | Need |
| Goal (What/Why/How) | |
| Task (how is goal going to be reached) | |

| Member Name | Member ID |
|---|---|
| | |

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

| Strength | Need |
|---|---|
| Strength | Need |
| Strength | Need |
| Goal (What/Why/How) | |
| Task (how is goal going to be reached) | |

## EDUCATION (improve self, involved in, want to be involved in)

| Strength | Need |
|---|---|
| Strength | Need |
| Strength | Need |
| Goal (What/Why/How) | |
| Task (how is goal going to be reached) | |

## BEHAVIOR (aggressive, irritated, sleep patterns, wondering)

| Strength | Need |
|---|---|
| Strength | Need |
| Strength | Need |
| Goal (What/Why/How) | |
| Task (how is goal going to be reached) | |

| Member Name | Member ID |
|---|---|
| | |

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

| | |
|---|---|
| Strength | Need |
| Strength | Need |
| Strength | Need |
| Goal (What/Why/How) | |
| Task (how is goal going to be reached) | |

## DECISION MAKING (able to, need assistance  POA / Guardianship)

| | |
|---|---|
| Strength | Need |
| Strength | Need |
| Strength | Need |
| Goal (What/Why/How) | |
| Task (how is goal going to be reached) | |

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

| | |
|---|---|
| Strength | Need |
| Strength | Need |
| Strength | Need |
| Goal (What/Why/How) | |
| Task (how is goal going to be reached) | |

| Member Name | Member ID |
|---|---|
| | |

## EMPLOYMENT (do they want to work, retired, need help getting to work)

| Strength | Need |
|---|---|
| Strength | Need |
| Strength | Need |
| Goal (What/Why/How) | |
| Task (how is goal going to be reached) | |

## OTHER (addictions, anything they want to add)

| Strength | Need |
|---|---|
| Strength | Need |
| Strength | Need |
| Goal (What/Why/How) | |
| Task (how is goal going to be reached) | |