PARTICIPANT SERVICE PLAN - AUTISM SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 600 (2-2025)

Clear Fields

SECTION I. CLIENT IDENTIFICATION

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

SECTION II. SERVICES (formal)

SERVICE	PROVIDER	PROVIDER NUMBER	UNIT RATE	UNITS PER MONTH	COST/MONTH
Contingency Plan				**Total Cost**	

SECTION III. VINELAND SCORE

Communication	Daily Living	Socialization
Motor	V-scale Score	Total Score

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 by eligible for Waiver services listed above.
- ☐ I understand I can change this plan by contacting my service 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
Service Manager Signature	Date	Service Manager Signature	Date

Distribution: **Original** - Client's Case File **Copy** - Client or Legal Representative **Copy** - State Office (with 3 days of completion)

Client Name	Client ID

SECTION V. RESTRICTIONS

Date	Reviewed - No restrictions required ☐
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.

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)

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 (able to be left alone 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) - ABA Services

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.	