# PERSONAL CARE SERVICES PLAN OF CARE

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AGING SERVICES/HOME AND COMMUNITY BASED SERVICES (HCBS)
SFN 662 (8-2018)

Clear Fields

## SECTION I - CLIENT INFORMATION

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

## SECTION II - PERSONAL CARE SERVICES ELIGIBILITY

Qualifies for: ☐ PCS - A ☐ PCS - B ☐ PCS - C ☐ Daily ☐ Basic Care

Rural Differential: ☐ RD1 ☐ RD2 ☐ RD3

Date RD Removed

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

☐ Bathing ☐ Eating ☐ Mobility Inside ☐ Transfer ☐ Dressing ☐ Toileting ☐ Continence

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

☐ **Meal Preparation** ☐ Communication ☐ **Laundry** ☐ **Taking Medication** ☐ Shopping

☐ Mobility Outside ☐ Transportation ☐ **Housework** ☐ Management of Money

## 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

| Service | Provider | Service | Provider |
|---|---|---|---|
| | | | |

## 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 Notice will be effective on _____ and I 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 sooner than 11 days after client signs the Personal Care Services Plan.

Reason for Completion of Plan or Change in Existing Care Plan:

☐ Initial Assessment ☐ Provider ☐ Added ☐ Deleted-Date: _____

☐ Annual Assessment

☐ Six-Month Assessment ☐ Current Care Plan Terminated-Date: _____

☐ Other Assessment

☐ Other Change-Describe: ☐ Case Terminated-Date: _____

Reason Case Terminated

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

☐ I have been given a copy of my appeal rights (Right to Hearing).

☐ I am not in agreement with this plan.

| **Effective Date of Plan** From To | Client/Legal Representative 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/Legal Representative Signature | Date |
|---|---|---|
| | Case Manager Signature | Date |

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

# 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 on promptly or if action is taken to deny, suspend, terminate, or reduce services.

You may request a hearing if you believe the department made an error in the decision to reduce, deny, or terminate services.

The request for a hearing must be made within 30 days from the date of the receipt of the Reduction Notice on page one, Section V, of this form (SFN 662)
or from the date of the receipt of a completed Notice of Reduction, Denial, or Termination form (SFN 1647).

If the department's decision reduces or terminates a service you were already receiving, and you request a hearing before the effective date of the Reduction Notice in Section V of this form (SFN 662) or the effective date on the Notice of Reduction, Denial, or Termination Form (SFN 1647), services can continue until a hearing decision has been made.

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 with 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 service organizations.

To request a list of legal service organizations or instructions on how to request a hearing, call 701-328-2311 or send a letter to:

Appeals Supervisor
ND Department of Human Services
600 E Boulevard Ave.
Dept 325
Bismarck, ND 58505-0250