SPED/ExSPED INDIVIDUAL CARE PLAN

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AGING SERVICES/HOME AND COMMUNITY BASED SERVICES (HCBS)
SFN 1467 (1-2019)

Clear Fields

SECTION I. CLIENT IDENTIFICATION

Name (Last)	First	Middle	Client Identification Number (ND Number) ND
Physical Address		County of Residence	
City	State / ZIP Code	Does plan overlap previous plan? ☐ Yes ☐ No	

SECTION II. APPROVED SERVICES: ☐ SPED ☐ ExSPED ☐ RD1 ☐ RD2 ☐ RD3 ☐ RD Removed

Service	Service Provider	Provider Number	Unit Rate	Units Per Month	Cost/Month
1. C.M. Annual/Initial Assessment				1	Costs when the service is provided
C.M. Reassessment				1	Costs when the service is provided
2.					
3.					
4.					
5.					

Estimated Monthly Cost to Client for Services % $	Plus Amount for HCBS Case Management	Total Cost	
Contingency Plan		Reduction Citation Provided to Client ☐ Yes ☐ No	

SECTION III. OTHER AGENCIES/INDIVIDUALS PROVIDING SERVICES

1. Service	Provider	2. Service	Provider

SECTION IV. GOALS

Goal	Start Date	End Date

SECTION V. 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 VI. 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 ExSPED services listed above

☐ 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