INDIVIDUAL CARE PLAN - DEVELOPMENTAL DISABILITIES

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
DEVELOPMENTAL DISABILITIES/HOME AND COMMUNITY BASED SERVICES
SFN 1811 (2-2015)

Clear Fields

SECTION I. CLIENT IDENTIFICATION

Name (Last, First)	Medicaid ID Number		
Physical Address	City	State	ZIP Code
County of Residence	Regional Developmental Disabilities Office		

SECTION II. DD HCBS WAIVER SERVICES

Approved DD HCBS Waiver Services: ☐ RD1 ☐ RD2 ☐ RD3	RD Removed Date

SERVICE	SERVICE PROVIDER	PROVIDER NUMBER	UNIT RATE	UNITS PER MONTH	COST/MONTH
1.					
2.					
3.					
				Total Cost	

QSP Contingency Plan

SECTION III. OTHER AGENCIES/INDIVIDUALS PROVIDING SERVICES

SERVICE	PROVIDER	SERVICE	PROVIDER
1.		3.	
2.		4.	

SECTION IV. GOALS

CLIENT STATED GOAL	DATE GOAL ESTABLISHED	DATE GOAL COMPLETED	CONTINUED	COMPLETED	NO LONGER APPLICABLE
1.			☐	☐	☐
2.			☐	☐	☐

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 the plan by contacting my program manager.

☐ 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 Signature	Date	Client Signature	Date
DDPM Signature	Date	DDPM Signature	Date

DISTRIBUTION: **Original** - Client's Case File **Copy** - Client or Legal Representative **Copy** - Within 3 days of completion forward to Developmental Disabilities/HCBS