# HCBS SERVICE PLAN

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|---|---|---|---|---|
| Member Name: | | Enrollment Date:<br>Update: | Discharge | Readmits |
| Level of Care Evaluation Date: | | Met LOC: YES☐ NO☐ | Screened by: MPQH ☐<br>CMT ☐ | |
| Social Security Number: | Medicaid ID#: | Phone Number: | | |
| Physical Address: | | Mailing address: | | |
| Care Category ☐ Basic ☐ AR ☐ CC3 | | Email Address: | | |
| Date of Birth: | Height: | Weight: | Sex: | Marital Status: |
| ☐ _____ ☐ ☐ ☐ _____ __ | | | | |
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| OPA: | | | | |
| Pharmacy: | | | Phone: | |
| Residential Status:<br>☐ Lives Alone<br>☐ Lives with family/significant other<br>☐ Live in attendant | ☐ Residential Habilitation; Type:_____<br>☐ Other: | | | |
| Medicare ☐ Yes ☐ No | Medicare # | Effective Date (if Known): | | |
| Medicare D: | Other Insurance: | Veteran or spouse of Veteran<br>☐ Yes ☐ No | | |
| Primary Diagnosis: | | ICD 10: | | |

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# MEDICAL INFORMATION

## NUTRITIONAL STATUS

| | |
|---|---|
| Diet: | ☐ General ☐ Diabetic ☐ Low salt ☐ Other (Specify): |
| Supplements | |

## MEDICAL DIAGNOSIS

| Date | Medical Diagnoses | ICD-9/10 Code | Date | Medical Diagnoses | ICD-10 Code |
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## MEDICATION LIST

| Date | Medications | Dosage | Frequency | Date | Medications | Dosage | Frequency |
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Medication Allergies: Other Allergies:

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| Medication Dispensing System: | Pharmacy: |

Comments:

# PSYCHOSOCIAL INDICATORS

List indicators that currently affect member and/or service delivery:

Mental status/orientation :

## FUNCTIONAL OVERVIEW

| Task | Independent | Needs Assistance | Dependent | Task | Independent | Needs Assistance | Dependent |
|---|---|---|---|---|---|---|---|
| Bathing | | | | Laundry | | | |
| Dressing | | | | Shopping | | | |
| Exercise | | | | Socialization | | | |
| Grooming | | | | Telephone | | | |
| Toileting | | | | Vision | | | |
| Continence | | | | Hearing | | | |
| Transfer | | | | Speech | | | |
| Mobility | | | | Banking | | | |
| Assistive Devices | | | | Money Mgmt | | | |
| Meal Preparation | | | | Orientation | | | |
| Eating | | | | Transportation | | | |
| Medications | | | | Time Mgmt | | | |
| Escort | | | | Other | | | |
| Household | | | | Other | | | |

## ASSISTIVE DEVICE INFORMATION

| Needs | Has | Device | Needs | Has | Device |
|---|---|---|---|---|---|
| | | Bath Chair/Bench | | | Environmental Control Unit |
| | | Cane | | | Non-Skid tub mat |
| | | Commode Chair | | | Communication Device |
| | | Commode seat, raised rails | | | Scooter |
| | | Grab Bars | | | Personal Alert/Safety/Response System |
| | | Handheld shower | | | Trapeze Bar |
| | | Specialized Bed | | | Walker |
| | | Positioning Bar | | | Wheelchair |
| | | Lift System/Lift Chair | | | Wheelchair Ramp |
| | | Service Animals | | | Other: |

DME Provider(s):

## SERVICE OPTIONS

| SERVICE | SUPPORT REQUIRED | PROVIDER | FREQUENCY |
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## OTHER SERVICES AND INFORMAL SUPPORT SYSTEMS

| Service | Need | Provider | Frequency |
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# PLAN ASSESSMENT SUMMARY

Physical Summary:

Long-Term Goals:

Short-Term Objectives:

Psychosocial Summary**:**

Long-Term Goals:

Short-Term Objectives:

Discharge Plan:

Emergency Backup Plan:

Emergency Evacuation Plan:

Emergency Contact: Phone:

Location of Medications & Important Documents:

## SAFETY INFORMATION

Please check the following safety concerns as they apply:

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|---|---|---|---|---|---|
| ☐ | Access to phone in emergency is limited | ☐ | Entrance/exit to home not accessible | ☐ | Concern for safety in community |

Comments/Issues:

Need for formal risk assessment Yes ☐ No ☐ Date assessment will be completed:

## SIGNATURE SECTION

| | |
|---|---|
| My plan addresses my needs and personal goals, including health and safety. | ☐ |
| I have made a free choice of services and qualified providers for each service included in my Service Plan. | ☐ |
| I have received a choice between institutional care or HCBS. | ☐ |
| I have received information on Abuse/Neglect and Exploitation and know how to report. | ☐ |
| I understand there is a service plan cost limit and a limit on the type of services available through the HCBS Program. | ☐ |
| I have participated in the development of this service plan and agree with it. | ☐ |
| The case management team has verified that HCBS services in this plan cannot be reimbursed by state plan Medicaid, Medicare or private insurance. | ☐ |

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|---|---|
| Member Signature: | Date: |
| Legal Representative: | Date: |
| Primary Care Provider Signature: | Date: |
| CMT Nurse: | Date: |
| CMT: Social Worker: | Date: |
| Other: | Date: |

## ANY OTHER COMMENTS / NOTES