SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

HOME AND COMMUNITY BASED WAIVER Policy Manual	Section: APPENDIX
	Subject: Service Plan Short Form (135B) Instructions SLTC

References: ARM: 37.40.1420

PURPOSE:

To provide a brief assessment of a member's need for Home and Community Based Services (HCBS) and to develop a service plan, with the member, to meet the member's short-term and/or one time only needs, Hospice or residential Hospice. The Case Management Team (CMT) completes form SLTC 135B upon initial assessment for members enrolled for short-term temporary placement.

This service plan is an agreement between the member and the CMT for the provision of short term and/or one time only HCBS services. A discharge plan must be discussed with the member and documented on this form.

DISTRIBUTION

Once all signatures are obtained, the CMT retains a copy in their file and sends a copy to the member. A copy of the completed service plan will also be sent to the member's health care professional.

INSTRUCTIONS

Member name: Enter name of member

Enrollment date: Enter the date of initial admit

Level of Care Evaluation Date: Enter the date the Level I was approved by Mountain Pacific Quality Health (MPQH). (Reminder: This date must be the same as or before the admission date)

Met LOC: Mark checkbox - Yes or No

Screened by: Mark entity that completed the screen

SSN:	Enter member social security number
Medicaid ID:	Enter member Medicaid ID number
Address/Phone:	Enter member physical and mailing address, phone number and email address
Care Category:	Enter appropriate level of care. Care Category 3 (CC3) plans require prior authorization
Demographics:	Enter member date of birth, height, weight, sex and marital status
Legal Rep:	Check box POA type and enter type. Enter Legal Representatives name, address and phone number
Significant Other:	Enter member significant other name, address and phone number
Primary Health Care Provider:	Enter provider name, address and phone number
Additional Health Care Providers:	Enter member's other health care providers name, address and phone number
Pharmacy:	Enter member pharmacy name and phone number
Residential Status:	Enter member residential status (private residence, with a spouse or relative, nursing facility, hospital, group residence, licensed personal care facility, adult foster home or other – please specify
Medicare/Other/Ins Veteran status:	Check box – Yes or No. Enter Medicare number and effective date if known. Enter other insurance information and check mark veteran status box

Primary Diagnosis ICD 10: Enter member primary diagnosis and ICD 10 code

Brief Description of Need for services: Summary statement describing primary reasons the member needs waiver services

Medical and Psychosocial Summary: Summary statement of medical diagnoses. If member has diagnoses in addition to the primary diagnosis, enter name and ICD10 code. Include any allergies and other pertinent medical information. Enter any psychosocial issues that could affect and/or influence the effectiveness of the service plan

Service Plan: Enter the home and community based services (HCBS) to be provided, the type of service, provider and frequency. Include at least one goal/objective in the service plan section

Discharge Plan: Enter member discharge plan from HCBS

Discharge Date: Enter date of discharge

Signature Section: The member/legal representative and the CMT **must** sign the service plan **before** any services can be provided and paid for. The Department recognizes and accepts electronic signatures, provided the signature mechanism and protocol meet generally accepted industry standards.

This includes dates signatures for the following:

1. Member – The member must sign the plan unless able to do so. An "X" is acceptable but must be co-signed by another person. The signature page of the service plan should contain a note explaining that the

member was unable to sign. No one should sign the member's name on his/her behalf. If the member has a legal representative, the representative must sign;

2. Health Care Professional: A health care professional (HCP) may be a physician, certified physician assistant or a nurse practitioner. The signature of the health care professional is not mandatory, but can be requested at the team's discretion. In all instances, a copy of the completed service plan will be sent to the health care professional; and

3. Case Management Staff: Only one member of the CMT is required to develop the SLTC-135B. This staff member must sign and date the service plan.