(Rev. 02/2015)

Self-Directed CFC/PAS Service Plan

☐ Intake ☐Annual ☐ Amendment ☐Temporary Authorization ☐ High Risk ☐Other				
MPQH Profile Date Span:			MPQH Total Profile Bi-Weekly Units (15 Minutes = 1 Unit):	
SERVICE PLAN SCHEDULE Member Name:			Medicaid ID Number:	
AM/PM	ADL Tasks	Frequency Week One	Frequency Week Two	Comments
AM/PM	HMA Tasks	Frequency Week One	Frequency Week Two	Comments
AM/PM	IADL Tasks	Frequency Week One	Frequency Week Two	Comments
AM/PM	Skill Acquisition	Frequency Week One	Frequency Week Two	Comments
Total ADLHMA/ Units:		Total IADL Units:	Total Skill Acquisition Units:	Total Bi-Weekly Units:

COMMENTS AND SPECIAL INSTRUCTIONS FOR SERVICE PLAN IMPLEMENTATION:

ACTION PLAN *(Utilized when member preferences cannot be met. Indicate agency plan and associated time line to address the situation)*

TEMPORARY AUTHORIZATION/AMENDMENT ☐ Change In Condition ☐ Change In Task ☐ Change In Task Frequency
☐ High Risk ☐ Addition Of Skills Acquisition

DESCRIBE ADL/HMA/IADL CHANGE: ☐ Short Term ☐ Permanent

TEMPORARY AUTHORIZATION: Start Date: End Date: Total Time: Date Faxed to MPQH:

MEMBER: My Plan Addresses My Personal Assistance Needs, Including Health And Welfare.

MEMBER/PERSONAL REPRESENTATIVE SIGNATURE **DATE**	☐ Concur ☐ Do Not Concur

PROVIDERS
☐ This Service Plan Does Not Require Completion Of A Risk Negotiation Form ☐ I Agree with the Amendment Request

SD CFC/PAS PROVIDER SIGNATURE **AGENCY** **DATE**	☐ Concur ☐ Do Not Concur
PLAN FACILITATOR SIGNATURE **AGENCY** **DATE**	☐ Concur ☐ Do Not Concur