LONG TERM CARE SERVICE PLAN – Persons Living With Aids Waiver

IDENTIFYING INFORMATION

Client Name (Last, First, MI)

Staffing Date _____/____/_____

Dates Covered / / THRU / /

Program(s)

☐ BI ☐ CES ☐ CDAS ☐ CDCE ☐ CWA ☐ CHCBS
☐ CHRP ☐ DD ☐ EBD ☐ MI ☐ PLWA ☐ SLS

Legal Guardian(s) Name

Additional Health Insurance

	NAME
☐ Private Insurance	_____
☐ HMO	_____
☐ Medicare	_____
☐ Veterans	_____
☐ Other	_____

AREAS OF CONCERN IDENTIFIED BY THE ASSESSMENT (check all that apply)

☐ Abuse/Neglect/ Mistreatment/Exploitation	☐ Dressing	☐ Hygiene	☐ Mobility	☐ Supervision/Behav.
☐ Accessing Resources	☐ Eating	☐ Laundry	☐ Money Management	☐ Toileting
☐ Advocacy Activities	☐ Employment Activities	☐ Lifelong Learning Activities	☐ Physical Environment	☐ Transferring
☐ Bathing	☐ Health & Safety Activities	☐ Meal Preparation	☐ Shopping	☐ Transportation
☐ Behav. Supports Needed	☐ Hearing	☐ Medical Supports Needed	☐ Skilled Healthcare	☐ Other _____
☐ Communication	☐ Home Living Activities	☐ Medication Management	☐ Skin Care	☐ Other _____
☐ Community Living Activities	☐ Housework	☐ Memory/Cognition	☐ Social Activities	
	☐ Housing	☐ Mental Health	☐ Substance Abuse	

STATE PLAN BENEFITS

Program/Services	Provider/Frequency, if applicable	Program/Services	Provider/Frequency, if applicable
☐ **Acute Medical**		☐ **Medical Transportation**	
☐ **Early & Periodic Screening Diagnosis &Treatment** (EPSDT ages 0-20)		☐ **Mental Health**	
☐ **Hospice**		☐ **Private Duty Nursing** (PDN)	
☐ **Medical Equipment**		☐ **Professional Therapies** (Physical, Occupational, Speech)	
☐ **Medical Supplies**		☐ **Targeted Case Management**	

**** State Plan Benefits May Require Prior Authorization***

NON-MEDICAID SUPPORTIVE SERVICES			
Program/Services	**Provider/Frequency, if applicable**	**Program/Services**	**Provider/Frequency, if applicable**
☐ **Child / Adult Prot. Services**		☐ **Money Management** (outside of waiver services)	
☐ **Dental Care** (outside of waiver services)		☐ **Optical Services** (outside of waiver services)	
☐ **Benefits Programs**		☐ **Rehabilitation Services**	
☐ **Food Stamps**		☐ **Senior Companion**	
☐ **LEAP**		☐ **Subsidized Housing**	
☐ **Legal Services**		☐ **Other** _____	
☐ **Meals**		☐ **Other** _____	

HOME HEALTH					
MEDICAID				MEDICARE	
Provider	Frequency	Revisions	Frequency	Provider	Frequency
☐ **Certified Nurses Aide** (CNA)		Reason Date ___/___/____		☐ **Certified Nurses Aide** (CNA)	
☐ **Skilled Nursing** *Specify Tasks*		Reason Date ___/___/____		☐ **Skilled Nursing** *Specify Tasks*	
☐ **Occupational Therapy** *(ages 0-17)*		Reason Date ___/___/____		☐ **Occupational Therapy**	
☐ **Physical Therapy** (ages 0-17)		Reason Date ___/___/____		☐ **Physical Therapy**	
☐ **Speech Therapy** *(ages 0-17)*		Reason Date ___/___/____		☐ **Social Worker**	
				☐ **Speech Therapy**	

OTHER STATE PROGRAMS			
ADULT FOSTER CARE (AFC)		HOME CARE ALLOWANCE (HCA)	
Provider:	_____Days __/__/__ Thru __/__/__	**Provider(s):** ☐ Relative ☐ Non-relative ☐ Same Household	_____Visits/week _____Hours/visit

LONG TERM CARE SERVICES HOME AND COMMUNITY BASED SERVICES (HCBS-PLWA)				
Services	**Frequency**	**Revisions**	**Frequency**	**Service Goals**
☐ **Adult Day Services** **Provider:**	_____Days/week _____Half-days/week _____Total Units	**Reason** **Provider:** **Date** ___/___/____	_____Days/week _____Half-days/ Week _____Total Units	
☐ **Home Maker** **Provider:**	_____Visits/week _____Hours/visit _____Travel/visit (TRAVEL TIME) _____Total Units	**Reason** **Provider:** **Date** ___/___/____	_____Visits/week _____Hours/visit _____Hours/visit (TRAVEL TIME) _____Total Units	
☐ **Non-Medical Transportation** **Provider:**	_____1-way trip/week OR _____Miles/1-way trip _____Total Units	**Reason** **Provider:** **Date** __/___/____	_____1-way trip/wk OR _____Miles/1-way _____Total Units	

LONG TERM CARE SERVICES
HOME AND COMMUNITY BASED SERVICES (HCBS-PLWA)

Services	Frequency	Revisions	Frequency	Service Goals
☐ **Personal Care** **Provider:** - - - - - - - - - - - - - - **Specify Type** ☐ **Agency** ☐ **Relative**	_____Visits/week AGENCY _____Hours/visit _____Hours/visit (TRAVEL TIME) _____Total Units - - - - - - - - - - - - - - _____Visits/week RELATIVE _____Hours/visit _____Hours/visit (TRAVEL TIME) _____Total Units	**Reason** **Provider:** **Date** ___/___/____ - - - - - - - - - - - - - -	_____Visits/week AGENCY _____Hours/visit _____Hours/visit (TRAVEL TIME) _____Total Units - - - - - - - - - - - - - - _____Visits/week RELATIVE _____Hours/visit _____Hours/visit (TRAVEL TIME) _____Total Units	
☐ **Personal Emergency Response System** ***(Electronic Monitoring)*** **Provider:**	_____ Monthly _____ Specify Item _____Total Units	**Reason** **Provider:** **Date** ___/___/____	_____ Monthly _____ Specify Item _____Total Units	

CONTINGENCY PLAN

Identify a back-up plan to address contingencies such as "emergencies" that put a participant's heath and welfare at risk.
Emergencies include the failure of a family member, support worker, or caregiver to appear when scheduled to provide necessary services when the absence of the services presents a risk to the participant.

CLIENT GOAL

My goal for this Service Plan year is:

CLIENT ROLES and RESPONSIBILITIES

I agree to participate in the coordination of my services and will be responsible to:

- **Give accurate information to my case manager regarding my ability to complete activities of daily living.**
- **Assist in promoting my own independence.**
- **Cooperate with my providers and case management agency.**
- **Notify my case manager of changes in my support system, medical condition and living situation including any hospitalizations, emergency room admissions, nursing home placements or Intermediate Care Facility for the Mentally Retarded (ICF/MR) placements.**
- **Notify my case manager if I have not received Home and Community Based Services for 30 calendar days.**
- **Notify my case manager of any changes in my care needs and/or problems with services.**
- **Notify my case manager of any changes that may affect Medicaid eligibility.**

CASE MANAGER ROLES and RESPONSIBILITIES

The Case Manager agrees to:

- **Coordinate needed services.**
- **Communicate with service providers regarding service delivery, and concerns.**
- **Review and revise services, as necessary.**
- **Notify clients regarding any change in services.**
- **Notify clients when services are denied, suspended, terminated, or reduced.**
- **Document, report, and resolve client complaints and concerns.**
- **Report abuse, neglect, mistreatment, and exploitation to the appropriate authority.**

CONTACT INFORMATION

If you are having problems with services or need to make changes in your care needs contact

_____ at _____.
Case Manager **Phone**

If you are having problems with a case manager you may contact his/her supervisor

_____ at _____ or the _____ at _____.
Supervisor Name **Phone** **Administrator** **Phone**

If the problem is still not resolved you may call the Colorado Department of Health Care Policy and Financing at 1-800-221-3943.

APPEAL RIGHTS

If you did not receive a notice of decrease or change in services from the case management agency, you may ask for the notice with your appeal rights. If you received a decrease or change in services you may appeal in writing to the State for a hearing at the:

Office of Administrative Courts, 633 Seventeenth Street, Suite 1300, Denver, CO 80202. Phone Number (303) 866-2000.

STATEMENT OF AGREEMENT

Client Name (Last, First, MI) | **Client State Medicaid Identification #** or **Date of Birth**

Program(s) | **Agency**

I understand that my eligibility to receive long term care benefits is contingent upon my being eligible for Medicaid. I have been informed of the choice of available long term care programs, services, and providers. I understand I may change providers at anytime and that a provider has the right to accept or deny my request for services. I will notify my case manager when I want to change providers. I have reviewed the services contained in this Service Plan and choose to accept these services. I choose to accept these services in the following setting:

☐ COMMUNITY ☐ NURSING FACILITY ☐ ICF/MR ☐ HOSPITAL

SIGNATURE OF CLIENT _____ Date _____

SIGNATURE OF LEGAL GUARDIAN _____ Date _____
☐ Court Appointed Guardian

SIGNATURE OF CASE MANAGER _____ Date _____

SIGNATURE OF LEGAL GUARDIAN _____ Date _____
☐ Court Appointed Guardian

☐ **6 MONTH REVIEW-** *I attest that I have reviewed this Service Plan with the client and/or authorized representative and have made all necessary revisions.*

SIGNATURE OF CASE MANAGER _____ Date _____

☐ **SERVICE PLAN REVISIONS -** *I attest that I have reviewed the revisions made to this Service Plan.*

SIGNATURE OF CLIENT _____ Date _____

SIGNATURE OF CASE MANAGER _____ Date _____

SIGNATURE OF LEGAL GUARDIAN _____ Date _____

SIGNATURE OF LEGAL GUARDIAN _____ Date _____