“Service Care Plan” for Long Term Care HCBS Waiver

HEALTH CARE FINANCING
SERVICE CARE PLAN

Client Name

Facility/Home Address

Telephone #

Agency **County**

Public Health Nurse

Address **Telephone #**

DATE	NEEDS STATEMENT	DESIRED OUTCOME	DATE	TYPE OF HELP NEEDED	PAY CODE	SERVICE PROVIDER	SERVICE DELIVERY PATTERN (UNIT FREQUENCY)	OUTC. CODE	DATE

SIGNATURE OF CLIENT (OR CLIENT DESIGNEE):

_____ DATE: _____

PLAN PARTICIPANTS (PLEASE LIST):

_____ _____

_____ _____

_____ _____

_____ _____

PAYMENT SOURCE CODES

Medicaid …….	**A**
Medicare ……..	**B**
Informal Support ……	**C**
Formal Support - Fee ……..	**D**
Formal Support - No Fee ……...	**E**
Other Public Funding ……..….	**F**

OUTCOME CODES

Delivered as planned ……	**Q**
Delivered with Changes ……	**R**
Not Delivered ……..	**S**
Discontinued ……..	**T**
Resolved ……..	**U**
Refused ……...	**V**