

GUIDELINES FOR COMPLETING THE LTC/HCBS C 501-B

This assessment must be performed prior to admission into the Consumer-Directed Care option of the LTC/HCBS Waiver and for the six-month renewal. This Plan of Care will be submitted to the waiver Program Manager at the Aging Division for evaluation. The Plan of Care must be done, and approved before the waiver is finalized.

Individualized Plan of Care

Client Long Term Goals. This would include the client's goals concerning his/her status that are 3-5 years in the future.

Client Short Term Goals. This would include the client's goals for the period of this Plan of Care.

Objectives. The objectives should address the client's needs and be reflected in planned services. They may be met with both informal and formal services.

Outcomes. The outcomes should reflect the desired result of the planned services and be related to the objectives.

Goals Met/Not Met. This area is only used on renewal Plans of Care. If the goals are not met they may need to be changed. When goals are met, new goals need to be established.

Resources. Any other services used, both formal and informal, that are in addition to the services on the Plan of Care should be listed here.

Care Conference Attendees and Discipline. All those who will attend the care conference for this client should be listed along with their role. This may also include participants from other agencies used on the Plan of Care.

Agency Name & Provider Number: Your agency's name and the provider number under which you are enrolled as a waiver provider.

Fax No: The number of the fax machine that you want your Plan of Care returned to.

Case Manager Name, Phone No: Please include the phone number where you can be reached.

Date of LT101: Enter the date of the LT101 used for this Plan of Care.

LT101 Points: Enter the actual number of points the individual earned.

Six-Month Period, From-To: The beginning and end dates that the Waiver Plan of Care is in effect.

Recipient Medicaid ID#: The individual's Medicaid ID# assigned by the Department of Family Services. (It is always 10 digits and begins with 0600.)

Recipient SSN: The individual's Social Security number. Please do not use their Medicare number.

Recipient Last Name, First and County: The complete name of the individual evaluated and the county of their residence.

Service Start Date: Date each service begins.

Medicaid Provider #: Enter the Medicaid provider number for each of the waiver services.

Units Month 1-6: Enter the number of units for each waiver service.

Diagnosis Code: Enter the appropriate code from the *Diagnosis Code List*.

The form must be signed and dated by the Case Manager and the waiver client.