

Assisted Living Waiver Plan of Care

Aging Division
6101 Yellowstone Road, Suite 259B
Cheyenne, WY 82002

Aging Division
Fax #: (307)777-5340

Client Long Term Goals:	Client Short Term Goals:
Objective(s)	Outcomes
Goals Met:	
Goals Not Met:	
Resources (other services):	

Case Conference Attendees and Discipline:

Agency Name & Provider Number	Fax No.	Twelve-Month Period From:	To:
Case Manager Name	Phone No.	Recipient Medicaid ID#:	Recipient SSN:
Date of LT101	LT101 points	Recipient Last Name County	First

Service Start Date	Procedure Code	Procedure Description	Medicaid Provider #	Unit Charge	Units Month 1	Units Month 2	Units Month 3	Units Month 4	Units Month 5	Units Month 6	Diagnosis Code
	T2024	Case Manager		\$4/day							
	T2031	ALF Level I		\$42/day							
	T2031 TF	ALF Level II		\$46/day							
	T2031 TG	ALF Level III		\$50/day							
Service Start Date	Service Start Date	Procedure Description	Medicaid Provider #	Unit Charge	Units Month 7	Units Month 8	Units Month 9	Units Month 10	Units Month 11	Units Month 12	Diagnosis Code
	T2024	Case Manager		\$4/day							
	T2031	ALF Level I		\$42/day							
	T2031 TF	ALF Level II		\$46/day							
	T2031 TG	ALF Level III		\$50/day							

AN APPROVAL OF THIS PLAN OF CARE IS NOT A GUARANTEE OF ELIGIBILITY OR PAYMENT. COVERAGE OF SERVICES UNDER THE APPROVED PLAN OF CARE IS CONTINGENT UPON THE CLIENT'S ONGOING MEDICAID ELIGIBILITY.

Signature of Client (or Client Designee) Date Signature of Case Manager Date

Office Use: Faxed _____ Mailed _____
(date) (date)

PROVIDER-WHITE COPY CLIENT-YELLOW

ALF HCBS (06/06)
ASSISTED LIVING WAIVER PLAN OF CARE C-501C

GUIDELINES FOR COMPLETING THE ALF-HCBS C501-C

This assessment must be performed prior to admission into the Assisted Living Facility Waiver and for the 12 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.

Twelve-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 the Case Manager and for the Assisted Living provider, selecting Level I, Level II or Level III.

Level I: 13-14 points on LT101. Provides 24-hr supervision, medication assistance and personal care.

Level II: 15-16 points on the LT101. Provides 24-hr supervision, medication assistance and increased level of personal care.

Level III: 17 or more points on the LT101. Provides 24-hr supervision, medication assistance and significant personal care.

Units Month 1-12: Enter the number of units for each waiver service. Units are days per month.

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.