STATE OF MONTANA
Department of Public Health and Human

HOME AND COMMUNITY BASED SERVICES
PLAN OF CARE SHORT FORM

Admission Date: _____ (Date)

Annual Update: _____ (Date)

Level I: _____ (Date)

Level II: No ☐ Yes ☐ MR ☐ MI ☐

Date: _____

Individual's Name (Last, First, Middle)	Address				Phone
Medicaid Number (SSN)	Date of Birth	Height	Weight	Sex	Marital Status
Responsible Party (Name/Relationship)	Address				Phone
Attending Health Care Professional	Address				Phone
Residential Status Veteran ☐ Yes ☐ No	Eligibility Category: ☐ Elderly ☐ Disabled ☐ SDMI		Care Category: *Not applicable for SDMI Waiver* ☐ Nursing Facility (CC1/CC2) ☐ Hospital (CC3)		
Date of Referral	Referral Source		Phone Number		Interview Date

Brief Description of Need for Services

Medical Summary/Allergies/Diagnosis/ICD9 Code

Person-Centered Plan

Discharge Date:

☐ I have a free choice of all qualified providers of HCBS for each service included in my Plan of Care.

☐ I understand there is a Plan of Care cost limit and a limit on the type of services available through the HCBS program.

☐ I have participated in the development of this Plan of Care and agree with it.

Individual: _____ (Signature) (Date)

Legal Representative: _____ (Signature) (Date)

Significant Other: _____ (Signature) (Date)

CMT Staff: _____ (Signature) (Date)

Health Care Professional: _____ (Signature) (Date)