



**SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU**

**HOME AND COMMUNITY BASED WAIVER
Policy Manual**

Section: CASE MANAGEMENT SYSTEM

Subject: SERVICE PLAN REEVALUATIONS

REQUIREMENT

Service plans must be formally reevaluated by the Case Management Team (CMT) to review changes in member’s need for Home and Community Based Services. Formal reevaluations of plans of care or service plan updates must be completed no later than six months from the initial plan approval. The first annual service plan update is due 12 months from the initial enrollment date. (Refer to Appendix HCBS 899-15 for a copy of the HCBS Reevaluation Form DPHHS-SLTC-139 and instructions).

PROCEDURE

During the service plan reevaluation, the CMT should:

1. See the member to assess the current situation.
2. Check with the member’s attending health care professional for any new orders (optional).
3. Check with the service provider(s) to review the quality of services being provided (as needed)
4. Evaluate the member’s discharge potential.
5. Document the results of the service plan reevaluation that are not already addressed on the reevaluation form (SLTC-139), in the progress notes.
6. Reevaluate the member’s goals and objectives and revise if warranted.
7. Attach a service plan cost sheet (DPHHS-SLTC-134) to the Amendment form whenever the projected service plan costs change as a result of the reevaluation.

If it appears the member no longer meets level of care, (refer to HCBS 503 for Level of Care evaluation).

SIGNATURES

The only signatures required for service plan reevaluations are the CMT, nurse, and social worker. The Department recognizes and accepts electronic signatures, provided the signature mechanism and protocol meet generally accepted industry standards.