SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

HOME AND COMMUNITY BASED WAIVER Policy Manual	**Section: APPENDIX**
	Subject: Service Plan (SLTC 135) Instructions

References: ARM 37.40.1420

PURPOSE

A signed service plan is required before any Home and Community Based Services (HCBS) can be provided to a member. The service plan provides a comprehensive assessment of a member's physical and social needs for HCBS and is used to develop a system of supports that will assist the member in meeting his/her goals while ensuring health and safety. The case management team (CMT) completes form DPHHS SLTC 135 upon initial assessment and for annual update of the member's need for HCBS.

The service plan is an agreement between the member and the CMT for the provision of HCBS. A discussion of the member's discharge potential must take place during the initial assessment and at the annual review. **Service plans must be developed and signed by the member during the on-site visit which must occur on or before the effective HCBS enrollment date or service plan renewal date. (Service plan reevaluations must be signed on or before the effective reevaluation date).**

DISTRIBUTION

The CMT obtains all relevant signatures, provides a copy of the plan to the member or legal representative if applicable and retains the original in the chart. IT is at the CMT's discretion whether to obtain the HCP's signature and to provide them with a copy of the Service Plan(SP).

INSTRUCTIONS

PAGE 1

Member — Enter all of the demographic information for the member (name, physical address, mailing address, email address and phone number).

Enrollment Date — Enter the date the member was first admitted to HCBS.

SP Date Span — Enter the effective date span of the service plan. This span should be no more than 365 days.

Discharge/ Readmits — Enter any discharge or readmit dates if applicable.

Level of Care Evaluation Date — Enter the date on which the latest LOC screen was completed; whether the member met LOC and whether the member was screened by MPQH or the CMT.

Social Security Number — Enter the member's SSN.

Medicaid Number — Enter the member's Medicaid identification number.

Care Category — Enter the appropriate level of care. Care Category (CC3) plans require prior authorization.

Date of Birth — Enter the member's date of birth.

Height/Weight — Enter member's current height and weight.

Sex — Enter M for Male or F for Female or O for other.

Marital Status — Enter the member's marital status. (Single, married, divorced, widowed or separated).

Member Representative — Under certain circumstances, members may avail themselves of representation. Not all representatives are legal representatives nor do they all have the same authority. It is important to identify the scope and limits of the decisions they may make on behalf of the member. If applicable, enter the type of any non-legal representative: payee, conservator, or other. Enter the name, address and phone number of the representative.

Legal Representative – A legal representative is a guardian or a medical DPOA when invoked. A copy of DPOA and guardianship papers must be present in the member's chart. Evert effort must be made to obtain a copy. If the CMTs are unable to obtain a copy, this must be documented in the chart. Enter name, address and phone number of the legal representative.

Significant Other — Enter the name, relationship to member, address and phone number of member's significant other.

Primary Health Care Provider	Enter the name, address and phone number of the member's primary health care provider.
Additional Health Care Providers And Type	Enter the name, address and phone number of other relevant health care providers such as a dentist, OT, PT, mental health practitioner, oncologist, surgeon, etc.
OPA County	Enter phone number of OPA county.
Pharmacy	Enter the name and phone number of pharmacy.
Residential Status	Enter the member's residential status under HCBS. IF residential habilitation, indicate whether it's assisted living/adult foster home residential hospice, child foster care, group home or TBI-AR.
Medicare	Enter "Yes" if Medicare eligible and Medicare number. If known, enter the effective date of Medicare eligibility. Enter "No" if not Medicare eligible.
Medicare D	If applicable, enter the name of the member's plan.
Other Insurance	Enter name of any other insurance. **Reminder:** Some private insurers will cover waiver-like services if pressed and must be billed for services before HCBS.
Veteran or Spouse of Veteran	Enter "Yes" or "No".
Primary Diagnosis	Enter the primary diagnosis.
ICD-10 Code	Enter the ICD-10 code for primary diagnosis.
Advance Directives	Check any that apply. IF applicable, document where the member's Advance Directives are kept and the name of their Health Care Proxy. Check whether the member has a Burial Plan or not. Document the specifics.

INSTRUCTIONS **PAGE 2**

Member Name	Enter member name and date.

Diet	Enter type of diet.
Supplements	List any supplements taken by member.
Medical Diagnoses	If the member has diagnoses in addition to the primary diagnosis entered on the first page, enter the name, ICD10 code and the date(s) of diagnoses if possible.
Medication List	Enter all current medications, prescribed, dosages and frequency. Include OTC and non-prescribed medications the member takes on a regular basis as well. Enter any known medication allergies and other allergies. If the member utilizes a Medication Dispensing System, enter the type and any other relevant information.
Comments	Enter any other pertinent comments relating to the member's medications.
Psychosocial Indicators that currently affect member and/or service delivery	List any psychosocial issues that could affect and/or influence the effectiveness of the service plan. For example: new diagnosis of mental and/or physical condition, change in housemates, change in pets, death of family or friend, support person moves from area, APS involvement, change in guardianship, change in any hobbies, crafts, interests, suicide attempt or ideation, start/stop counseling, new diagnosis with family members, change with ability to cope with disability, change with cognitive skills such as orientation, memory, judgment, insight, or change with long term goals.
Mental Status/ Orientation	Briefly describe the member's mental status (lucid, alert, confused, comatose, etc.). Describe orientation status (person, place and time). Enter any problems with orientation, judgment, or memory.

INSTRUCTIONS **PAGE 3**

Member Name	Enter member name and date.
Functional Overview	Enter for each task whether the member is independent, needs assistance or is dependent. Indicate whether

tasks are done by someone other than the member (i.e. spouse). Compare these to the assessments on the Level of Care Determination form (SLTC 86). If there is a significant difference, contact your RPO or MPQH.

Assistive Devices — List any appliances/prosthetic devices/assistive technology that the member uses or needs such as a walker, wheelchair, specialized bed, environmental control unit, personal alert/safety/response system, etc.

DME Providers — List the DME providers used and if appropriate which specific items are tied to each one.

INSTRUCTIONS **PAGE 4**

Member Name — Enter member name and date.

Service options — Enter each HCBS service the member will receive, the identified support required, the type and/or name of the service provider and frequency of service. Service provider and frequency must be specific (i.e. 2 hours per day, 3 times per week).
Reminder: The schedule should whenever possible be dictated by the member.

Other Services and Informal Support Systems — Enter other treatments, therapies or services provided to the member. Enter the service, need, provider and frequency of service. This section would include services to the member that are not paid for through HCBS (i.e., personal assistance services, therapies, adult protective services, home health, vocational rehabilitation, volunteer services, etc.) and informal supports such as family, friends, neighbors, church, etc.

INSTRUCTIONS **PAGE 5**

Member Name — Enter member name and date.

Plan Assessment Summary — Summarize the member's serviced plan, including **member's** short-term objectives and long-term goals.

Be specific in stating goals and objectives. Objectives should be broken down into measurable and achievable tasks that can be reviewed during and at the end of the service plan year. Attach additional pages if needed. RN should complete the physical summary and SW should complete social summary.

INSTRUCTIONS **PAGE 6**

Member Name — Enter member name and date.

Discharge Plan — The CMT must address the member's discharge potential and plan from HCBS.

Emergency Backup Plan — Discuss the member's emergency backup plan in the event that formal support services are not available. Document the results of this discussion.

Emergency Evacuation Plan — Document member's plan of evacuation in an emergency.
Reminder: If the member has pets and/or service animals, plans should also be in place for them.

Location of Medications and Important Documents — Document location of these items.

Safety Information — Check any safety concerns regarding access to phone, entrance/exit accessibility to home and/or concerns for safety in the community that apply to the member.

Comments/Issues — Document concerns identified during the development of the service plan. These may include but are not limited to the following:

1. Unsanitary/unsafe living conditions
2. Smoke detectors not available or not working
3. Bathing facilities not adequate
4. At risk for exploitation or abuse
5. Suicide ideation
6. Substance abuse

Summarize the safety evaluation and possible interventions to mitigate safety concerns.

Need for formal risk assessment — Check "Yes" or "No" and if marked "Yes", date the referral was made.

INSTRUCTIONS **PAGE 7**

Member Name — Enter member name and date.

Ensure that member/legal representative checks all the boxes and signs and dates the service plan.
CMT Nurse and SW must sign and date service plan.
If member/legal representative requests that another individual sign and date the service plan, make sure they do so.

Other Comments and Notes — Add any other information pertinent to this service plan that was not addressed elsewhere.

Signatures — The member/legal representative and the CMT **must** sign the service plan **BEFORE** any services can be provided and paid for. The Department recognizes and accepts electronic signatures, provided the signature mechanism and protocol meet generally accepted industry standards.

This includes dated signatures of the following:

Member — The member must sign the plan unless unable to do so. An "X" is acceptable but must be co-signed by another person. The signature page of the service plan should contain a note explaining that the member was unable to sign. No one should sign the member's name on their behalf. If the member has a guardian, the guardian must sign. If the member has the appropriate medical DPOA and it has been invoked, the medical DPOA must sign the service plan. However, in all instances, members should participate in the development of the service plan and sign it themselves.

Health Care Provider — The signature of a health care provider is not mandatory, but can be requested at the team's discretion. In all

instances, a copy of the completed service plan will be sent to the health care professional.

CMT Nurse and Social Worker

Both members of the CMT must sign the service plan. The plan may be initially approved with only one signature if one team member is not available, but the other member must review, sign and date the plan upon their return.