|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| TYPE: | [ ]   | Initial |  | Waiver: NOW |  |  [ ]  LEVEL \_\_\_\_ |
|  | [ ]   | Annual |  | Level of Care: ICFMR |  |  [ ]  SHARED SUPPORT |
| Individual’s Name (Last Name, First Name) | Legal Guardian/Authorized Representative |
| Social Security Number | DOB **/ /**  | Relationship |
| Medicaid # | Medicare # | Legal Status: [ ]  Minor [ ]  Interdicted [ ]  Power of Attorney [ ]  Competent Major [ ] Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address (Physical) | Mailing (If Different) | Address (Physical) | Mailing (If Different) |
| City/State/Zip Code | Parish | City/State/Zip Code | Parish |
| Day Phone | Night Phone | Day Phone | Night Phone |
| Case Management Agency (No Abbreviations) | Provider Number |
| Case Management Agency Address | Support Coordinator (type/print) | SC Supervisor (Type/print) |
| City/State/Zip Code | Telephone Number |
| **Sex:**  [ ]  Male [ ]  Female | **Ethnicity:** [ ]  African-American [ ]  Caucasian [ ]  Hispanic [ ]  Asian [ ]  Other  |
| **Education:**  [ ]  Attends School [ ] Homebound [ ]  N/A | **90L:** | Physician Date: |  | CM Rec’d: |  |
| **Primary Disability/Diagnosis:** |  | **Date of Onset:** | / / |
| **Secondary Disability/Diagnosis:** |  | **Date of Onset:** | / / |
| **MR:**  [ ]  Mild [ ]  Moderate [ ]  Severe [ ]  Profound [ ]  Other:  |
| **Adaptive Functioning:**  [ ]  Mild [ ]  Moderate [ ]  Severe [ ]  Profound  | **Ambulation:** [ ]  Independent [ ]  With Personal Assistance [ ]  With Assistive Device(s) [ ]  Does not ambulate  |
| **SIL:** [ ]  Yes [ ]  No | **24-Hour Service:** [ ]  Yes [ ]  No | **Primary Mode of Locomotion:** [ ]  Ambulation [ ]  Wheelchair without assistance [ ]  Wheelchair with assistance [ ]  Other |
| **Emergency Self-Evacuate:** [ ]  Yes [ ]  No | Attach Individualized Emergency Evacuation/Response Plan |
| **Emergency Response:** | **[ ]  Level 1** Total Assistance with Life Sustaining Equipment | **[ ]  Level 2** Total Assistance |
|  | **[ ]  Level 3** Can Respond/Needs Transportation | **[ ]  Level 4** Can Respond Independently |
| Will Residence Change with Waiver Participation? [ ]  Yes [ ]  No If Yes, When & Proposed Address? |
| Is This a Transition From a Developmental Center or Nursing Facility? [ ]  Yes [ ]  No Deposit Required? [ ]  Yes [ ]  No |
| Are There Multiple Waiver recipients in the Home? [ ]  Yes [ ]  No If So, How Many? \_\_\_\_\_ |
| Are There Multiple Individuals with Disabilities (Non-Recipient) in the Home? [ ]  Yes [ ]  No If So, How Many? \_\_\_\_\_ |
| Are Paid Care Givers Related to Individual? [ ]  Yes [ ]  No If Yes, Relationship & Service Provided |
| Do Paid Care Givers Live with Recipient? [ ]  Yes [ ]  No If Yes, Name & Service(s) |  |
| Does Individual Receive Home Health Service? [ ]  No [ ]  Yes If Yes, Attach a Home Health Plan. |
| Present Housing[ ]  Own Home (Alone)[ ]  Own Home (With Partner)[ ]  Own Home (With Others)[ ]  Other’s Home**Anticipated Housing:**  | [ ]  ICF/MR | [ ]  Nursing  Facility | **Rent Home**:[ ]  With Subsidy[ ]  Without Subsidy |
|
| **Rent Apartment:**[ ]  With Subsidy[ ]  Without Subsidy |
| **For WSS Use Only:** High Risk Recipient? [ ]  Yes [ ]  No (If Yes, WSS Will Add to High Risk Tracking) |
| **CPOC Begin Date:** |  | **CPOC End Date:** |  |

|  |  |
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| Section I: Emergency Information | Confidential |
| Attach Individualized Emergency Evacuation/Response Plan |
| Individual’s Name: |  | **Age:** |  |
| Address: |  |
| Directions to My Home: |  |
|  |
| **Person responsible for Evacuating/Bringing Supplies to Individual’s Home:** |
| Name: |  | Relationship: |  |
| Home Phone: |  | Work Phone: |  |
| Address: |  |
|  |  |
| **Family Members/Other to Contact in Case of Emergency (Including Providers):** |
| 1. Name:
 |  | Relationship: |  |
| Home Phone: |  | Work Phone: |  |
| Address |  |
| 1. Name:
 |  | Relationship: |  |
| Home Phone: |  |  | Work Phone: |  |
| Address: |  |
| 1. Name:
 |  | Relationship: |  |
| Home Phone: |  | Work Phone: |  |
| Address |  |
| **Emergency Equipment in Home:** |  |  |  |  |  |
| [ ]  Fire Extinguisher: Location |  | [ ]  First Aid Supplies: Location |  |
| [ ]  Home Evacuation Plan: Location: |  | [ ]  Specialized Medical Equipment: (e.g., ventilator, suction machine, etc.) |
| [ ]  Smoke Detector(s): location: |  | Location: |  |
|  | [ ]  Other |  |
| Special Considerations/Necessities (Detailed Information Required): Utilizes Assistive Technology, Dependent on Ventilator, Medications, Etc. (See Individual Emergency Evacuation/Response Plan) |
|  |
|  |
| Doctor’s Name: |  | Primary: |  | Phone: |  |
| Doctor’s Name: |  | Specialty: |  | Phone: |  |
| Doctor’s Name: |  | Specialty: |  | Phone: |  |
| Doctor’s Name: |  | Specialty: |  | Phone: |  |
| Doctor’s Name |  | Specialty |  | Phone: |  |

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|  | SECTION II: Health Profile |  |  |  |  |  |  | Confidential |
| **A.** | Health Status |  |  |  |  |  |  |  |
| **1.** | **Physical (e.g., General Health, Mobility, Assistive Devices):** |  |  |
| **2.** | **Allergies (e.g., Medication, Food, Environmental):** |  |  |
|  | **Describe What Happens When There is An Allergic Reaction** |  |  |
| **3.** | **Medical Diagnoses/Significant Medical History/Concerns:** |
| **4.** | **Doctor Visits (Past Year and Scheduled Visits):** |
| **5.** | **Psychiatric/Behavior Concerns:** |
| **6.** | **Behavior Support Plan Attached (If Needed):** **[ ]  Yes** **[ ]  No**  |
| **7.** | **Incident Reports (For Past 6 Months):** |  |  |
|  | A. Critical Incidents |  |  |  | **Additional Information/Summary:** |  |
|  |  | 1. | Unplanned Hospital | **#** |  |  |
|  |  | 2. | ER Visits | **#** |  |
|  |  | 3. | Psychiatric Admits | **#** |  |
|  |  | 4. | Abuse/Neglect | **#** |  |
|  |  | 5. | Other | **#** |  |
|  | B. Non-Critical Incidents | **#** |  |
|  | C. Hospital Admissions | **#** |  |
|  | D. Emergency Doctor Visits | **#** |  |
|  | E. Psychiatric Hospital Admissions | **#** |  |
|  |  |  |  |  |  |

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| **B. List of Medications: (Including Over the Counter Medications)** | Confidential |
| **Medications** | **What Is It For?** | **Dosage/Frequency** | **How Is It Taken?** | **Prescribing Physician \*(Check Box If Physician Delegation is Needed)** | To Be Given by:**(Self, Family, Staff, CMA, CNA, Etc.)** |
|  |  |  |  | [ ]  |  |
|  |  |  |  | [ ]  |  |
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|  |  |  |  | [ ]  |  |
| **C. List of Treatments (e.g. Catherizations, Tube Feeding, Dressing Changes, Suctioning, Oxygen, Splints, Braces, Etc.)** |
| **Treatments** | **What Is It For?** | **Frequency** | **How Is It Performed?** | **Prescribing Physician \*(Check Box If Physician Delegation is Needed)** | To Be Given by:**(Self, Family, Staff, CMA, CNA, Etc.)** |
|  |  |  |  | [ ]  |  |
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| Section III. All About Me | Confidential |
| Information included in this section is relevant to my life today and is my way of sharing social/family history with you. I hope that this information will be helpful in assisting you to help me achieve my personal outcomes. My personal outcomes worksheet (see attached Personal Outcomes Worksheets) will assist you in helping me tell you about myself. If I need assistance telling my story, please ask those who know me best. |
| 1. **Historical Information: Information** in this section includes historical issues, for example, nature and cause of person’s disability, person’s age at onset of disability (if not known, please indicate by writing “unknown” in this section), education, work history; recurring situations that impact support needs; summary of events leading to request for support at this time.
 |
| 1. **Current Living Situation: Information** in this section includes family’s involvement and understanding of individual’s strengths, skills and abilities, current issues/situations that may present barriers to individual obtaining supports and services they desire, individual’s/family/circle of support knowledge of disability and how individual wants to be supported; economic issues, including current employment; connections to community and natural supports, relationships/friends/family/other, where and with whom individual lives, rural/urban area, accessibility to resources, own home/rents/lives with relative/extended family/alone, does physical home environment meet accessibility/safety needs, health and age of family care-givers (if supported by family), feelings of safety and continuity of supports/care, etc.
 |
| 1. **Current Community Supports or Other Agency Involvement:** Information in this section includes significant life events, including family issues, social/law enforcement issues, social services caseworker or Probation Officer involvement which may require interaction with legal/social agencies, current community supports and resources being utilized, etc.
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| SECTION IV: Things You Need to Know to Support Me | Confidential |
| **A.** | **My gifts and talents:** |
| **B.** | **I communicate best by (speaking, gesturing, communication board, sign language, behaving in certain ways, etc.):****List of non-verbal ways I communicate in this communication log**

|  |  |
| --- | --- |
| **When I do this** | **It means this** |
|  |  |
|  |  |
|  |  |
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 |
| **C.** | **I understand best when (shown and told how, shown, use hand-over hand techniques, etc.):** |
| **D.** | **I need help with:** |
| **E.** | **When I am scared I need someone to:** |
| **F.** | **When I am angry I need you to:** |
| **G.** | **Things that work/things I like (favorite things such as…food hobbies, past time):** |
| **H.** | **Things that don’t work/things I dislike:** |
| **I.** | **Other things I’d like you to know about me:** |

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| **Section V: Personal Outcomes** | Confidential |
| **Vision:**NOTE: Planning must include and reflect emergency backup plans where the health and welfare of the recipient may be adversely affected. |
| **My Personal Outcomes** | **Support Strategy Needed** | **How Often For Supports** **and Services** | **Review/Accomplished Date** |
| What I want for myself.What is important to me right now?What do I want /expect as a result of supports and services?  | What I need to achieve my personal outcomes.How will services and supports be provided to me?Who will deliver the services and supports (Paid/unpaid)?Where will services and supports be provided?What (if any) assistive devices will be required?**Be Specific** | How and when (how often) do I want services and supports provided?**Be Specific** | When/how often will the supports and services be reviewed. When was the personal outcome accomplished/achieved? Is this still an outcome I want in my life now? Has anything changed in my life that needs to be addressed at this time?**Be Specific**Review Date Accomplished |
|  | 1.
 | 1.
 | 1.
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| **Section V: Personal Outcomes (CONTINUED)** | Confidential |
| NOTE: Planning must include and reflect emergency backup plans where the health and welfare of the recipient may be adversely affected. |
| **My Personal Outcomes** | **Support Strategy Needed** | **How Often For Supports** **and Services** | **Review/Accomplished Date** |
| What I want for myself.What is important to me right now?What do I want /expect as a result of supports and services?  | What I need to achieve my personal outcomes.How will services and supports be provided to me?Who will deliver the services and supports (Paid/unpaid)?Where will services and supports be provided?What (if any) assistive devices will be required?**Be Specific** | How and when (how often) do I want services and supports provided?**Be Specific** | When/how often will the supports and services be reviewed. When was the personal outcome accomplished/achieved? Is this still an outcome I want in my life now? Has anything changed in my life that needs to be addressed at this time?**Be Specific**Review Date Accomplished |
| 1.
 | 1.
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| **Section VI: Identified Services, Needs, and Supports** | **Confidential** |
| Identified services and supports that will help me maintain and/or achieve my personal outcomes. |
| NOW Waiver | NOW Waiver | **Medicaid Funded Services** | **Non-Waiver Support** |
| [ ]  Individual/Family Support (IFS) | [ ]  Supported Employment | [ ]  Dental | [ ]  OCDD |
|  | [ ]  | Day (D) |  | [ ]  | Transportation – REG | [ ]  Eye Glasses |  |
|  | [ ]  | Night (N) |  | [ ]  | Transportation – W/C | [ ]  Home Health Extended |  |
|  Shared Supports | [ ]  Employment-Related Training | [ ]  Hospice | [ ]  LRS |
|  | [ ]  | IFS – D | [ ]  Day Habilitation | [ ]  Medical Transportation |  |
|  | [ ]  | IFS – N | [ ]  Day Hab/Employment-Related Training Services Transportation | [ ]  Mental Health |  |
|  | [ ]  | Skilled Nursing | [ ]  Podiatry Services |  |
|  | [ ]  | CID |  | [ ]  | Transportation – REG | [ ]  Substance Abuse |  |
| [ ]  Substitute Family Care |  | [ ]  | Transportation – W/C | [ ]  Prescriptions/Medication | [ ]  DSS |
| [ ]  Center-Based Respite |  | [ ]  Others |  |
| [ ]  Professional Consultation |  |  |  |
| [ ]  Professional Services |  |  |  |
| [ ]  Transition Professional Support |  |  |  |
| [ ]  Skilled Nursing Services |  |  |  |
| [ ]  Environmental Accessibility Adaptations |  |  |  |
| [ ]  Specialized Medical Equipment and Supplies |  |  |  |
| [ ]  Personal Emergency Response System (PERS) |  |  |  |
| [ ]  Community Integration Development (CID) |  |  |  |
| [ ]  Supported Independent Living (SIL) |  |  | [ ]  Natural Supports |
| [ ]  One-Time Transitional Expenses |  |  | **[ ]** Community Supports |
| NOTE: Informed individual of all state plan services. Case Manager Initials: \_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| Section VII: Typical Weekly Schedule | Confidential |
| For Planning Purposes Only. If needs change, I will contact my case manager as soon as possible. |
| **Time** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** |
| 12:00 AM |  |  |  |  |  |  |  |
| 1:00 AM |  |  |  |  |  |  |  |
| 2:00 AM |  |  |  |  |  |  |  |
| 3:00 AM |  |  |  |  |  |  |  |
| 4:00 AM |  |  |  |  |  |  |  |
| 5:00 AM |  |  |  |  |  |  |  |
| 6:00 AM |  |  |  |  |  |  |  |
| 7:00 AM |  |  |  |  |  |  |  |
| 8:00 AM |  |  |  |  |  |  |  |
| 9:00 AM |  |  |  |  |  |  |  |
| 10:00 AM |  |  |  |  |  |  |  |
| 11:00 AM |  |  |  |  |  |  |  |
| 12:00 PM |  |  |  |  |  |  |  |
| 1:00 PM |  |  |  |  |  |  |  |
| 2:00 PM |  |  |  |  |  |  |  |
| 3:00 PM |  |  |  |  |  |  |  |
| 4:00 PM |  |  |  |  |  |  |  |
| 5:00 PM |  |  |  |  |  |  |  |
| 6:00 PM |  |  |  |  |  |  |  |
| 7:00 PM |  |  |  |  |  |  |  |
| 8:00 PM |  |  |  |  |  |  |  |
| 9:00 PM |  |  |  |  |  |  |  |
| 10:00 PM |  |  |  |  |  |  |  |
| 11:00 PM |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **CODE** | **HOURS** |  | **COMMENTS:** |
| F = Family |  |  |
| Fr = Friends |  |  |
| S = Self |  |  |
| Sc = School |  |  |
| W = Work |  |  |
| Pw = Paid Waiver |  |  |
| P = Paid Support |  |  |
| Total |  |  |  |

\* For all PW Services Identify – Example = PW-IFS

# Section VIII – Typical Alternate Schedule Confidential

**For Planning Purposes Only. If needs change, I will contact my case manager as soon as possible.**

|  |
| --- |
|  |

 JANUARY 20\_\_ FEBRUARY 20\_\_ MARCH 20\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** |  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **8** | **9** | **10** | **11** | **12** | **13** | **14** |  | **8** | **9** | **10** | **11** | **12** | **13** | **14** |  | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| **15** | **16** | **17** | **18** | **19** | **20** | **21** |  | **15** | **16** | **17** | **18** | **19** | **20** | **21** |  | **15** | **16** | **17** | **18** | **19** | **20** | **21** |
| **22** | **23** | **24** | **25** | **26** | **27** | **28** |  | **22** | **23** | **24** | **25** | **26** | **27** | **28** |  | **22** | **23** | **24** | **25** | **26** | **27** | **28** |
| **29** | **30** | **31** |  |  |  |  |  | **29** |  |  |  |  |  |  |  | **29** | **30** | **31** |  |  |  |  |
| **COMMENTS:** |
|  |

 APRIL 20\_\_ MAY 20\_\_ JUNE 20\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **1** | **2** | **3** | **4** | **5** | **6** | **7** |  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **8** | **9** | **10** | **11** | **12** | **13** | **14** |  | **8** | **9** | **10** | **11** | **12** | **13** | **14** |  | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| **15** | **16** | **17** | **18** | **19** | **20** | **21** |  | **15** | **16** | **17** | **18** | **19** | **20** | **21** |  | **15** | **16** | **17** | **18** | **19** | **20** | **21** |
| **22** | **23** | **24** | **25** | **26** | **27** | **28** |  | **22** | **23** | **24** | **25** | **26** | **27** | **28** |  | **22** | **23** | **24** | **25** | **26** | **27** | **28** |
| **29** | **30** |  |  |  |  |  |  | **29** | **30** | **31** |  |  |  |  |  | **29** | **30** |  |  |  |  |  |
| **COMMENTS:** |
|  |

## JULY 20\_\_ AUGUST 20\_\_ SEPTEMBER 20\_\_

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| **1** | **2** | **3** | **4** | **5** | **6** | **7** |  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **8** | **9** | **10** | **11** | **12** | **13** | **14** |  | **8** | **9** | **10** | **11** | **12** | **13** | **14** |  | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| **15** | **16** | **17** | **18** | **19** | **20** | **21** |  | **15** | **16** | **17** | **18** | **19** | **20** | **21** |  | **15** | **16** | **17** | **18** | **19** | **20** | **21** |
| **22** | **23** | **24** | **25** | **26** | **27** | **28** |  | **22** | **23** | **24** | **25** | **26** | **27** | **28** |  | **22** | **23** | **24** | **25** | **26** | **27** | **28** |
| **29** | **30** | **31** |  |  |  |  |  | **29** | **30** | **31** |  |  |  |  |  | **29** | **30** |  |  |  |  |  |
| **COMMENTS:** |
|  |

## OCTOBER 20\_\_ NOVEMBER 20\_\_ DECEMBER 20\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** |  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **8** | **9** | **10** | **11** | **12** | **13** | **14** |  | **8** | **9** | **10** | **11** | **12** | **13** | **14** |  | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| **15** | **16** | **17** | **18** | **19** | **20** | **21** |  | **15** | **16** | **17** | **18** | **19** | **20** | **21** |  | **15** | **16** | **17** | **18** | **19** | **20** | **21** |
| **22** | **23** | **24** | **25** | **26** | **27** | **28** |  | **22** | **23** | **24** | **25** | **26** | **27** | **28** |  | **22** | **23** | **24** | **25** | **26** | **27** | **28** |
| **29** | **30** | **31** |  |  |  |  |  | **29** | **30** |  |  |  |  |  |  | **29** | **30** | **31** |  |  |  |  |
| **COMMENTS:** |
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| SECTION IX (A): CPOC Requested Waiver Services (Budget Sheet) – Typical Weekly & Alternate Schedule | Confidential |
| List The Individual’s Requested Services As Described In The CPOC. SSN#  |
| **TYPICAL WEEKLY SCHEDULE – Daily Service Totals**  |  |  |  |
| **Provider Name** **(Full Name)** | **Service Procedure Code(s)** | **Service type** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** | **Sunday** | **Total Weekly** **# of Units of Service**  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **TYPICAL ALTERNATE SCHEDULE – Total Additional Units of Service Per Quarter**  |
|  | **Mth/ Day/ Yr \_\_\_\_\_\_** **Mth/Day/Yr- ------------****1st Partial Quarter** | **Mth/Yr------------****Mth/Yr. ----------****1st Full quarter** | **Mth/Yr.\_\_\_\_\_\_\_** **Mth/ Yr.\_\_\_\_\_\_****2nd quarter** | **Mth/Yr.\_\_\_\_\_\_\_** **Mth/ Yr.\_\_\_\_\_\_****3rd Quarter** | **Mt/ /Yr\_\_\_\_\_\_\_** **Mth/Day/ / Yr.\_\_\_\_\_\_****4th Partial Quarter**  | **Total Alt. Cost for all Quarters** |
| **Provider Name** **(Full Name)** | **Service Procedure Code(s)** | **Service type** | **Total # of Units**  | **Date/****Purpose** | **Total # of Units** | **Date/****Purpose** | **Total # of Units** | **Date/****Purpose** | **Total # of Units** | **Date/ Purpose** | **Total Units****(+ or -)** | **Date/ Purpose**  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **\*I HAVE REVIEWED THE BUDGET SHEET AND AGREE TO PROVIDE THE ABOVE STATED SERVICES.** | **Total Typical Alternate Schedule Cost** |  |

\*Provider Name/Provider Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Provider Name/Provider Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I HAVE REVIEWED THE BUDGET SHEET AND AM IN AGREEMENT WITH SERVICES AS OUTLINED ABOVE: RECEIPIENT/GUARDIAN SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_**

WSS Approval Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| SECTION IX (B): CPOC Requested Waiver Services (Budget Sheet)  |
| **1. Provider Name (Full Name)** | 1. **Provider #**
 | **3. Service Type** | **4. Procedure Code(s)** | **5. Typical Weekly # Of Units** | X | **6. Cost/****Rate Per Unit** | **=** | **7. TOTAL TYPICAL Weekly Costs** | X | **8. # of Weeks in CPOC Year (52 weeks in a Yr.)** | **=** | **9. Total Typical Annual Costs** |
|  |  |  |  |  | **X** |  | **=** |  | **X** |  | **=** |  |
|  |  |  |  |  | **X** |  | **=** |  | **X** |  | **=** |  |
|  |  |  |  |  | **X** |  | **=** |  | **X** |  | **=** |  |
|  |  |  |  |  | **X** |  | **=** |  | **X** |  | **=** |  |
|  |  |  |  |  | **X** |  | **=** |  | **X** |  | **=** |  |
|  |   **10. Total Typical Schedule Annual Cost**  |  |
|  | **11. Total Typical Alternate Schedule Annual Cost** |  |
| **\*I HAVE REVIEWED THE BUDGET SHEET AND AGREE TO PROVIDE THE ABOVE STATE SERVICES.**  | **12. Total Combined Typical & Alt. Schedule Annual Cost** |  |
| \*Provider Name/Provider Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*Provider Name/Provider Representative Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Case Manager Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **I HAVE REVIEWED THE BUDGET SHEET AND AM IN AGREEMENT WITH SERVICES AS OUTLINED ABOVE: RECEIPIENT/GUARDIAN SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date\_\_\_\_\_\_\_\_\_\_\_  |
| **FOR WSS USE ONLY:** |
| **Approved**: |  | **Denied:** |  |  **APPROVED CPOC Begin Date:** |  | **APPROVED CPOC End Date:** |  |  |
| **WSS Authorized Representative:** |  | **Initials** |  | **Date**: |  |  |

|  |  |
| --- | --- |
| Section X: CPOC Participants | Confidential |
| SIGNATURES OF ALL PLANNING MEETING PARTICIPANTSPlanning Participant/Relationship Planning Participant/Relationship |
|  |  |
|  |  |
|  |  |
|  |  |  |  |
| **Support Coordinator Signature** |  | Date |  |
|

|  |  |
| --- | --- |
|  | Participant/Authorized Representative Initials |
| I have been offered a choice between waiver and institutional services and I have chosen (check one): \_\_\_ waiver \_\_\_ institutional  |  |
| I have been informed of the available support coordination agencies and I have chosen: (Name of Agency Chosen)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| I have been offered the choice of available direct service providers from the OCDD Provider Freedom of Choice Listing and I have chosen: (List all Chosen Providers)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| I have been informed of all state plan services. |  |
| I have been informed of my rights and responsibilities regarding home and community based waiver services and have been given the WSS Rights and Responsibilities Form which includes information on how to report abuse, neglect, exploitation, or extortion. |  |
| My support coordinator has provided me with the toll-free number to contact the Health Standards Section if I want to report a complaint about my support coordinator or waiver service provider(s). That number is 1-800-660-0488. |  |

I have reviewed the services contained in this plan. I choose to accept this plan and the services described instead of the alternatives explained or offered to me. I understand it is my responsibility to notify my support coordinator of any change in my status, which might affect the effectiveness of this program. I further agree to notify my support coordinator of any changes in my income, which might affect my financial eligibility. I understand that I have the right to accept or refuse all or part of the services identified in this support plan.I understand that if I disagree with any decision rendered regarding the approval of this plan, I have the right to an informal discussion by contacting my WSS Regional Office and/or a fair hearing through the Division of Administrative Law-Health & Hospitals Section within 30 days of the approved/denied decision. However, if I disagree with a recommendation to reduce my Individual & Family Support (IFS) hours through the OCDD Guidelines for Support Planning/Resource Allocation process, I must first request a review through the OCDD Guidelines for Planning State Office Review Committee (GPSORC) by contacting my support coordinator who will assist me in submitting a justification to the GPSORC about why I need more IFS hours. I understand that I must receive the GPSORC’s final decision before I can appeal and request a fair hearing through the Division of Administrative Law-Health & Hospitals Section. I understand that my WSS Regional Office will provide me with an Appeal Notice for this purpose. I understand that I can contact the Division of Administrative Law-Health & Hospitals Section by mail at P.O. Box 4189, Baton Rouge, Louisiana 70821-4189; or by fax at (225)219-9823; or by phone at (225) 342-5800. ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*****Participant/Guardian Signature Date** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Witness Date**Reviewed by Support Coordinator Supervisor - Signature/Title:\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_­­\_\_\_\_ |
| **FOR WSS USE ONLY:** |
| **P Participant Name:** |  | **Program Type:** | **New Opportunities Waiver** |
| **Date Complete CPOC Received in WSS RO:** |  | **WSS Pre-Cert Home Visit Date:** |  |
| **This CPOC Meets the Identified Needs of the Individual:** | **[ ]  Approved** | **[ ]  Denied** |  |  |
| **Without the Services Available Through This Waiver, the Recipient Would Qualify for Institutional Care:** [ ]  Yes [ ]  No  |
| **Approved CPOC Begin Date:** |  |  | Approved CPOC End Date: |  |  |
| **Services Approved:** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| **Signature/Title of WSS Representative:** |  | **Date:** |  |

PERSONAL OUTCOMES WORKSHEETS

(Required as part of CPOC)

|  |  |
| --- | --- |
| “My Personal Outcomes” Worksheet | Confidential |
|  | Current Life Situation | **Current Support Situation – Natural and Paid** (What’s Going on That Supports My Desired Outcome?) | **Current Level of****Satisfaction**(1 to 5 Scale) |
| Identity – “Who Am I?” |  |  |  |
| 1. What Goals have I set for myself?
2. Where and with whom do I want to live?
3. What do I want to do for my work?
4. Who is closest to me?
5. How satisfied am I with the services and supports I receive?
6. How satisfied am I with my personal life situation?
 |  |  |  |
| Autonomy – “My Space” |  |  |  |
| 1. What are my preferred daily routines?
2. Do I have the time, space, and opportunity for the privacy I need?
3. Am I in control of who knows personal information about me?
4. Do my home, work, and other environments support what I want and need to be?
 |  |  |  |
| Affiliation – “My Community” |  |  |  |
| 1. Do I have access to the place I want to be?
2. Do I participate in what happens in my community?
3. Am I pleased with the type and extent of my interaction with other people in my community?
4. Am I known for the different social roles I play?
5. Do I have enough friends?
6. Am I respected by others?
 |  |  |  |
| Attainment – “My Success” |  |  |  |
| 1. Are the supports and services I receive the ones I want?
2. Have I realized any of my personal goals?
 |  |  |  |
| Safe Guards – “My Safe Guards” |  |  |  |
| 1. Am I connected to the people who support me the most?
2. Am I safe?
 |  |  |  |
| Rights – “My Rights” |  |  |  |
| 1. Do I exercise the rights that are important to me?
2. Do I feel that I am treated fairly?
 |  |  |  |
| Health and Wellness – “My Health” |  |  |  |
| 1. Is my health as good as I can make it?
2. Am I free from Abuse and Neglect?
3. Do I have a sense of continuity and security?
 |  |  |  |
| **Current Level of Satisfaction**:1. – Not At All Satisfied: Area discussed but no plans to address – not at all satisfied/no progress
2. – Not Very Satisfied: Area discussed but no adequately addressed/planned for – little or no satisfaction/progress
3. – Somewhat Satisfied: Area discussed and addressed/planned for – some satisfaction/progress
4. –Satisfied: Area discussed/planned for – mostly satisfied with noticeable progress
5. –Very Satisfied : area discussed and adequately planned for (i.e., to maintain current status, continue with current or adjusted plan, etc.) – very satisfied at this time
 |

Top/Most Important Personal Outcomes/Goals

Look at the Personal Outcomes Worksheet, Personal Outcomes Importance and Satisfaction Worksheet, as well as other information that will help you in choosing the top/most important things you would like to see change, improve or maintain in your life right now. What matters to you the most? The number of Personal Outcome/Goals will be based on what is most important to you. (Copy this form as needed.)

Use the space below to help you with identifying what matters the most to you in your life right now, and then decide what help/support you need to get what you want.

# Outcome/Goal # \_\_\_\_\_\_\_\_\_\_

I want (my desired outcome/goal):

What is currently in place to support/help me get what I want?

What are some barriers that may keep me from getting what I want? (Things/actions that move me further away from what I want):

What do I need to help me get what I want (reach my desired outcome/goal)?

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