

Money Follows the Person Demonstration Services Plan of Care

To: _____

Date: _____

From: _____

Demonstration Services Start Date: _____

Did the participant elect Self Direction? Yes No

If so, which service: _____ Waiver State Plan

Plan of Care: **Initial**
 Revised

Revision Effective Date: _____

Reason for Revision: (Check all that apply)

- Service discontinued** **Self Direction status changed**
- New Service initiated**
- Service modified**

General Client Information

Client Name: _____ Phone: _____

SSN#: _____ Medicaid#: _____

Date of Birth: _____ County of Residence: _____

Waiver: _____ Begin Date: _____

Service/ Provider	Service Goal/Justification	Schedule: Units; Days per Week; Hours per Day	Projected Start/ End Date
<p>Tele-Monitoring Technology/ In-Home Monitoring Services <i>(Please Check all that that is Required)</i></p> <p>Independence Technology <input type="checkbox"/> <i>Medicine Dispenser</i> <input type="checkbox"/> <i>PERS(Only for MFP AAPD and DD Client)</i></p> <p>Provider Name: 1. AMA Lifeline</p> <p>Contact Information: <i>(Contact Person, Address and Number)</i> 1. Dana Christian 479.484.0020</p>	<p>Medication Dispenser: <input type="checkbox"/> Cognitive status requires enhanced medication management. <input type="checkbox"/> Behavioral issues requires enhanced medication management. <input type="checkbox"/> Other: _____</p> <p>PERS <input type="checkbox"/> To manage fall risk <input type="checkbox"/> Other: _____</p> <p>Monitoring Sensor: <input type="checkbox"/> To manage fall risk <input type="checkbox"/> To manage wandering behavior <input type="checkbox"/> Environmental monitoring is necessary for health and welfare issues. <input type="checkbox"/> Other: _____</p>	<p>Unit: Month</p> <p>Sun-Sat: 24 hour coverage</p>	<p>Start: Day of d/c End: 365 days post d/c</p>
<p>Tele-Medicine <i>(Please Check all that is Required)</i></p> <p><input type="checkbox"/> <i>1.Tele-Health</i> <input type="checkbox"/> <i>2.Tele-Rehab</i> <input type="checkbox"/> <i>3.Nursing</i></p> <p>Provider Name: 1. Home Health Agency in your Area 2. Baptist Medical Hospital 3. Same Info as # 1</p> <p>Contact Information: <i>(Contact Person, Address and Number)</i> 1. Info on Home Health Agency in your Area 2. Baptist Home Health Agency 11900 Col. Glenn Rd. Ste.200 Little Rock, AR 501-202-7480 3. Same Info as # 1</p>	<p>Tele-Health: <input type="checkbox"/> To assess vital health data daily due to medical condition(s). <input type="checkbox"/> To monitor client adherence to medical care regime. <input type="checkbox"/> To reduce incidences of medical complications, through earlier detection.</p> <p>Tele-Rehab: <input type="checkbox"/> To increase client adherence to treatment regime. <input type="checkbox"/> Other: _____</p> <p>Nursing: <input type="checkbox"/> Necessary to comply with Tele-Health protocol.</p>	<p>Unit: Daily Monitoring of Tele-Health. Sun-Sat: Daily.</p> <p>Tele-Rehab: Unit: Visit Schedule: _____</p>	<p><i>To be completed by ITM</i></p>

<p>Community Transition Services</p> <p>Provider Name: 1.</p> <p>Contact Information: <i>(Contact Person, Address and Number)</i> 1.</p>	<p>To purchase needed goods and services for initial residential set up that are necessary to maximize the potential of the client to successfully transition and acclimate to the most independent level of functioning possible.</p> <p>Attach separate detailed description</p>	<p>Unit: Varies to the goods and services needed.</p> <p><i>ITM to provide schedule and cost estimate with the detailed description (attached to P.O.C.)</i></p>	<p><i>To be completed by ITM:</i></p>
<p>Goods and Services</p> <p>Provider Name: 1.</p> <p>Contact Information <i>(Contact Person, Address and Number)</i> 1.</p>	<p>To secure one time necessary goods and services, otherwise not available to the client, to improve quality of life and potential for independent living, inclusion in the community, safety, educational and social interactions.</p> <p>Attach separate detailed description</p>	<p>Unit: Varies to the goods and services needed.</p> <p><i>ITM to provide schedule and cost estimate with the detailed description (attached to P.O.C.)</i></p>	<p><i>To be completed by ITM.</i></p>
<p>Supported Living <i>(Service Provided In-Side Facility Only)</i></p> <p>Provider Name: 1.</p> <p>Contact Information: <i>(Contact Person, Address and Number)</i> 1.</p>	<p><input type="checkbox"/> To provide a secure temporary care arrangement for health and welfare of client.</p> <p><input type="checkbox"/> Emergency temporary placement due to relocation/safe housing needs.</p> <p><input type="checkbox"/> Other: _____ _____</p>	<p>Unit: Day (24 hour)</p> <p>Schedule: <i>To be completed by ITM</i></p>	<p><i>To be completed by ITM.</i></p>
<p>24 Hour Attendant Care <i>(Service Provided In-Home Only)</i></p> <p>Provider Name: 1.</p> <p>Contact Information: <i>(Contact Person, Address and Number)</i> 1.</p>	<p><input type="checkbox"/> Temporary emergency need for additional hours due to medical condition.</p> <p><input type="checkbox"/> Temporary need for transition purposes, to observe and train client in re-entry techniques.</p> <p><input type="checkbox"/> Other: _____ _____</p>	<p>Unit: 15 minute increments</p> <p>Schedule: <i>To be completed by ITM</i></p>	<p><i>To be completed by ITM.</i></p>

<p>Intense Transition Management</p> <p>Provider Name: 1.</p> <p>Contact Information: <i>(Contact Person, Address and Number)</i> 1.</p>	<p>To closely assist the client in the development, execution and monitoring of the individual transition and risk management plan.</p>	<p>Unit: 15 minute increments</p> <p>Schedule: Ongoing during the 365 day individual demonstration period.</p>	<p>Start: <i>(list date of initial assessment)</i></p> <p>End: <i>365 days post d/c</i></p>
<p>Therapeutic Intervention</p> <p>Provider Name: 1.</p> <p>Contact Information: <i>(Contact Person, Address and Number)</i> 1.</p>	<p>To provide additional assessment and treatment in critical areas associated with increased risk of re-institutionalization and to achieve intervention goals to reduce that risk.</p>	<p>Unit: Visit</p> <p>Schedule: <i>To be completed by ITM</i></p>	<p><i>To be completed by ITM</i></p>

Intense Transition Manager Signature

Date

Client's Signature

Date

Reviewed by (MFP Transition Coordinator)

Date

Total Projected MFP Demonstration Services Cost: \$
(To be completed by MFP Staff)

Comments: