

**ARKANSAS DEPARTMENT OF HUMAN SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES**

**ACS WAIVER PERSON CENTERED SERVICE PLAN  
DEMOGRAPHICS**

\_\_\_\_\_  
Individual's Name

\_\_\_\_\_  
Medicaid #

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Mailing Address

\_\_\_\_\_  
City, State, Zip Code

( ) -  
\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
County

\_\_\_\_\_  
School Name (if attending)

**GUARDIANSHIP/POWER OF ATTORNEY**

Guardianship:     Self     Power of Attorney (Explain Below)     Other (Explain Below)  
*(Power of Attorney which conveys same rights as guardianship)*

\_\_\_\_\_  
Guardian's/Power of Attorney's Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Guardian's/Power of Attorney's County

\_\_\_\_\_  
Guardian's/Power of Attorney's Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Guardian's/Power of Attorney's Mailing Address

\_\_\_\_\_  
City, State, Zip Code

( ) -  
\_\_\_\_\_  
Guardian's/Power of Attorney's  
Home Phone

( ) -  
\_\_\_\_\_  
Guardian's/Power of Attorney's  
Work Phone and Extension

( ) -  
\_\_\_\_\_  
Guardian's/Power of Attorney's  
Cell Phone

**Individuals Residing in Home of Recipient and Type of Residence:**

\_\_\_\_\_  
Total number individuals in home with  
developmental disabilities

\_\_\_\_\_  
Total number individuals with  
developmental disabilities in home related  
to waiver person

- Residence owned, rented or managed by a DDS Provider
- Home owned or rented by individual or family that person lives with (Host Home or Foster Care)
- Home owned or rented by one or more individuals with developmental disabilities
- Home of related family member



**ARKANSAS DEPARTMENT OF HUMAN SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES**

**ACS WAIVER PLAN SUPPORTED LIVING ARRAY WORKSHEET (WORD)**

Individual's Name \_\_\_\_\_

Medicaid # \_\_\_\_\_

Total Number of Days in Plan of Care Year Service is Requested: \_\_\_\_\_

Total Days DDS Approved: \_\_\_\_\_

Supported Living Array includes supportive living and respite care. Salary and fringe are calculated as one rate. Fringe cannot exceed 32%. Any fringe 25% or more must be justified. Supported Living Array components cannot exceed the maximum rate for the level of care, i.e. pervasive, extensive or limited. Supportive Living includes direct salaries and fringe for supportive living staff, direct care supervisor, transportation and indirect costs. Note: If staff positions are vacant and filled with a higher or lower salary than submitted, a revision **MUST** be submitted.

SERVICE COMPONENT	TOTAL REQUESTED			DDS TOTAL APPROVED		
	DAYS	ANNUAL SALARY AND FRINGE AND/OR ANNUAL RATE	BILLING RATE	DAYS	ANNUAL SALARY AND FRINGE AND/OR ANNUAL RATE	BILLING RATE
H2016 Supportive Living	Days			Days		
S5151 Respite Care	Days			Days		
A. TOTAL						

B. Supported Living Array Daily Rate (A ÷ Days in POC Year Requested) \_\_\_\_\_

(A ÷ Days in POC Year Approved) \_\_\_\_\_

Level of Care:

Level of Care

DDS Use Only

Pervasive



Extensive



Limited



\_\_\_\_\_  
Provider Designee/Agency Signature

\_\_\_\_\_  
Date

DDS USE ONLY

\_\_\_\_\_  
Reviewed by

\_\_\_\_\_  
Date Reviewed

**ARKANSAS DEPARTMENT OF HUMAN SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES**

**ACS WAIVER PLAN ADAPTIVE EQUIPMENT/ENVIRONMENTAL MODIFICATIONS AND  
SPECIALIZED MEDICAL/SUPPLEMENTAL SUPPORT /COMMUNITY TRANSITION  
SERVICES WORKSHEET (WORD)**

Individual's Name \_\_\_\_\_

Medicaid # \_\_\_\_\_

Adaptive Equipment, Emergency Response Installation and Testing, Emergency Response System Purchase and Environmental Modifications (unit = one package). Emergency Response System Service Fee (unit = month).

PROCEDURE CODE, MODIFIER, AND SERVICE COMPONENT	TOTAL REQUESTED		DDS TOTAL APPROVED	
	ITEM OR MONTHS	ANNUAL COST	ITEM OR MONTHS	ANNUAL COST
S5165 U1 Adaptive Equipment				
S5160 Emergency Response System Installation and Testing				
S5161 Emergency Response System Service Fee				
S5162 Emergency Response System Purchase				
K0108 Environmental Modifications				
<b>TOTAL</b>				

Specialized Medical Supplies and Supplemental Support (unit = month). Community Transition services (unit = one package).

PROCEDURE CODE, MODIFIER, AND SERVICE COMPONENT	TOTAL REQUESTED		DDS TOTAL APPROVED	
	ITEM OR MONTHS	ANNUAL COST	ITEM OR MONTHS	ANNUAL COST
T2028 Specialized Medical Supplies				
T2020 UA Supplemental Support				
T2020 UA U1Community Transition Services				
<b>TOTAL</b>				

\_\_\_\_\_  
Provider Designee/Agency Signature

\_\_\_\_\_  
Date

**DDS USE ONLY**

\_\_\_\_\_  
Reviewed by

\_\_\_\_\_  
Date Reviewed

**ARKANSAS DEPARTMENT OF HUMAN SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES  
ACS WAIVER PLAN SERVICE PROVIDER INFORMATION**

Individual's Name \_\_\_\_\_

Medicaid # \_\_\_\_\_

Case Manager Name \_\_\_\_\_

Case Management Provider \_\_\_\_\_

Direct Care Supervisor \_\_\_\_\_

Direct Service Provider \_\_\_\_\_

PLAN APPROVAL TYPE:  Initial  CSR  Revision

TYPE OF REVISION:  Extension  Update  Provider Change  Closure

REASON FOR CLOSURE:  Deceased  Moved Out of State  Withdrew  Unable to Locate  
 Failure to Cooperate with Administrative Requirements  Requested Closure  
 Failure to Cooperate with Plan Implementation  No Longer Meets ICF/MR Requirements  
 No longer Meets Medicaid Income Eligibility Requirements  Inability to Insure Health and Safety  
 Entered Long Term Care Facility  
 Other (specify): \_\_\_\_\_

\_\_\_\_\_  
Plan of Care  
Implementation Date

\_\_\_\_\_  
Continued Stay  
Review Date

\_\_\_\_\_  
Transition Meeting Date  
(if applicable)

PROVIDER CHANGE (IF APPLICABLE):

\_\_\_\_\_  
Case Management Approved Units

\_\_\_\_\_  
Units Used

\_\_\_\_\_  
Balance

\_\_\_\_\_  
Supportive Living Array Approved Dollars

\_\_\_\_\_  
Dollars Used

\_\_\_\_\_  
Balance

**ARKANSAS DEPARTMENT OF HUMAN SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES  
ACS WAIVER PLAN BUDGET SHEET (WORD)**

Individual's Name \_\_\_\_\_

Medicaid # \_\_\_\_\_

Provider Name and Number	OHCDS Check if Applies	Services being Requested Procedure Code/ Modifier/Service	Total Requested		Begin Date	End Date	DDS Total Approved	
			Units	Amount			Units	Amount
	<input type="checkbox"/>	H2016 Supportive Living	N/A				N/A	
	<input type="checkbox"/>	S5151 Respite Care	N/A				N/A	
	<input type="checkbox"/>	S5165 U1 Adaptive Equipment	N/A				N/A	
	<input type="checkbox"/>	S5160 Emergency Response System Installation and Testing	N/A				N/A	
	<input type="checkbox"/>	S5161 Emergency Response System Service Fee	N/A				N/A	
	<input type="checkbox"/>	S5162 Emergency Response System Purchase	N/A				N/A	
	<input type="checkbox"/>	K0108 Environmental Modifications	N/A				N/A	
	<input type="checkbox"/>	T2028 Specialized Medical Supplies	N/A				N/A	
	<input type="checkbox"/>	T2020 UA Supplemental Support	N/A				N/A	
	<input type="checkbox"/>	T2022 Case Management						
	<input type="checkbox"/>	H2023 Supported Employment						
	<input type="checkbox"/>	T2025 Consultation						
	<input type="checkbox"/>	T2034 U1 UA Crisis Intervention						
	<input type="checkbox"/>	T2022 U2 Transitional Case Management						
	<input type="checkbox"/>	T2020 UA U1 Community Transition Services	N/A				N/A	
Total								

Provider Designee/Agency Signature \_\_\_\_\_

Date \_\_\_\_\_

**DDS USE ONLY** I have verified totals are within approved limits. I have compared this request to the prior year's POC expenditures. If the request has a significant increase or decrease in the prior year's POC expenditures, the provider has identified and justified in the PCSP Narrative why the amount increased/decreased from the prior year's POC costs

Reviewed by \_\_\_\_\_

Date Reviewed \_\_\_\_\_



**ARKANSAS DEPARTMENT OF HUMAN SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES  
ACS WAIVER PERSON CENTERED SERVICE PLAN  
PHYSICIAN LEVEL OF CARE CERTIFICATION/ PRESCRIPTION**

Individual's Name \_\_\_\_\_

Medicaid # \_\_\_\_\_

A. DIAGNOSIS: *(Please check all that apply):*

Intellectual Disability (Mental Retardation)     Cerebral Palsy     Epilepsy     Autism

Mental Illness (explain) \_\_\_\_\_

Other (explain) \_\_\_\_\_

B. MEDICAL DIAGNOSIS (if applicable): \_\_\_\_\_

C. MEDICATION (List all medications below)

1. List all non-psychotropic medications: \_\_\_\_\_

2. List all psychotropic medications: \_\_\_\_\_

D. Is any psychotropic medication used for behavior?     Yes     No

E. MEDICATION MANAGEMENT PLAN (for medication(s) listed in C): \_\_\_\_\_

F. PROGNOSIS: \_\_\_\_\_

G. SPECIAL ORDERS: \_\_\_\_\_

I have examined the patient within the past 30 days, and I have reviewed the Person Centered Service Plan *(check one)*.

I certify the waiver services and level of care listed in the plan.

I disagree with the waiver services and level of care listed in the plan.

I disagree with the following waiver service(s) listed in the plan: \_\_\_\_\_

Physician's Name (Printed): \_\_\_\_\_ Telephone (    )    -    \_\_\_\_\_ Ext \_\_\_\_\_

Address: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_