

**DEPARTMENT OF HUMAN SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES  
ACS WAIVER PERSON CENTERED SERVICE PLAN AND CONTINUED STAY REVIEW  
NARRATIVE FORM**

Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_

Medicaid Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Plan of Care Begin Date: \_\_\_\_\_ Plan of Care End Date: \_\_\_\_\_

1) Social History Update:

- A) Current living arrangements including any change in address or phone number (specify who, what, when and where): \_\_\_\_\_
- B) Summary of events or circumstances that have impacted the participant during the prior year including major illness, injury, loss of primary caregiver (s), loss of home, graduation, awards, etc. that impact service delivery and have a direct effect on service needs: \_\_\_\_\_
- C) List any anticipated events that will impact next years plan, such as graduation from school, moving, etc. NOTE: When the individual reaches age 16, a transition plan is to be developed and ready for implementation upon graduation/certification of education. When applicable, explain plan or attach a copy of plan: \_\_\_\_\_
- D) Legal status including any changes in guardianship name, address phone number (if legal status has changed must attach proof): \_\_\_\_\_

2) Person Centered Service Plan Meeting (Note: Variances to E and F will be tracked and trended):

- A) Date and time of meeting: \_\_\_\_\_
- B) Who attended: \_\_\_\_\_
- C) For those who were invited and unable to attend, how were they invited, when were they invited and why were they not able to attend: \_\_\_\_\_
- D) Where meeting held: \_\_\_\_\_
- E) Plan must be submitted 45 days prior to POC expiration. If not, please explain why: \_\_\_\_\_
- F) Invitations must be sent at least five business days prior to the meeting. If not, please explain why: \_\_\_\_\_

3) Summary of participant's progress, regression, maintenance for each service objective from prior to current year. Include objective for any new services not provided in the prior year; for example, how has the adaptive equipment served the person – working as desired, no impact (explain), etc.:

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A) Supportive Living: \_\_\_\_\_

B) Respite Care: \_\_\_\_\_

C) Adaptive Equipment: \_\_\_\_\_

D) Emergency Response System: \_\_\_\_\_

E) Environmental Modifications: \_\_\_\_\_

F) Specialized Medical Supplies: \_\_\_\_\_

G) Supplemental Support: \_\_\_\_\_

H) Community Transition Services: \_\_\_\_\_

I) Case Management: \_\_\_\_\_

J) Transitional Case Management: \_\_\_\_\_

K) Consultation (Specify types): \_\_\_\_\_

L) Supported Employment: \_\_\_\_\_

M) Crisis Intervention: \_\_\_\_\_

4) Participant Input and Safeguards:

A) Participant input related to service needs including schedules and staffing: \_\_\_\_\_

B) Participant satisfaction with current services: \_\_\_\_\_

C) Medication management plan in place for all medications? Yes  No  If no, when will plan be in place? \_\_\_\_\_

D) Staff trained on all medication and side affects? Yes  No  If no, when will training be completed? \_\_\_\_\_

E) Guardian trained on all medication and side affects? Yes  No  If no, when will training be completed? \_\_\_\_\_

F) Who administers medications? \_\_\_\_\_

G) How is medication times and administration of dosages documented? \_\_\_\_\_

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- H) Positive Behavior Plan in place for any psychotropic prescribed for behavior? Yes  No  If no, when will plan be in place? \_\_\_\_\_ Progress of plans effectiveness: \_\_\_\_\_
- I) If Positive Behavior Plan is not in place for psychotropic, did prescribing physician certify that psychotropic is not for behavior? Yes  No  If no, when will certification be in place? \_\_\_\_\_
- J) Specify back up/support plan for service delivery in the event of natural emergencies such as fire, flood, power failure, earthquake, tornado, ice storm, etc; as well as, loss of non-paid and/or paid caregivers or loss of home: \_\_\_\_\_
- K) Assurance of health and safety of person, person's caregivers, workers and others (Identify any known risks, such as, aggression, elopement, aging primary caregivers, drug/alcohol abuse, criminal history, gait hazard, medical conditions, overly friendly with strangers, etc.) Specify preventive and follow up measures if risks are exhibited: \_\_\_\_\_
- L) Safeguards to assure participant rights:
- a) Emergency Drills: Yes  No  If no, when will plan be in place? \_\_\_\_\_
  - b) First Aid Kit: Yes  No  If no, when will plan be in place? \_\_\_\_\_
  - c) Fire Alarms: Yes  No  If no, when will plan be in place? \_\_\_\_\_
  - d) CO2 Alarms: Yes  No  If no, when will plan be in place? \_\_\_\_\_
  - e) Seat Belt Usage: Yes  No  If no, when will plan be in place? \_\_\_\_\_
  - f) Adaptive Equipment such as lift for person with wheelchair: Yes  No  If no, when will plan be in place? \_\_\_\_\_
  - g) Emergency 911 Registry: Yes  No  If no, when will plan be in place? \_\_\_\_\_
  - h) Elopement: Yes  No  If no, when will plan be in place? \_\_\_\_\_
  - i) Aggression toward self or others: Yes  No  If no, when will plan be in place? \_\_\_\_\_
  - j) Participant specific training for maladaptive behavior and/or medical issues: Yes  No  If no, when will plan be in place? \_\_\_\_\_
  - k) Training for health and safety of caregiver? Yes  No  If no, when will plan be in place? \_\_\_\_\_

5) Justification for new plan:

- A) Justification for services requested including amount (units and dollars) of service:

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**B) Explanation of any increase/decrease in days of service from prior to current year:**

- a) Days of service billed: \_\_\_\_\_
- b) Days of service provided with billing pending: \_\_\_\_\_
- c) Explanation of any unused balance: \_\_\_\_\_
- d) Explanation if there is a request for more days: \_\_\_\_\_
- e) Explanation if there is a request for fewer days: \_\_\_\_\_

**C) Explanation of any increase/decrease in plan total amount from prior to current year:**

- a) Total dollars billed: \_\_\_\_\_
- b) Total dollars provided with billing pending: \_\_\_\_\_

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- c) Explanation of any balance: \_\_\_\_\_
- d) Explanation if there is a request for more dollars: \_\_\_\_\_
- e) Explanation if there is a request for fewer dollars: \_\_\_\_\_
- D) Explanation for any new services requested: \_\_\_\_\_
- E) Generic or Medicaid State Plan services explored and/or accessed: \_\_\_\_\_
- F) Explanation of how transportation is used (must be non-medical), miles used in current plan, explanation and justification of how miles will be used, changes requested, and progress toward outcome: \_\_\_\_\_
- a) How much transportation is requested? \_\_\_\_\_
- b) Explanation if there is a request for more miles: \_\_\_\_\_
- c) Explanation if there is a request for fewer miles: \_\_\_\_\_
- G) For adaptive equipment, do products, goods and services meet applicable codes and standards? Yes  No  If no, explain: \_\_\_\_\_
- H) For adaptive equipment, were three itemized bids obtained for items costing over \$1,000.00? Yes  No  If no, explanation of why three bids were not obtained: \_\_\_\_\_
- I) For adaptive equipment, was lowest bid accepted? Yes  No  If no, explain why lowest bid was not accepted: \_\_\_\_\_
- J) For adaptive equipment, has applicable therapist consultation and EPSDT (for children) been obtained and attached? Yes  No
- K) For environmental modifications, do products, goods and services meet applicable codes and standards? Yes  No  If no, explain: \_\_\_\_\_
- L) For environmental modifications, were three itemized bids obtained for items costing over \$1,000.00? Yes  No  If no, explanation of why three bids were not obtained: \_\_\_\_\_
- M) For environmental modifications, was lowest bid accepted? Yes  No  If no, explain why lowest bid was not accepted: \_\_\_\_\_
- N) For environmental modifications, has applicable therapist consultation and EPSDT (for children) been obtained and attached? Yes  No

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O) For environmental modifications, are the following attached?

- a) "to scale" drawings, Yes  No
- b) pictures, Yes  No

P) For Organized Health Care Delivery System (OHCDS) does written subcontract exist for all services to be delivered through OHCDS? (Note: if no, then this service cannot be approved.) Yes  No  If no, when will subcontract be in place? \_\_\_\_\_

Q) Is Direct Care Staff serving more than one participant? Yes  No

a) If yes, has Pro-rated Staff form been used? Yes  No

b) Has the time between participants been pro-rated? Yes  No

c) If yes, what percent of time is applied to this participant? \_\_\_\_\_

R) Is Direct Care staff related to waiver participant? Yes  No  If yes, please state relationship.  
\_\_\_\_\_

S) For Direct Care staff, has the following been completed?

a) Reference check? Yes  No  If no, explain: \_\_\_\_\_

b) Central Registry check? Yes  No  If no, explain: \_\_\_\_\_

c) Criminal Background check? Yes  No  If no, explain: \_\_\_\_\_

d) Alcohol & Drug Screening? Yes  No  If no, explain: \_\_\_\_\_

e) Minimum training in accordance with DDS ACS certification standards? Yes  No   
If no, explain: \_\_\_\_\_

T) Is waiver payer of last resort? Yes  No  If no, please explain: \_\_\_\_\_

6) Other information: \_\_\_\_\_

7) Case Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

8) Case Management Provider Agency: \_\_\_\_\_

9) Case Manager Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Ext. \_\_\_\_

10) Case Manager E-Mail Address: \_\_\_\_\_

11) Case Manager Fax Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_