| **CES 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) |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| PASSE: |       | Date Attributed: |       |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **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 |

| **CES WAIVER PLAN PROPOSED OUTCOMES, IMMEDIATE NEEDS & LONG TERM GOALS** |
| --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|       |  |  |  |       |  |  |  |  |  |  |  |
| Individual’s Name |  |  |  | Medicaid # |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Facilitator’s Name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| About Me: (Summary of strengths, preferences, talents and skills. Summary should reflect what is important to the person, and be written in plain language) |
|       |  |
|  |
|  |
|  |
|  |
|  |
|  |
| Disclaimer: Waiver will not supplant other responsible authorities. |

| Individual’s Goals(Must be specific, measurable, achievable, relevant and time-bound) | Activities(How goals will be met) | Target Date | Identify ServicesWaiver Medicaid State Plan & All Other Generic Services(Parents/Guardians, Regular Medicaid, Private Insurance, Name of School, etc.) | Expected Outcomes(Specify any Service Barriers) |
| --- | --- | --- | --- | --- |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

| **CES 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 | BILLINGRATE | DAYS | ANNUAL SALARY AND FRINGE AND/OR ANNUAL RATE | BILLINGRATE |
| 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) |       |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Tier** |  |  |  |  |  |  | **Tier** |  |  |  |  |  |  | **DDS Use Only** |
| Tier 2 |  |  |  |  |  |  | [ ]  |  |  |  |  |  |  | [ ]  |
| Tier 3 |  |  |  |  |  |  | [ ]  |  |  |  |  |  |  | [ ]  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|       |  |  |  |  |  |  |  |       |
| Provider Designee/Agency Signature |  |  |  |  |  |  |  | Date |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| DDS USE ONLY |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|       |  |  |  |  |  |  |  |       |
| Reviewed by |  |  |  |  |  |  |  | Date Reviewed |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

| **CES WAIVER PLAN Service Provider Information** |
| --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|       |  |  |  |       |  |  |  |  |  |  |  |
| Individual’s Name |  |  |  | Medicaid # |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|       |  |       |
| Service Coordinator Name |  | Service Coordination 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/ID Requirements |
| [ ]  No longer Meets Medicaid Income Eligibility Requirements [ ]  Inability to Insure Health and Safety |
| [ ]  Entered Long Term Care Facility |
| [ ]  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |       |  |  |  |  |       |  |  |  |  |       |  |  |
|  |  | Plan of CareImplementation Date |  |  |  |  | Continued Stay Review Date |  |  |  |  | Transition Meeting Date (if applicable) |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Provider Change (if applicable): |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |
| Service Coordination Approved Units |  | Units Used |  | Balance |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|       |  |       |  |       |
| Supportive Living Array Approved Dollars |  | Dollars Used |  | Balance |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|       |  |  |       |  |
| Individual’s Name |  |  | Medicaid # |  |
|  |  |  |  |  |  |  |  |  |
| ProviderName and Number | OHCDSCheck ifApplies | Services being RequestedProcedure Code/ Modifier/Service | Total Requested | BeginDate | EndDate | DDS Total Approved |
| Units | Amount | Units | Amount |
|       | [ ]  | H2016 Supportive Living | N/A |       |       |       | N/A |       |
|       | [ ]  | S5151 Respite Care | N/A |       |       |       | N/A |       |
|       | [ ]  | S5165 U1 Adaptive Equipment | N/A |       |       |       | N/A |       |
|       | [ ]  | S5160 Emergency Response System Installation and Testing | N/A |       |       |       | N/A |       |
|       | [ ]  | S5161 Emergency Response System Service Fee | N/A |       |       |       | N/A |       |
|       | [ ]  | S5162 Emergency Response System Purchase | N/A |       |       |       | N/A |       |
|       | [ ]  | K0108 Environmental Modifications | N/A |       |       |       | N/A |       |
|       | [ ]  | T2028 Specialized Medical Supplies | N/A |       |       |       | N/A |       |
|       | [ ]  | T2020 UA Supplemental Support | N/A |       |       |       | N/A |       |
|       | [ ]  | T2022 Care Coordination |  |       |       |       |  |       |
|       | [ ]  | H2023 Supported Employment |      |       |       |       |      |       |
|       | [ ]  | H2023 U1 SE Discovery |      |       |       |       |      |       |
|       | [ ]  | H2023 U2 SE Job Development |      |       |       |       |      |       |
|       | [ ]  | H2023 U3 SE Employment Path |      |       |       |       |      |       |
|       | [ ]  | H2023 U4 SE Extended Support |      |       |       |       |      |       |
|       | [ ]  | T2025 Consultation |      |       |       |       |      |       |
|       | [ ]  | T2034 U1 UA Crisis Intervention |      |       |       |       |      |       |
|       | [ ]  | T2022 U2 Transitional Care Coordination/PCSP development |  |       |       |       |  |       |
|       | [ ]  | 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 |  |

| **CES Waiver PLAN Cooperative Agreement** |
| --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|       |  |  |  |       |  |  |  |  |  |  |  |
| Individual’s Name |  |  |  | Medicaid # |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|       |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Plan Meeting Date |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| The people attending this meeting are people I invited. I have no objections to anyone who is/was present for the person centered service plan meeting. |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| All providers identified in this plan of care were chosen by [ ]  Me [ ]  My Legal Representative [ ]  Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Signature of Waiver Individual/Legal Guardian/Legal Representative/Power of Attorney |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| As members of an interagency service planning development team, we will review confidential information on children/adults and families referred to the team. In carrying out this network of services and case planning, the agencies and persons below commit to work cooperatively together and to keep confidential all information disclosed. We agree any changes must be requested in advance, as changes cannot be implemented without prior approval. We agree the waiver rules and regulations will be followed |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Name** | **Title** | **Date** | **Signature** |
|       |       |       |  |
|       |       |       |  |
|       |       |       |  |
|       |       |       |  |
|       |       |       |  |
|       |       |       |  |
|       |       |       |  |
|       |       |       |  |
|       |       |       |  |
|       |       |       |  |
|       |       |       |  |

| **CES WAIVER PERSON CENTERED SERVICE PLAN**  **Physician LEVEL OF CARE CERTIFICATION/ Prescription** |
| --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|       |  |  |  |       |  |  |  |  |  |  |  |
| Individual’s Name |  |  |  | Medicaid # |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. DIAGNOSIS: *(Please check all that apply)*:
 |
| [ ]  | Intellectual Disability [ ]  Cerebral Palsy [ ]  Epilepsy [ ]  Autism |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [ ]  | Mental Illness (explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| [ ]  | Other (explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. MEDICAL DIAGNOSIS (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. MEDICATION (List all medications below)
 |
| * 1. List all non-psychotropic medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| * 1. List all psychotropic medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Is any psychotropic medication used for behavior? [ ]  Yes [ ]  No
 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. MEDICATION MANAGEMENT PLAN (for medication(s) listed in C): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. PROGNOSIS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. 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: |       |