AGED AND DISABLED WAIVER – SERVICE PLAN

ADW Participant's Name: _____ Plan Month/Year: _____

Date	Initial	Six Month	Annual	Change in Need/Service Level	Dual Services

I. DEMOGRAPHICS:

Last Name:	**First Name:**
Medicaid ID (and PPL ID):	**Service Level/Hours:** **Anchor Date:**
Case Management Agency or Personal Options Resource Consultant (Name/Phone):	**Plan Begin Date:** **Plan End Date:**
Primary Personal Attendant Agency Name/Number:	**Secondary Personal Attendant Agency Name/Phone:**
Legal Representative Name/Phone:	**Informal Support Name(s)/Phone:**
Personal Options Budget:	**Take Me Home WV:**

II. GOAL(S) AND PREFERENCES:

What are my goals? *(In own words, what I expect from the program):*	***How can my program support my goals?***
Describe your personal strengths.	***List specific things you do or do not want your worker to do for you.***

III. RISK PLAN: (For Service Plan Updates, CM/RC add date/initials with new risk)

RISK(S) *Describe the identified risks on the assessment needing addressed.*	**RISK PLAN(S)** *Describe how the risk(s) will be addressed.*

ADW Participant's Name: _____ Plan Month/Year: _____

IV. SERVICE PLAN *(For Service Plan Updates: CM/RC add date/initials for new service)*

ADW Service Do not list worker name	**Amount** ***Number of Hours/Day***	**Frequency** ***Number of Days/Week***	**Service Plan** **Duration**
Personal Attendant Services or Personal Options:			

Other Service(s) Other ADW Services, Home Health, PT, etc.	**Provider (or Personal Options)** Do not list worker name	**Service Amount, Frequency and Duration**
Case Management		
Skilled Nursing Services		
Transportation Services		
Other:		
Other:		
Other:		
Other:		

V. RESOURCE PLAN *(For Service Plan Updates, CM/RC add date/initials for new risk)*

Resource(s) Needed *(Food stamps, HUD, etc.)*	**Provider/Referral Source/Physicians**

NOTE: MAY ATTACH ADDITIONAL PAGES WHEN NECESSARY.

VI. HOME AND COMMUNITY BASED SETTING

Where I live*: I choose to live in a home that is in the community (not an institution) where I have a choice of who lives with me, what I do in my home, who I talk with on the phone, visitors coming into my home, my meals, how I manage my resources and who I interact with outside my home.* Yes No

ADW Participant's Name: _____ Plan Month/Year: _____

VII. MY EMERGENCY BACK UP PLAN

INFORMAL SUPPORT: *What activities are to be completed by the informal support?*	*What Days/Times are activities completed?*	*Who provides the informal support?*

Personal Attendant Availability

For Traditional Services, I will accept a substitute Personal Attendant if my assigned PA is not available. Yes No

I will use my informal supports when a Personal Attendant is not available. Yes No

I understand that no services within 180 days may result in my ADW case being closed. Yes No

For Traditional Services when no Personal Attendant is available, I prefer that you contact:
Me or **Name:** **Phone:**

As a back-up, I need the following things to occur. Describe what will happen if no one is available, who to call for informal support, the person's urgent needs and any actions that need to take place.

Access to Emergency Assistance

If I'm unable to answer the door when the worker arrives, please contact the individual(s) below for access to my home:

Name: **Home Phone:** **Cell Phone:** **Work Phone:**

Name: **Home Phone:** **Cell Phone:** **Work Phone:**

Other Directions:

I can access emergency assistance by dialing 911. Yes No
I need additional assistance such as Life Alert, Safe Link, etc.
I have a hospital preference: Yes No Name of hospital: _____ Comment:

Disaster Emergency Plan

I have a plan in place for: floods, extended power outage, snow, fire, etc. Described the person's urgent needs and any actions that need to take place.

ADW Participant's Name: _____ Plan Month/Year: _____

Other *(Please indicate the status of available resources such as family, friends, or other community resources):*
Directions to my home:
How to report abuse/neglect/exploitation: I understand how to report abuse/neglect/exploitation because it was explained me at the time of my service planning meeting. _____Yes _____No
Choice: I understand that I have the right to choose program models, types of services and agencies. ___Yes ___ No

SERVICE PLAN SIGNATURES AND PLAN AGREEMENT

_____	_____	_____	_____
ADW Participant/Legal Representative Signature	Agree	Disagree	Date
_____			_____
Case Manager Signature			Date
_____			_____
RN or Resource Consultant Signature			Date
_____			_____
Other			Date
_____			_____
Other			Date

ADW Service Plan Disagreement

Only complete this section if "disagree" was marked above by the ADW person. <u>This does not apply to issues related to ADW policy compliance (Example: Transportation Services).</u>

If disagree was marked above, state the reason for the disagreement with the plan.

Describe the resolution.

If unresolved, I have been referred to the ADW Grievance Process.

Yes, No **ADW Person's Initials _____**

Service Plan was provided to the ADW Participant and the Personal Attendant Agency. **Date:** _____

*Note: If you are accessing this document on Word, any alterations of the original form will result in improper documentation and disallowance.