WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

☐ Initial ☐ 6-Month ☐ Annual ☐ Transfer ☐ Discharge ☐ TMH Participant Service Plan Begin Date: __/___/_____

Service Plan End Date: __/___/_____

Last Name:	First Name:	Middle Initial:	Medicaid #:	DOB:
Case Manager Provider:		Phone:		
Personal Attendant Service Agency or PPL:		Phone:		
Other service provider agencies (if applicable): ☐ Personal Care-Dual ☐ Home Health		Phone:		
Service Model Choice: ☐ Traditional ☐ Personal Options		Check Attachments: ☐ Personal Options Spending Plan (if applicable) ☐ Prior Authorization Cover Letter ☐ Other: _____		

What do I expect from this program?

PERSONAL PREFERENCES

1. What would you like your personal attendant to do for you?

I Prefer These Activities, on These Days, During These Times: (bathing, dressing, grooming etc.)

Day	Activity	Strategies/Interventions needed during the activity	Time (in minutes)	Formal Support	Informal Support
MON					
TUES					
WED					
THURS					

Day	Activity	Strategies/Interventions needed during the activity	Time (in minutes)	Formal Support	Informal Support
FRI					
SAT					
SUN					

2. Are there any things you prefer the Personal Attendant not do for you?

3. Risk Reduction (Health and Safety)

Identified Problem/ Risk as Noted in Participant Assessment	Service(s) Needed to Address Problem/Risk	Provider	Date of Contact	Date Problem/Risk Addressed	Outcome(s) and Date

Evaluation	Date of Evaluation	Summary of Assessment/ Evaluation Results and Identified Needs	Recommendations	Outcome(s)
PAS				
Rancho Los Amigos Scale				
Psychological/ Psychiatric				
Medical		List all physicians, date of last appointment		
Transportation				
Therapy (PT, OT, ST, etc.)				
Person-Centered Assessment				
IEP / 504 Plan				
Other				

PRIMARY CARE PHYSICIAN

Name:

Specialty:

Address:

City/State/Zip:

Phone

Fax:

Frequency: Last Visit:

Other: Specialists, PT, OT, ST, Counselors, Psychiatrist, etc

Name:

Specialty:

Address:

City/State/Zip:

Phone

Fax:

Frequency: Last Visit:

Other: Specialists, PT, OT, ST, Counselors, Psychiatrist, etc.

Name:

Specialty:

Address:

City/State/Zip:

Phone

Fax:

Frequency: Last Visit:

Other: Specialists, PT, OT, ST, Counselors, Psychiatrist, etc.

Name:

Specialty:

Address:

City/State/Zip:

Phone

Fax:

Frequency: Last Visit:

Other: Specialists, PT, OT, ST, Counselors, Psychiatrist, etc.	
Name:	
Specialty:	
Address:	
City/State/Zip:	
Phone:	Fax:
Frequency: Last Visit:	
Other: Specialists, PT, OT, ST, Counselors, Psychiatrist, etc.	
Name:	
Specialty:	
Address:	
City/State/Zip:	
Phone:	Fax:
Frequency: Last Visit:	
Add additional pages if needed.	

INFORMAL SUPPORTS		
Name:		
Relationship:		
Address:		
City/State/Zip:		
Phone:		
Name:		
Relationship:		
Address:		
City/State/Zip:		
Phone:		
School Information (If applicable)		
Name of school:	County:	Grade/Hrs. in School
Address:		
Phone number:	Teacher Name:	

MY EMERGENCY BACK UP PLAN for PERSONAL ATTENDANT SERVICES AVAILABILITY

1. I will accept substitute Personal Attendants if my assigned Attendant is not available. ☐ Yes ☐ No
2. I will use my informal supports when a Personal Attendant is not available. ☐ Yes ☐ No
3. I understand that no services within 180 days may result in my TBI Waiver case being closed. ☐ Yes ☐ No
4. When no Personal Attendant is available, I prefer that you contact: ☐ **Me** ☐ **Someone else**

Name: _____ **Phone Number:** _____

5. If no one is available to assist me, I need the following things to occur: **(Describe participant's urgent needs and any actions that need to take place).**

ACCESS TO EMERGENCY ASSISTANCE

If I am **unable** to answer the door when the Personal Attendant or Case Manager arrives please contact:

Name: _____ **Phone:** _____ for access to my home (key)

I can access emergency assistance by dialing 911 ☐ Yes ☐ No

I need additional assistance such as Lifeline, Alert, or Safe Link. ☐ Yes ☐ No

DISASTER EMERGENCY PLAN

I have a plan in place for: floods, extended power outage, snow, fire, etc. **(Describe participant's urgent needs and any actions that need to take place.)**

SUMMARY PAGE

Service Code	Service Description	Provider	Needed?	Frequency
T1016 UB	**Case Management**		☐ Yes ☐ No	
S5125 UB/ S5125 UC	**Personal Attendant Services**		☐ Yes ☐ No	
A0160 UB/A0160 U2	**Transportation**		☐ Yes ☐ No	

Note: UB codes used for Traditional Service Model and UC/U2 codes used for Personal Option Service Model
T1016 UB Case Management used for both Models

Additional Services (include all State Medicaid Plans, Personal Care Services, Home Health, Special Education and other services participant is/will be receiving)	**Service Description**	**Provider**

TRAUMATIC BRAIN INJURY WAIVER
Person-Centered SERVICE PLAN :

Signature Page

In order to be a valid Service Plan **all** involved persons are to sign and date this document. If a participant is unable to sign please provide justification as to why s/he could not sign and verification that s/he was in attendance.

The right to address dissatisfaction with services through the provider agency's or Personal Options' grievance procedure and information on how to access the West Virginia DHHR Fair Hearing process has been explained to me. Participant's/Legal Representative's Initials _____

By signing, I certify that the reported information is complete and accurate. Assessments were reviewed with the participant and were considered in the development of this plan. I understand that payment for the services certified on this form will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under Medicaid Fraud.

Signatures:

Relationship	Signature	Date
Participant		
Legal Representative		
Case Manager		
Personal Attendant Service Agency		
Other:		
Other:		
Other:		

Start time of Service Plan meeting: _____ End time of Service Plan meeting: _____

Copy of Service Plan was provided to Participant/Legal Representative on: ____/___/_____

Copy of Service Plan was provided to Personal Attendant Services Agency on: ____/___/_____

Copy of Service Plan was provided to PPL on: ____/___/_____ or NA

It is the Case Management Agency's responsibility to send a copy of the Service Plan and the approved final Budget to the person and/or their legal representative (if applicable) within seven (7) business days from receipt of approval from the UMC.