TRAUMATIC BRAIN INJURY WAIVER PROGRAM
INTERIM SERVICE PLAN

(Initial Service Plan **must** be completed in 30 calendar days from Program Enrollment)
Date of Program Enrollment __/__/____
Date Interim Service Plan was developed __/__/____

Last Name	First Name	Medicaid #
Case Manager Name: Case Management Provider:		Phone Number:
Personal Attendant Name: Personal Attendant Provider:		Phone Number:

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	Informal
MON				☐	☐
				☐	☐
				☐	☐
				☐	☐
TUES				☐	☐
				☐	☐
				☐	☐
				☐	☐
WED				☐	☐
				☐	☐
				☐	☐
				☐	☐

THUR					
					
					
					

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

WHAT SERVICES AND RESOURCES DO I NEED?

Service Type or Resource	Provider	Amount/Frequency

Service Type or Resource	Provider	Amount/Frequency

Document any current identified risk to health and safety. _____
Personal Attendant Services will begin on __/__/____ (3 business days of plan development)

_____ _____ _____ _____
Member/Legal Representative Signature Date Case Manager Signature Date

Date copy of interim service plan send to Member/Legal Representative ___/___/_____

6/2016
Revised V2 8 2023
Revised V3 3 2024