AGED AND DISABLED WAIVER
CASE MANAGEMENT MONTHLY/QUARTERLY CONTACT

Member name: Person spoken to: **Note**: if not the member, explain in Comments section below.	Medicaid Number:	_____ Face to Face Contact _____ Telephone Contact _____ Quarterly Visit

	Yes	No	Comments
Did you receive the services that were listed on your Service Plan such as bathing, dressing, meals, errands? ***CM: Discuss how you can help.***			
Have you had any concerns with the people who come into your home? If yes, who is the person and what types of problems are you having? ***CM: Describe and discuss how it can be resolved.***			
Are there times when you needed help and didn't get it? If yes, what happened? ***CM: Discuss how to prevent it or a new Crisis Back-up Plan.***			
Have your needs for assistance changed since we last talked? If so, How?			
Have you visited a physician, hospital or nursing home as a patient since we last talked? If so, what was the reason for the visit? ***CM: Discuss if there is a need for a change in Service Plan?***			
Do you need resources such as medical equipment, food, housing, utilities or medications or help making any appointments? If yes, with who and when? ***CM: Get details.***			
Have you had any incidents such as falling? ***CM: If so, discuss a risk plan or a way to prevent it.***			
Are you having any problems paying for or getting food, housing, utilities or medications?			
Have there been any changes in your life that affect your need for service (death, loss, divorce, etc.)?			
If anything happens, do you know how to report problems (lack of services or abuse, neglect or exploitation)? ***CM: If not, advise the member.***			
Have there been any changes to your prescribed medications? ***CM: If yes, get details.***			
Have you received any letters (DHHR, Social Security or your Medicaid eligibility)?			
Has there been a change in your phone number or address? ***CM: Enter new information in CareConnection.***			
Do you feel safe with your current living arrangements? ***CM: If no, get details.***			

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Describe the appearance of the member (e.g., safe, neat, clean) and the condition of the home (e.g., safe and clean). Were any needs observed?

_____
_____
_____
_____
_____

Comments:

_____
_____
_____
_____
_____

By signing, I certify that the reported information is complete and accurate. 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.

_____ _____ _____

Case Manager Signature (Include Credentials) Date Time