

WV AGED AND DISABLED WAIVER PROGRAM INTERIM SERVICE PLAN

Interim Service Plan can be in effect up to 21 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					

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INTERIM SERVICE PLAN**

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

SERVICES AND RESOURCES

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

Start Time _____ Stop Time _____

Date copy of Interim Service Plan sent to Personal Attendant Agency _____

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