AGED AND DISABLED WAIVER – SERVICE PLAN

ADW Member's Name:

Date	Initial	Six Month	Anchor Date / Annual	Plan Begin Date: Plan End Date:	
				Anchor Date:	
I. DEMOGRAPHICS:					
Last Name:				**First Name:**	
Medicaid Number:				**Service Level/Hours:**	
Case Management Agency:				**Personal Options Resource Consultant (Name/Phone):**	
Primary Personal Attendant Agency Name/Phone:				**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:					
Choice: I understand that I have the right to choose program models, types of services and agencies. ___Yes ___ No					
What are my goals? *(In member's own words, what I expect from the program):* ***Describe your personal strengths.***				***How can my program support my goals?*** ***List specific things you do or do not want your worker to do for you.***	
	III. RISK PLAN: (*For Service Plan Updates, use Service Plan Addendum form.*)				
RISK(S)				**RISK PLAN(S)**	

ADW Member's Name:

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

IV. SERVICE PLAN *(For Service Plan Updates, use Service Plan Addendum form.)*

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

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

V. RESOURCE PLAN *(For Service Plan Updates, use Service Plan Addendum form.)*

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

ADW Member's Name:

NOTE: MAY ATTACH ADDITIONAL PAGES WHEN NECESSARY.

VI. HOME AND COMMUNITY-BASED SETTING

Was the Settings Rule (Member-Controlled or Provider-Controlled) survey completed? Yes No
If a Provider-Controlled survey is needed, was the BMS Program Manager notified? Yes No
Were the results incorporated for Service Planning purposes? Yes No
Date Completed: ___________________________
Completed by: ____
Name and Title/Credentials

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? Please include name and relationship.*

Personal Attendant Availability

For Traditional Services, I will accept a substitute Personal Attendant if my assigned Personal Attendant 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 the regular Personal Attendant is not available and/or the agency has no substitute worker, I prefer that you notify:
Me or,

Name: _______________________________________ **Phone:** _______________________________________

ADW Member's Name:

BACK UP PLAN, Cont'd: As part of this back-up plan, the following things need to be addressed. (Describe what will happen when there is no agency PA and no one else is available, who to call for informal support (name and phone number), the person's urgent needs and how they will be addressed, 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. Yes No

I have a hospital preference: Yes No Name of hospital: _______________________________________

Disaster Emergency Plan

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

Other *(Please indicate the status of available resources such as family, friends, or other community resources):*

Directions to my home:

Reporting Abuse/Neglect/Exploitation

ADW Member's Name:

I understand how to report abuse/neglect/exploitation because it was explained to me at the time of my service planning meeting. ______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 member.* ***This does not apply to issues related to ADW Policy.***
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 _____________**

Member's Service Plan was provided to the ADW Member and the Personal Attendant Agency.

Date: ___________________________________

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