Money Follows the Person
Demonstration Services Plan of Care

To: _____ Date: _____

From: _____

Demonstration Services Start Date: _____

Did the participant elect Self Direction? ☐Yes ☐No
If so, which service: _____ ☐Waiver ☐State Plan

Plan of Care: ☐**Initial**
☐**Revised** **Revision Effective Date: _____**

Reason for Revision: (Check all that apply)
☐ **Service discontinued** ☐ **Self Direction status changed**
☐ **New Service initiated**
☐ **Service modified**

General Client Information

Client Name: _____ Phone: _____

SSN#: _____ Medicaid#:_____

Date of Birth: _____ County of Residence: _____

Waiver: _____ Begin Date: _____

Service/ Provider	Service Goal/Justification	Schedule: Units; Days per Week; Hours per Day	Projected Start/ End Date
Tele-Monitoring Technology/ In-Home Monitoring Services *(Please Check all that that is Required)* AMA Lifeline ☐ *Medicine Dispenser* ☐ *PERS* **Provider Name:** **1.** **Contact Information:** ***(Contact Person, Address and Number)*** **1.**	**Medication Dispenser:** ☐ Cognitive status requires enhanced medication management. ☐Behavioral issues require enhanced medication management. ☐ Other: _____ **PERS** ☐ To manage fall risk ☐Other: _____	Unit: Month Sun-Sat: 24-hour coverage	Start: Day of d/c End: 365 days post d/c
Tele-Medicine (*Please Check all that is **required**)* ☐ ***1.****Tele-Health* ☐ ***2.****Tele-Rehab* ☐ ***3****.Nursing* **Provider Name:** **1.** Home Health Agency in your Area **2.** Same Info as #1 **3.** Same Info as # 1 **Contact Information:** ***(Contact Person, Address and Number)*** **1.** Info on Home Health Agency in your Area **2.** Same Info as #1 **3.** Same Info as # 1	**Tele-Health:** ☐ To assess vital health data daily due to medical condition(s). ☐ To monitor client adherence to medical care regime. ☐To reduce incidences of medical complications, through earlier detection. **Tele-Rehab:** ☐ To increase client adherence to treatment regime. ☐Other: _____ **Nursing:** ☐Necessary to comply with Tele-Health protocol.	Unit: Daily Monitoring of Tele-Health. Sun-Sat: Daily. Tele-Rehab: Unit: Visit Schedule:_____ _____	***To be completed by ITM***

Community Transition Services **Provider Name:** **1.** **Contact Information:** ***(Contact Person, Address and Number)*** **1.**	To purchase needed goods and services for initial residential set up that are necessary to maximize the potential of the client to successfully transition and acclimate to the most independent level of functioning possible. **Attach separate detailed description**	Unit: Varies to the goods and services needed. ***ITM to provide schedule and cost estimate with the detailed description (attached to P.O.C.)***	***To be completed by ITM:***
Goods and Services **Provider Name:** **1.** **Contact Information** *(Contact Person, Address and Number)* **1.**	To secure one-time necessary goods and services, otherwise not available to the client, to improve quality of life and potential for independent living, inclusion in the community, safety, educational and social interactions. **Attach separate detailed description**	Unit: Varies to the goods and services needed. ***ITM to provide schedule and cost estimate with the detailed description (attached to P.O.C.)***	***To be completed by ITM.***
Supported Living *(Service Provided **In-Side** Facility Only)* **Provider Name:** **1.** **Contact Information:** ***(Contact Person, Address and Number)*** **1.**	☐To provide a secure temporary care arrangement for health and welfare of client. ☐Emergency temporary placement due to relocation/safe housing needs. ☐Other: _____ _____	Unit: Day (24 hour) Schedule: ***To be completed by ITM***	***To be completed by ITM.***
24 Hour Attendant Care *(Service Provided **In-Home** Only)* **Provider Name:** **1.** **Contact Information:** ***(Contact Person, Address and Number)*** **1.**	☐ Temporary emergency need for additional hours due to medical condition. ☐Temporary need for transition purposes, to observe and train client in re-entry techniques. ☐ Other: _____ _____	Unit: 15-minute increments Schedule: ***To be completed by ITM***	***To be completed by ITM.***

Intense Transition Management **Provider Name:** **1.** **Contact Information:** ***(Contact Person, Address and Number)*** **1.**	To closely assist the client in the development, execution and monitoring of the individual transition and risk management plan.	Unit: 15-minute increments Schedule: Ongoing during the 365-day individual demonstration period.	***Start: (list date of initial assessment)*** ***End: 365 days post d/c***
Intense Transition Management *(Assistant)* **Provider Name:** **1.** **Contact Information:** ***(Contact Person, Address and Number)*** **1.**	To assist ITM to fulfill non-skilled related tasks.	Unit: 15-minute increments Schedule: Ongoing during the 365-day individual demonstration period.	***Start: (list date of initial assessment)*** ***End: 365 days post d/c***
Therapeutic Intervention **Provider Name:** **1.** **Contact Information:** ***(Contact Person, Address and Number)*** **1.**	To provide additional assessment and treatment in critical areas associated with increased risk of re-institutionalization and to achieve intervention goals to reduce that risk.	Unit: Visit Schedule: ***To be completed by ITM***	***To be completed by ITM***
Clothes: ☐**Summer/Spring** ***(Total $300)*** ☐**Winter/Fall** ***(Total $300)***	Participant is allowed to purchase clothing when they first move out of Qualified Residence. They are allowed to spend a total of $300; things that are allowed are shoes, coats, socks, underwear, pants, shirts, sleepwear, shorts, etc. The participant is then allowed to purchase clothes again 6 months later, when the weather changes, we realize that if you transition out in the summer, you will need a coat in the winter. You will then be allowed to spend the other $300.00 of your budget.	Unit: N/A Schedule: ***To be completed by ITM***	***To be completed by ITM***

_____ _____

Intense Transition Manager Signature Date

_____ _____

Client's Signature Date

_____ _____

Reviewed by (MFP Transition Coordinator) Date

Total Projected MFP Demonstration Services Cost: $
(*To be completed by MFP Staff)*

Comments: