Plan of Care Worksheet for EMWS

Instructions

This worksheet is provided as an optional tool for printing and recording plan of care information during team meetings or other visits with the participant, family and providers. Information shall be entered into the Electronic Medicaid Waiver System. For more convenience and to save paper, you may only want to print the pages you need.

Plan of Care Information

Participant Name: _____	**Waiver (circle): SUPPORT / COMPREHENSIVE**
Case Manager: _____	**SSN: _____ -____ - _____ Medicaid ID: _____**
Plan Dates: ___/___/_ _ _ _ to ___/___/_ _ _ _ MM/DD/YYYY	

Individual Preferences

Annual Team Planning Meeting: ___/___/_____ MM/DD/YYYY **6 Month Review**: ___/___/_____ MM/DD/YYYY

Participant's Desired Accomplishments for the Upcoming Plan Year: Use information from the previous "About Me" section.

Participant's Personal Preferences: What does the person like and want in their life?

Important Things to Know About Participant: What does a staff person need to know to work with the person best?

Plan of Care Worksheet for EMWS

Participant Demographics

Last Name: _____	**First Name**: _____
Middle Name: _____	**Suffix**: _____ (Jr, Sr, II, II, III, etc)
Birth Date: _____/_____/_____MM/DD/YYYY	**Gender**: _____(Male, Female)
Ethnicity: _____ (African American, Asian Pacific Islander, Latino Hispanic, Native/Alaskan American, White, Not Hispanic, Other)	**Method of Contact**: _____ (Email, Mail, Phone)
Communication Barriers: How can staff, the state, other people best communicate with this person?	

Physical Address:	**City:**	**State:**	**Zip Code:**
(NOTE: If Physical and Mailing address are same, select "Physical/Mailing" for the "Address Type" in the Waiver system)			
Mailing Address:	**City:**	**State:**	**Zip Code:**

Phone Numbers **Home**	(_____) - _____ -_____ Primary? Yes or no	**Fax**	(_____) - _____ -_____
Mobile	(_____) - _____ -_____ Primary? Yes or no	**Other (specify):**_____	(_____) - _____ -_____

Email Addresses **Personal**		**Primary email?**	
Other (specify):_____		**Primary email?**	

*Rights and Restrictions – needs to be updated to match the new rights restrictions section * those that will need to be addressed either through an assessment or a doctor's note required.*

Specific Rights:

Privacy in my home

Explain why the right is being restricted. Describe the assessed health or safety need that necessitates the restriction.

Explain and upload the document that authorizes someone besides the participant to restrict the right. Upload any supporting documentation for this right restriction: (letters/ notes from medical professionals, data) Note: Guardianship Orders must be current and reflect the guardian's authority to restrict the specific right.

When is the waiver provider expected to restrict the right? Describe behaviors, times, places, etc. Describe how the provider will ensure dignity and respect of the participant while restricting this right.

How is the waiver provider expected to restrict the right?

Prior to deciding on a rights restriction, describe any positive interventions or alternatives to restricting the right that were used. Explain what they were, how you collected information or data showing they were unsuccessful and why they didn't work. Note: not restricting the right previously is not sufficient information

What information/data is the provider required to collect to ensure the restriction is working to address the health or safety need? You must include the frequency of the collection; how often the team will review the information; and how the team will determine if the restriction is successful.

Describe how the restriction will be reviewed by the team, and the team's plan for restoring the right.

How was the participant's informed consent obtained for this restriction to be added to the plan of care?

Has the entire IPC team including the participant, providers, and LAR agreed that this right restriction is necessary? Yes No

Locks on sleeping and living quarters

Explain why the right is being restricted. Describe the assessed health or safety need that necessitates the restriction.

Explain and upload the document that authorizes someone besides the participant to restrict the right. Upload any supporting documentation for this right restriction: (letters/ notes from medical professionals, data) Note: Guardianship Orders must be current and reflect the guardian's authority to restrict the specific right.

When is the waiver provider expected to restrict the right? Describe behaviors, times, places, etc. Describe how the provider will ensure dignity and respect of the participant while restricting this right.

How is the waiver provider expected to restrict the right?

Prior to deciding on a rights restriction, describe any positive interventions or alternatives to restricting the right that were used. Explain what they were, how you collected information or data showing they were unsuccessful and why they didn't work. Note: not restricting the right previously is not sufficient information

What information/data is the provider required to collect to ensure the restriction is working to address the health or safety need? You must include the frequency of the collection; how often the team will review the information; and how the team will determine if the restriction is successful.

Describe how the restriction will be reviewed by the team, and the team's plan for restoring the right.

How was the participant's informed consent obtained for this restriction to be added to the plan of care?

Has the entire IPC team including the participant, providers, and LAR agreed that this right restriction is necessary? Yes No

Plan of Care Worksheet for EMWS

Choose with whom and where to live

Explain why the right is being restricted. Describe the assessed health or safety need that necessitates the restriction.

Explain and upload the document that authorizes someone besides the participant to restrict the right. Upload any supporting documentation for this right restriction: (letters/ notes from medical professionals, data) Note: Guardianship Orders must be current and reflect the guardian's authority to restrict the specific right.

When is the waiver provider expected to restrict the right? Describe behaviors, times, places, etc. Describe how the provider will ensure dignity and respect of the participant while restricting this right.

How is the waiver provider expected to restrict the right?

Prior to deciding on a rights restriction, describe any positive interventions or alternatives to restricting the right that were used. Explain what they were, how you collected information or data showing they were unsuccessful and why they didn't work. Note: not restricting the right previously is not sufficient information

What information/data is the provider required to collect to ensure the restriction is working to address the health or safety need? You must include the frequency of the collection; how often the team will review the information; and how the team will determine if the restriction is successful.

Describe how the restriction will be reviewed by the team, and the team's plan for restoring the right.

How was the participant's informed consent obtained for this restriction to be added to the plan of care?

Has the entire IPC team including the participant, providers, and LAR agreed that this right restriction is necessary? Yes No

Freedom to furnish and decorate

Explain why the right is being restricted. Describe the assessed health or safety need that necessitates the restriction.

Explain and upload the document that authorizes someone besides the participant to restrict the right. Upload any supporting documentation for this right restriction: (letters/ notes from medical professionals, data) Note: Guardianship Orders must be current and reflect the guardian's authority to restrict the specific right.

When is the waiver provider expected to restrict the right? Describe behaviors, times, places, etc. Describe how the provider will ensure dignity and respect of the participant while restricting this right.

How is the waiver provider expected to restrict the right?

Prior to deciding on a rights restriction, describe any positive interventions or alternatives to restricting the right that were used. Explain what they were, how you collected information or data showing they were unsuccessful and why they didn't work. Note: not restricting the right previously is not sufficient information

What information/data is the provider required to collect to ensure the restriction is working to address the health or safety need? You must include the frequency of the collection; how often the team will review the information; and how the team will determine if the restriction is successful.

Describe how the restriction will be reviewed by the team, and the team's plan for restoring the right.

How was the participant's informed consent obtained for this restriction to be added to the plan of care?

Has the entire IPC team including the participant, providers, and LAR agreed that this right restriction is necessary? Yes No

Control over own schedule and activities

Explain why the right is being restricted. Describe the assessed health or safety need that necessitates the restriction.

Explain and upload the document that authorizes someone besides the participant to restrict the right. Upload any supporting documentation for this right restriction: (letters/ notes from medical professionals, data) Note: Guardianship Orders must be current and reflect the guardian's authority to restrict the specific right.

When is the waiver provider expected to restrict the right? Describe behaviors, times, places, etc. Describe how the provider will ensure dignity and respect of the participant while restricting this right.

How is the waiver provider expected to restrict the right?

Prior to deciding on a rights restriction, describe any positive interventions or alternatives to restricting the right that were used. Explain what they were, how you collected information or data showing they were unsuccessful and why they didn't work. Note: not restricting the right previously is not sufficient information

What information/data is the provider required to collect to ensure the restriction is working to address the health or safety need? You must include the frequency of the collection; how often the team will review the information; and how the team will determine if the restriction is successful.

Describe how the restriction will be reviewed by the team, and the team's plan for restoring the right.

How was the participant's informed consent obtained for this restriction to be added to the plan of care?

Has the entire IPC team including the participant, providers, and LAR agreed that this right restriction is necessary? Yes No

Freedom and support to access food at any time

Explain why the right is being restricted. Describe the assessed health or safety need that necessitates the restriction.

Explain and upload the document that authorizes someone besides the participant to restrict the right. Upload any supporting documentation for this right restriction: (letters/ notes from medical professionals, data) Note: Guardianship Orders must be current and reflect the guardian's authority to restrict the specific right.

When is the waiver provider expected to restrict the right? Describe behaviors, times, places, etc. Describe how the provider will ensure dignity and respect of the participant while restricting this right.

How is the waiver provider expected to restrict the right?

Prior to deciding on a rights restriction, describe any positive interventions or alternatives to restricting the right that were used. Explain what they were, how you collected information or data showing they were unsuccessful and why they didn't work. Note: not restricting the right previously is not sufficient information

What information/data is the provider required to collect to ensure the restriction is working to address the health or safety need? You must include the frequency of the collection; how often the team will review the information; and how the team will determine if the restriction is successful.

Describe how the restriction will be reviewed by the team, and the team's plan for restoring the right.

How was the participant's informed consent obtained for this restriction to be added to the plan of care?

Has the entire IPC team including the participant, providers, and LAR agreed that this right restriction is necessary? ○ Yes ○ No

Have visitors at any time and associate with persons of one's choice

Explain why the right is being restricted. Describe the assessed health or safety need that necessitates the restriction.

Explain and upload the document that authorizes someone besides the participant to restrict the right. Upload any supporting documentation for this right restriction: (letters/ notes from medical professionals, data) Note: Guardianship Orders must be current and reflect the guardian's authority to restrict the specific right.

When is the waiver provider expected to restrict the right? Describe behaviors, times, places, etc. Describe how the provider will ensure dignity and respect of the participant while restricting this right.

How is the waiver provider expected to restrict the right?

Prior to deciding on a rights restriction, describe any positive interventions or alternatives to restricting the right that were used. Explain what they were, how you collected information or data showing they were unsuccessful and why they didn't work. Note: not restricting the right previously is not sufficient information

What information/data is the provider required to collect to ensure the restriction is working to address the health or safety need? You must include the frequency of the collection; how often the team will review the information; and how the team will determine if the restriction is successful.

Describe how the restriction will be reviewed by the team, and the team's plan for restoring the right.

How was the participant's informed consent obtained for this restriction to be added to the plan of care?

Has the entire IPC team including the participant, providers, and LAR agreed that this right restriction is necessary? Yes No

Communicate with people of their choosing (includes to make and receive phone calls)

Explain why the right is being restricted. Describe the assessed health or safety need that necessitates the restriction.

Explain and upload the document that authorizes someone besides the participant to restrict the right. Upload any supporting documentation for this right restriction: (letters/ notes from medical professionals, data) Note: Guardianship Orders must be current and reflect the guardian's authority to restrict the specific right.

When is the waiver provider expected to restrict the right? Describe behaviors, times, places, etc. Describe how the provider will ensure dignity and respect of the participant while restricting this right.

How is the waiver provider expected to restrict the right?

Prior to deciding on a rights restriction, describe any positive interventions or alternatives to restricting the right that were used. Explain what they were, how you collected information or data showing they were unsuccessful and why they didn't work. Note: not restricting the right previously is not sufficient information

What information/data is the provider required to collect to ensure the restriction is working to address the health or safety need? You must include the frequency of the collection; how often the team will review the information; and how the team will determine if the restriction is successful.

Describe how the restriction will be reviewed by the team, and the team's plan for restoring the right.

How was the participant's informed consent obtained for this restriction to be added to the plan of care?

Has the entire IPC team including the participant, providers, and LAR agreed that this right restriction is necessary? Yes No

Keep and use personal possessions and property

Explain why the right is being restricted. Describe the assessed health or safety need that necessitates the restriction.

Explain and upload the document that authorizes someone besides the participant to restrict the right. Upload any supporting documentation for this right restriction: (letters/ notes from medical professionals, data) Note: Guardianship Orders must be current and reflect the guardian's authority to restrict the specific right.

When is the waiver provider expected to restrict the right? Describe behaviors, times, places, etc. Describe how the provider will ensure dignity and respect of the participant while restricting this right.

How is the waiver provider expected to restrict the right?

Prior to deciding on a rights restriction, describe any positive interventions or alternatives to restricting the right that were used. Explain what they were, how you collected information or data showing they were unsuccessful and why they didn't work. Note: not restricting the right previously is not sufficient information

What information/data is the provider required to collect to ensure the restriction is working to address the health or safety need? You must include the frequency of the collection; how often the team will review the information; and how the team will determine if the restriction is successful.

Describe how the restriction will be reviewed by the team, and the team's plan for restoring the right.

How was the participant's informed consent obtained for this restriction to be added to the plan of care?

Has the entire IPC team including the participant, providers, and LAR agreed that this right restriction is necessary? Yes No

Keep and spend money

Explain why the right is being restricted. Describe the assessed health or safety need that necessitates the restriction.

Explain and upload the document that authorizes someone besides the participant to restrict the right. Upload any supporting documentation for this right restriction: (letters/ notes from medical professionals, data) Note: Guardianship Orders must be current and reflect the guardian's authority to restrict the specific right.

When is the waiver provider expected to restrict the right? Describe behaviors, times, places, etc. Describe how the provider will ensure dignity and respect of the participant while restricting this right.

How is the waiver provider expected to restrict the right?

Prior to deciding on a rights restriction, describe any positive interventions or alternatives to restricting the right that were used. Explain what they were, how you collected information or data showing they were unsuccessful and why they didn't work. Note: not restricting the right previously is not sufficient information

What information/data is the provider required to collect to ensure the restriction is working to address the health or safety need? You must include the frequency of the collection; how often the team will review the information; and how the team will determine if the restriction is successful.

Describe how the restriction will be reviewed by the team, and the team's plan for restoring the right.

How was the participant's informed consent obtained for this restriction to be added to the plan of care?

Has the entire IPC team including the participant, providers, and LAR agreed that this right restriction is necessary? ○ Yes ○ No

Right to access the community

Explain why the right is being restricted. Describe the assessed health or safety need that necessitates the restriction.

Explain and upload the document that authorizes someone besides the participant to restrict the right. Upload any supporting documentation for this right restriction: (letters/ notes from medical professionals, data) Note: Guardianship Orders must be current and reflect the guardian's authority to restrict the specific right.

When is the waiver provider expected to restrict the right? Describe behaviors, times, places, etc. Describe how the provider will ensure dignity and respect of the participant while restricting this right.

How is the waiver provider expected to restrict the right?

Prior to deciding on a rights restriction, describe any positive interventions or alternatives to restricting the right that were used. Explain what they were, how you collected information or data showing they were unsuccessful and why they didn't work. Note: not restricting the right previously is not sufficient information

What information/data is the provider required to collect to ensure the restriction is working to address the health or safety need? You must include the frequency of the collection; how often the team will review the information; and how the team will determine if the restriction is successful.

Describe how the restriction will be reviewed by the team, and the team's plan for restoring the right.

How was the participant's informed consent obtained for this restriction to be added to the plan of care?

Has the entire IPC team including the participant, providers, and LAR agreed that this right restriction is necessary? Yes No

Be free of physical and mechanical restraints

Explain why the right is being restricted. Describe the assessed health or safety need that necessitates the restriction.

Explain and upload the document that authorizes someone besides the participant to restrict the right. Upload any supporting documentation for this right restriction: (letters/ notes from medical professionals, data) Note: Guardianship Orders must be current and reflect the guardian's authority to restrict the specific right.

When is the waiver provider expected to restrict the right? Describe behaviors, times, places, etc. Describe how the provider will ensure dignity and respect of the participant while restricting this right.

How is the waiver provider expected to restrict the right?

Prior to deciding on a rights restriction, describe any positive interventions or alternatives to restricting the right that were used. Explain what they were, how you collected information or data showing they were unsuccessful and why they didn't work. Note: not restricting the right previously is not sufficient information

What information/data is the provider required to collect to ensure the restriction is working to address the health or safety need? You must include the frequency of the collection; how often the team will review the information; and how the team will determine if the restriction is successful.

Describe how the restriction will be reviewed by the team, and the team's plan for restoring the right.

How was the participant's informed consent obtained for this restriction to be added to the plan of care?

Has the entire IPC team including the participant, providers, and LAR agreed that this right restriction is necessary? Yes No

Be free of chemical restraints

Explain why the right is being restricted. Describe the assessed health or safety need that necessitates the restriction.

Explain and upload the document that authorizes someone besides the participant to restrict the right. Upload any supporting documentation for this right restriction: (letters/ notes from medical professionals, data) Note: Guardianship Orders must be current and reflect the guardian's authority to restrict the specific right.

When is the waiver provider expected to restrict the right? Describe behaviors, times, places, etc. Describe how the provider will ensure dignity and respect of the participant while restricting this right.

How is the waiver provider expected to restrict the right?

Prior to deciding on a rights restriction, describe any positive interventions or alternatives to restricting the right that were used. Explain what they were, how you collected information or data showing they were unsuccessful and why they didn't work. Note: not restricting the right previously is not sufficient information

What information/data is the provider required to collect to ensure the restriction is working to address the health or safety need? You must include the frequency of the collection; how often the team will review the information; and how the team will determine if the restriction is successful.

Describe how the restriction will be reviewed by the team, and the team's plan for restoring the right.

How was the participant's informed consent obtained for this restriction to be added to the plan of care?

Has the entire IPC team including the participant, providers, and LAR agreed that this right restriction is necessary? Yes No

Assessments

1) *LT 104 – ICF/ID Level of Care Assessment, if update is required*

Diagnosis:

	Acquired Brain Injury
	Asperger's
	Autism
	Cerebral Palsy
	Down's Syndrome

	Epilepsy, grand mal
	Epilepsy, other
	Epilepsy, petit mal
	Mental Retardation – Mild
	Mental Retardation – Moderate

	Mental Retardation – Profound
	Mental Retardation – Severe
	Mental Retardation – Severity Unspecified
	Other: _____

Services Needed

The individual meets at least one criteria in either **Medical** or **Psychological**, and at least one criteria in **Functional**, indicating that the individual requires the provision of waiver services monthly to develop skills necessary for maximum independence and/or the prevention of regression or loss of current skills/abilities and meets ICF/ID level of care.

Medical

	Daily monitoring due to medical condition where overall care planning is necessary.
	Supervision due to medication effects.

Psychological

	Supervision due to behavior, abusiveness or assaultiveness.
	Supervision due to impaired judgment and limited capabilities.
	Supervision due to psychotropic drug effects.

Functional

	A structured and safe environment that provides supervision as needed to keep the person safe.
	Assistance with activities of daily living and self-help skills such as feeding toileting, dressing and bathing.
	Assistance with ambulation, mobility.
	Routine incontinence care, catheter care, or ostomy.

2) ***Psychological Evaluation*** *(if update is required)*

Upload the following Psychological evaluation document:

Document Information

Evaluation Date: _____/_____/_____MM/DD/YYYY	Psychologist Name: _____
Non-standard IQ ☐	IQ: _____

List the Diagnosis information from the Psychological evaluation:

*Diagnosis 1:*_____ Qualifying Diagnosis for waiver? ☐

*Diagnosis 1:*_____ Qualifying Diagnosis? ☐

*Diagnosis 1:*_____ Qualifying Diagnosis? ☐

Note: If the Psychological evaluation diagnosis(es) entered here is/are not represented in the Waiver system diagnosis drop down table, please select "Other" from the table and type in the diagnosis written.

Plan of Care Worksheet for EMWS

Circle of Supports

Home Setting

	With Parents		Own home/apartment - alone
	With extended family or friends		Own home/apartment – with roommates(s)
	Foster Home		Community living home, with housemate(s)
	SFHH		Other

Circle of Support (Contacts) ***Contact Types***

Advocate	DFS Representative	Nonmedical Transportation	Representative Payee
Authorized Representative	Doctor	Other Family	School
Brother or Sister	Emergency Services	Other, non-family contact	Spouse
Case Worker	Employment	Parent	Waiver Manager
Child	Friend	Power of Attorney	Waiver Specialist
Community Agency	Guardian	Provider	
Community Support	Neighbor	Relative	

Contact 1:

Contact Type: _____ *Select from Contact Types above*

Name: Last: _____ First: _____ Phone: (_____) - _____ - _____

_____

Address City State Zip Code

Contact 2:

Contact Type: _____ *Select from Contact Types above*

Name: Last: _____ First: _____ Phone: (_____) - _____ - _____

_____

Address City State Zip Code

Contact 3:

Contact Type: _____ *Select from Contact Types above*

Name: Last: _____ First: _____ Phone: (_____) - _____ - _____

_____

Address City State Zip Code

Contact 4:

Contact Type: _____ *Select from Contact Types above*

Name: Last: _____ First: _____ Phone: (_____) - _____ - _____

_____

Address City State Zip Code

Other Services used (mark all accessed and utilized by the participant)

	Vocational Rehabilitation		Payee		Medicare		Speech
	Food Stamps		Private Health Insurance		Mental Health Services		SSDI
	Housing Assistance		Physical Therapy		Occupational Therapy		SSI
	Indian Health Services		School		Other: _____		Transportation Vouchers
	Other Medicaid Plan						

Plan of Care Worksheet for EMWS

Needs and Risks

Does this plan include remote supports? ***Yes*** ***No***

Assessments - Use the following Support Area Categories for filling in the Support Area spaces provided below.

Support Area Categories similar to the "My Supports" section of the plan of care used previously

Healthy Lifestyle	**Self-Care – Personal Hygiene, Bathing, etc.**
Financial & Property	**Self Advocacy**
Meal Time	**Vulnerability**
Housing	**Transportation**
Community	**Mobility**
Communication	**Medications & Medical Regimen**
Family & Friends	**Physical Conditions**
Employment/Employment Training	**Other**

Applicable Assessments for this participant include:

Support Area: _____ (select from **Support Area from above**)

How will the support be provided?

	High risk area		Natural (unpaid)supports		Non-waiver services
	Unmet need		Waiver services		Restricted due to behavior

How to assist the person in this area:

Protocol(s):		**Documents -** Upload the following documents:
	This assessment area has separate protocols	

Support Area: _____ (select from **Support Area from above**)

How will the support be provided?

	High risk area		Natural (unpaid)supports		Non-waiver services
	Unmet need		Waiver services		Restricted due to behavior

How to assist the person in this area:

Protocol(s):		**Documents -** Upload the following documents:
	This assessment area has separate protocols	

Plan of Care Worksheet for EMWS

Support Area: _____ (select from **Support Area from previous page**)

How will the support be provided?

	High risk area		Natural (unpaid)supports		Non-waiver services
	Unmet need		Waiver services		Restricted due to behavior

How to assist the person in this area:

Protocol(s):		**Documents -** Upload the following documents:
	This assessment area has separate protocols	

Support Area: _____ *(select from **Support Area from previous page**)*

How will the support be provided?

	High risk area		Natural (unpaid)supports		Non-waiver services
	Unmet need		Waiver services		Restricted due to behavior

How to assist the person in this area:

Protocol(s):		**Documents -** Upload the following documents:
	This assessment area has separate protocols	

Support Area: _____ (select from **Support Area from previous page)**

How will the support be provided?

	High risk area		Natural (unpaid)supports		Non-waiver services
	Unmet need		Waiver services		Restricted due to behavior

How to assist the person in this area:

Protocol(s):		**Documents -** Upload the following documents:
	This assessment area has separate protocols	

****Print additional copies of this page if more support areas are identified.**

Upload Assessment

Upload the following Assessment form:

Plan of Care Worksheet for EMWS

Medical

Medical Professional

Medical Professional 1

Name: _____ Phone: (_____) - _____ - _____

☐ Primary Medical Professional Specialty: _____

_____

Address City State Zip Code

Medical Professional 2

Name: _____ Phone: (_____) - _____ - _____

☐ Primary Medical Professional Specialty: _____

_____

Address City State Zip Code

Medical Professional 3

Name: _____ Phone: (_____) - _____ - _____

☐ Primary Medical Professional Specialty: _____

_____

Address City State Zip Code

***Note: If additional Medical Professionals apply, please continue on the back of this worksheet or print additional pages.*

Diagnosis

Diagnosis 1:_____ Note: If the diagnosis entered here is not represented in the Waiver system diagnosis drop down table, please select "Other" from the table and type in the diagnosis written here.
Qualifying Diagnosis? ☐

Diagnosis 2:_____ Note: If the diagnosis entered here is not represented in the Waiver system diagnosis drop down table, please select "Other" from the table and type in the diagnosis written here.
Qualifying Diagnosis? ☐

Diagnosis 3:_____ Note: If the diagnosis entered here is not represented in the Waiver system diagnosis drop down table, please select "Other" from the table and type in the diagnosis written here.
Qualifying Diagnosis? ☐

Note: If additional Diagnosis(es) apply, please continue on the back of this worksheet or print additional pages.

Plan of Care Worksheet for EMWS

Medications

Route Table

- G-Tube/J-Tube
- Inhalant
- Intramuscular
- Nasal (nose)
- Ophthalmic (eye)
- Oral
- Otic (ear)
- Rectal
- Subcutaneous (injection under the skin)
- Sublingual (under the tongue)
- Topical
- Transdermal (adhesive patch on skin)
- Vaginal

Purpose Table

- ADHD/Oppositional Defiance
- Allergies
- Anxiety
- Bowel Preparation
- Dementia
- Depression
- Diabetes
- Diuretic
- Ear Condition
- Eye Condition
- Flu/Cold Symptoms
- Heart/Blood Pressure
- Hormone/Glandular (thyroid) Therapy
- Lung/Respiratory
- Mood Disorder
- Other
- Pain
- Psychosis
- Sedative
- Seizures
- Skin Condition
- Spasticity
- Stomach Pain/Acid Relief
- Supplementation
- Urological
- Vomiting

Assistance Required Table

- No Assistance
- Storage Only
- Storage/Supervision
- Storage/Supervision/Physical Assistance
- Total

Medication Name: ______________________________

Dose: ______________________________

Route: ______________________________ (select from **Route Table** above)

Frequency: ☐ PRN ☐ Scheduled

Purpose: ______________________________ (select from **Purpose Table** above)

Type: ☐ Over the Counter ☐ Prescription

Assistance Required: ______________________________ (select from **Assistance Required Table** above)

Medication Name: ______________________________

Dose: ______________________________

Route: ______________________________ (select from **Route Table** above)

Frequency: ☐ PRN ☐ Scheduled

Purpose: ______________________________ (select from **Purpose Table** above)

Type: ☐ Over the Counter ☐ Prescription

Assistance Required: ______________________________ (select from **Assistance Required Table** above)

Medication Name: ______________________________

Dose: ______________________________

Route: ______________________________ (select from **Route Table** above)

Frequency: ☐ PRN ☐ Scheduled

Purpose: ______________________________ (select from **Purpose Table** above)

Type: ☐ Over the Counter ☐ Prescription

Assistance Required: ______________________________ (select from **Assistance Required Table** above)

Medication Name: ______________________________

Dose: ______________________________

Route: ______________________________ (select from **Route Table** above)

Frequency: ☐ PRN ☐ Scheduled

Purpose: ______________________________ (select from **Purpose Table** above)

Type: ☐ Over the Counter ☐ Prescription

Assistance Required: ______________________________ (select from **Assistance Required Table** above)

Note: If additional Medications apply, please continue on the back of this worksheet or print additional pages.

Documents

Upload the following medication documents:

Known Allergies/Serious Reactions

Check all that apply. If "other", then provide details in the "Other" space below.

	No Known Allergies		Eye		Other
	Aspirin		Food		Pet
	Bee Sting		Hay Fever		Poison Ivy and Plants
	Cosmetics		Hives		Sulfite
	Drug		Latex		Sun
	Eczema		Mold Allergy		

Other

Specialized Equipment

Equipment Type 1: _____(enter "Discontinued", "In Use", or "Need")

Equipment: _____

Recommendations

Equipment Type 2: _____(enter "Discontinued", "In Use", or "Need")

Equipment: _____

Recommendations

Equipment Type 3: _____(enter "Discontinued", "In Use", or "Need")

Equipment: _____

Recommendations

Note: If additional Support Areas apply, please continue on the back of this worksheet or print additional pages.

Plan of Care Worksheet for EMWS

Behavioral Supports

***ICAP Targeted Behaviors* - Categories table** **Note: Behaviors may be identified from the team or others sources besides the ICAP!**

Destructive to Property	Uncooperative Behavior
Disruptive Behavior	Unusual or Repetitive Habits
Hurtful to Others	Withdrawn or Inattentive Behavior
Hurtful to Self	Other
Socially Offensive Behavior	

ICAP Targeted Behavior 1: _____(select from **Behavior Categories table** above)

Response:

	Critical
	Moderate
	Serious

	Included in behavior plan
	No behavior plan needed

ICAP Targeted Behavior 2: _____ (select from **Behavior Categories table** above)

Response:

	Critical
	Moderate
	Serious

	Included in behavior plan
	No behavior plan needed

ICAP Targeted Behavior 3: _____ (select from **Behavior Categories table** above)

Response:

	Critical
	Moderate
	Serious

	Included in behavior plan
	No behavior plan needed

ICAP Targeted Behavior 4: _____ (select from **Behavior Categories table** above)

Response:

	Critical
	Moderate
	Serious

	Included in behavior plan
	No behavior plan needed

Positive Behavior Support Plans

Topics addressed in plan (check all that apply)

	Directions for provider
	Information based on the functional behavioral analysis of targeted behaviors
	Positive behavioral supports
	PRN information for behavioral modification (if applicable)
	Protocol for documenting observed targeted behaviors
	Replacement behaviors
	Review protocol
	Therapeutic actions/interventions

Restrictions (check all that apply)

	Communication		Community		Mechanical
	Possessions		Privacy		Physical

Comments

Upload the following behavior plan documents:

Plan of Care Worksheet for EMWS

Service Authorization

Services Table (Link to Service Page) Similar to the Preapproval form!

Participant Name:		**Approved Budget (IBA):** $	
☐**Annual Plan of Care**	**Plan Start Date**:	**Waiver:** ☐Supports Waiver ☐Comprehensive Waiver	
☐**Modification of an Approved Plan**	**Modification Effective Date:**		

Right click & choose "update field" to enable the calculation

Service Code & Name	Provider Name & NPI Number (9-10 Digits)	Goal for this service	Total Units (12 Months)	Service Rate (Dollars Per Unit)	Total Cost (For 12 Months)	*(Mod)* Units up	down
					$ 0.00	☐	☐
					$ 0.00	☐	☐
					$ 0.00	☐	☐
					$ 0.00	☐	☐
					$ 0.00	☐	☐
					$ 0.00	☐	☐
					$ 0.00	☐	☐
Proposed services under Self-Direction:				***Subtotal $***	$0.00		
		Amount Proposed to Self-Direct			$		
				Total $	$0.00		

Note: If additional Services apply, please continue on the back of this worksheet or print additional pages.

Verification Participant Guardian Verification (click here for the most recent version of this form)

The Participant or Guardian shall verify the following:

1. I have been present, encouraged, and involved at every possible level during the development of my plan of care and acknowledge my responsibilities as a waiver participant.

   ☐Yes ☐No

2. The plan of care that has been developed meets my assessed needs and goals.

   ☐Yes ☐No

3. The limitations in my rights and the restoration plan have been explained to me along with my responsibilities.

   ☐Yes ☐No

4. I agree with the rights limitations in this plan.

   ☐Yes ☐No ☐N/A

5. I understand how my rights limitations could be reduced or removed over time.

   ☐Yes ☐No ☐N/A

6. I have been informed of my right to be free from abuse, neglect, and exploitation, and have received information on how to identify and report these issues.

   ☐Yes ☐No

7. I have reviewed the waiver services available, and have made an informed choice about my services.

   ☐Yes ☐No

8. I know that home and community based services are voluntary. I understand I can contact my case manager to review possible changes to my providers. For this plan, I have reviewed the provider list and made an informed choice about my providers.

   ☐Yes ☐No

9. I have been informed of my rights to an Administrative Hearing if I am denied a provider, services, or eligibility to the waiver.

   ☐Yes ☐No

10. I consent to allow participant in Division sponsored quality assurance surveys, such as the National Core Indicators project, in order for the Division to collect and analyze data on service quality, choice, and participant satisfaction.

    ☐Yes ☐No

    Comments: _____

    _____

_____ _____

Participant Signature Date Legally Authorized Representative Signature Date

Relative Provider Disclosure *(Click here for the most updated version of this form)*

If a provider or an employee on the plan is related to the participant, complete the following:

☐	As a case manager, I am related to the participant.

If either is checked, upload this Relative Provider Disclosure form file:

Team Signature and Verification

Upload this Team Signature and Verification form file after signed and acknowledged by all parties:

Provider Acknowledgements

Provider Verification. Each Provider on the plan shall review and sign this form in the space provided to acknowledge their agreement to all of the statements below. A copy of this agreement shall be distributed to all team members by the case manager when the plan is approved. If the plan is modified and a provider's units are changed, then this form shall be signed by the provider before the modification is submitted to the Division to verify agreement to the change on the plan.

Service Documentation. The provider(s) shall be responsible for developing the schedule or form to document the provision of services in accordance with the documentation requirements listed in Wyoming Medicaid Rules Chapter 45, Section 25. As of June 1, 2011, the schedule or tracking form is no longer submitted to the Division for approval before being used.

Objectives. Habilitation services shall provide routine learning opportunities for the participant with meaningful and measurable objectives. The objectives shall align with the person's assessed needs, personal goals, and be developed in accordance with the Documentation Standards, Objective and Schedule requirements in Wyoming Medicaid Rules Chapter 45.

Service reporting and responsibility of providers. Providers shall keep a detailed record of services rendered, reporting services provided, and reporting objective progress to the case manager by the 10th business day of the next calendar month.

Team Participation. I have participated in the development of this plan, either by submitting service summaries and/or by attending the team meeting.

Relative Disclosure. Any provider who is related to the participant shall disclose their relationship prior to service authorization.

Plan Approval. I understand that the Division has final approval of the plan, and if there are changes to the plan during the approval process, the case manager will notify all team members. I agree to implement the plan of care as approved by the Division.

This page can be uploaded as the former "signature page"

Team Signature and Verification of Acknowledgements *(click here for the most up to date version of this form)*

Signature of Approval	Printed Name / Organization	Signature Date	Related to participant	Relationship / Service Provided
			☐	**Participant**
			☐	**Guardian**
			☐	**Case Manager**
			☐	
			☐	
			☐	

			☐	