Participant Name:	**Case Manager:**		**CM Phone #:**
☐**Annual Plan of Care**	**Plan Start Date**:	**Agency Name:**	
☐**Modification of a Plan**	**Mod Effective Date:**		

Service Code & Type	**Provider Number (9-10 Digits)**	**Provider Name**	**Total Units** (12 Months)	**Service Rate** ($ Per Unit)	**Total Cost** (12 Months)	***(Mod)* Units** up	down
				$	$	☐	☐
				$	$	☐	☐
				$	$	☐	☐
				$	$	☐	☐
				$	$	☐	☐
				$	$	☐	☐
				$	$	☐	☐
				$	$	☐	☐
				$	$	☐	☐
					Subtotal	$	
Proposed services under Self-Direction:				**Proposed Participant-Direction budget (FMS)**	$		
					Total	$	

Service reporting and responsibility of providers. Providers shall keep a detailed record of services rendered, reporting services provided, and reporting objective progress for review each calendar month.

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

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

Signature of Approval	**Printed Name / Organization**	**Signature Date**	**Related to participant**	**Relationship / Service Provided**
			☐	Participant
			☐	Legally authorized representative
			☐	Case manager
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	
			☐	