ALABAMA MEDICAID AGENCY LONG TERM CARE DIVISION

HCBS Waiver Plan of Care

Check if **MRW** ____ **or LAH**____ **ICAP Service Score** _____

Begin_____ End_____ Initial/Redet. Plan____ / Revision Num. ____ _____/_____/_____

This plan of care covers the period of: Check if Initial/Redet. Plan or Enter Revision # Date of Plan Meeting

_____ _____/_____/_____ _____

Participant Name Participant Social Security Number Participant Medicaid Number

_____

Participant Address: Street City State Abbr. Zip County

Year First Eligible for Waiver _____ MRW _____ LAH _____

In the first column below, enter "A" if adding service after initial plan; "T" if stopping a service. In Frequency, enter units per period of time: Per options are **calday**, **busday**, **week**, **mon**, **qtr**, **year**. Units for TCM or non- Medicaid services can include "As Needed." For Fund Source, the codes are: 1 = Waiver, 2 = Medicaid Regular, 3 = Medicaid EPSDT, 4 = Other

Act Code	Provider	Service	Frequency Units / Per ____		Service Start Date	Service End Date	Fund Source

FREE CHOICE TO PARTICIPATE IN THE HOME AND COMMUNITY BASED WAIVER PROGRAM

I elect to participate or continue to participate in the Home and Community Based Waiver Program as an alternative to placement in an ICF/MR facility (Intermediate Care Facility for persons with Mental Retardation). I understand that I may withdraw from the Waiver Program at any time and that my participation in the Waiver Program will not restrict any request for ICF/MR placement I may wish to make in the future.

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Witness **Date**

Signature of Others/Team Members:

_____ (_____)_____

Signature of Case manager Phone Number Date

_____ _____

Signature of Program QMRP Which Program? Day or Residential? Date

_____ _____

Signature Title/Relationship Date

_____ _____

Signature Title/Relationship Date

_____ _____

Signature Title/Relationship Date

Date of Case manager Review:					
Initials:					