Department of Medical Assistance Services
Individual and Family with Developmental Disabilities Support Waiver (IFDDS) Waiver
Plan of Care

☐ Initial/Wait list ☐ Enrollment ☐ Annual ☐ Revision ☐ Interruption ☐ Transfer ☐ Termination

POC Start Date: _____

Last Name	First Name	M.	POC End Date:

Medicaid Number	Social Security Number	DOB (mm/dd/yyyy)

Provider Name

Provider NPI/API Number

Provider Phone Number

Provider Fax Number

Current Living Arrangement:
- ☐ Resident of State Training Center
- ☐ Applicant to state or community ICR/MR
- ☐ Resident of state MH hospital
- ☐ Resident of community ICF/MR
- ☐ Living in community at risk of ICF/MR placement
- ☐ Living in Sponsored or Congregate Home
- ☐ Currently lives with

Name

Relationship

Waiver Services Requested	**Annual Hrs Requested (Enter total number of hours requested for plan of care year)**	**DMAS Function Only: Status of Requested Services**
☐ Adult Companion Care		
☐ CD – Attendant Care		
☐ CD – Companion Care		
☐ CD - Respite		
Crisis Stabilization		
☐ Intervention		
☐ Supervision		
Day support		
☐ Regular Intensity, Center Based		
☐ Regular Intensity, Community Based		
☐ High Intensity, Center Based		
☐ High Intensity, Community Based		
Prevocational Services		
☐ Regular Intensity		
☐ High Intensity		
☐ Family Caregiver Training		
☐ Personal Care		

Individual's Name _____ Medicaid ID _____

Personal Emergency Response System		
□ PERS Installation		
□ PERS and Med Monitoring Installation		
□ PERS Monitoring		
□ PERS and Med Monitoring		
□ PERS Nursing Service RN		
□ PERS Nursing Service LPN		
□ Respite Care		
□ In-Home Residential Supports		
Skilled Nursing		
□ RN		
□ LPN		
Supported Employment		
□ Enclave		
□ Individual		
Therapeutic Consultation		
□ Social Work		
□ Psychological		
□ Physical		
□ Speech		
□ Occupational		
□ Therapeutic Recreation		
□ Rehabilitation		
□ Psychiatry		
□ Psychiatry Clinical Nursing		
□ Behavioral		
MFP		
□ MFP Transition Service		
AT/EM	**Enter items requested and total cost from quote**	
□ Assistive Technology		
□ Environmental Modifications		

Individual's Name _____ Medicaid ID _____

The individual or parent/guardian has been given the choice between institutional care and DD Waiver services, has signed the "Documentation of Individual Choice" form, and has selected DD waiver. Signing this form, I certify that the above information is accurate, complete and maintained in the individual's record.

Individual/Guardian Signature	Case Manager Signature
Date	Date

FOR CASE MANAGEMENT TRANSFERS ONLY

Case Manager has reviewed current Plan of Care with individual/guardian and individual/guardian agrees that services and goals will continue as originally implemented.

Individual/Guardian Signature	Case Manager Signature
Date	Date

When a denial and/ or reduction of services is issued on the Plan of Care, the case manager must provide the waiver individual/ primary caregiver at the time of denial/reduction with written notification of 30 days of appeal rights.