

**APPENDIX E - PLAN OF CARE**

**APPENDIX E-1**

a. PLAN OF CARE DEVELOPMENT

1. The following individuals are responsible for the preparation of the plans of care:

- Registered nurse, licensed to practice in the State
- Licensed practical or vocational nurse, acting within the scope of practice under State law
- Physician (M.D. or D.O.) licensed to practice in the State
- Social Worker (qualifications attached to this Appendix)
- Targeted Service Manager
- Other (specify):  
County MH/MR Program

2. Copies of written plans of care will be maintained for a minimum period of 3 years. Specify each location where copies of the plans of care will be maintained.

- At the Medicaid agency central office
- At the Medicaid agency county/regional offices
- By Targeted Service Manager
- By the agency specified in Appendix A
- By consumers
- Other (specify):  
County MH/MR Program

STATE: \_\_\_\_\_

DATE: \_\_\_\_\_

1. The plan of care is the fundamental tool by which the State will ensure the health and welfare of the individuals served under this waiver. As such, it will be subject to periodic review and update. These reviews will take place to determine the appropriateness and adequacy of the services, and to ensure that the services furnished are consistent with the nature and severity of the individual's disability. The minimum schedule under which these reviews will occur is:

Every 3 months

Every 6 months

Every 12 months

Other (specify):

**X All person/family-directed support must be approved by the County MH/MR Program, as part of a person/family-directed support plan (P/FDSP), with the State retaining final administrative authority. The County MH/MR Program is responsible to ensure that the process of P/FDSP development and implementation follow person-centered planning principles established in the Department's agreement with the County, and that voluntary supports of family and friends are fully utilized, along with generic community resources. Waiver and non-waiver funded home and community services and supports the individual needs, together with informal and generic supports and safeguards necessary to assure the person's health and safety in the community, are included as part of the P/FDSP. Person/family-directed support shall be directed to assure that each person is able to live where and with whom they want, with the home and community-based support they need.**

STATE: \_\_\_\_\_

-50-

DATE: \_\_\_\_\_

## APPENDIX E-2

### a. MEDICAID AGENCY APPROVAL

The following is a description of the process by which the P/FDSP is made subject to the approval of the Medicaid agency:

The County MH/MR Program, as the agent of the Department, is responsible for approval of the P/FDSP by its authorization of home and community services. The Office of Mental Retardation, which is part of the Medicaid agency, retains final administrative authority for approval of the P/FDSP. The Regional Office of Mental Retardation also conducts periodic reviews of County MH/MR Programs which include review of the P/FDSP.

### b. STATUTORY REQUIREMENTS AND COPY OF PLAN OF CARE

1. The P/FDSP will contain, at a minimum, the type of services to be furnished, the amount, the frequency and duration of each service, and the provider which furnishes each service.
2. A copy of the P/FDSP form to be utilized in this waiver is attached to this Appendix.

STATE: \_\_\_\_\_

-51-

DATE: \_\_\_\_\_

VERSION 06-95