_____ **TREATMENT PLAN**

(Provider Name)

The Treatment Plan Template is a resource for DD Waiver Providers to utilize for authorization submission. Providers have the option to use their own Treatment Plan forms, provided that the requirements needed for review are still met.

Member Name: _____

(last) (first)

Member Number: _____ Date of Birth: _____

Plan of Care Begin Date: _____ Plan of Care End Date: _____

1) Summary of participant's progress, regression, maintenance for each service objective from prior to current year. Include objective for any new services not provided in the prior year (explain):

   A) Supportive Living: _____

   _____

   _____

   _____

   _____

   B) Respite Care: _____

   _____

   _____

   _____

   _____

   C) Supported Employment: _____

   _____

   _____

   _____

_____

D) Adaptive Equipment: _____

_____

_____

_____

_____

E) Emergency Response System: _____

_____

_____

_____

_____

F) Environmental Modifications: _____

_____

_____

_____

_____

G) Specialized Medical Supplies: _____

_____

_____

_____

_____

H) Supplemental Support: _____

_____

_____

_____

_____

I) Community Transition Services: _____

_____

_____

_____

_____

J) Service Coordination: _____

_____

_____

_____

_____

K) Transitional Case Management: _____

_____

_____

_____

_____

L) Consultation (Specify types): _____

_____

_____

_____

_____

M) Crisis Intervention: _____

_____

_____

_____

_____

2) Participant Input and Safeguards:

A) Participant input related to service needs including schedules and staffing (please include plan):

_____

_____

_____

_____

B) Participant satisfaction with current services:

_____

_____

_____

_____

C) Medication management plan in place for all medications? Yes ☐ No ☐

If no, when will plan be in place? _____

D) Positive Behavior Plan in place for any psychotropic prescribed for behavior? Yes ☐ No ☐

If no, when will plan be in place? _____

Progress of plans effectiveness: _____

E) Specify back up/support plan for service delivery in the event of natural emergencies such as fire, flood, power failure, earthquake, tornado, ice storm, etc; as well as, loss of non-paid and/or paid caregivers or loss of home:

_____

_____

_____

_____

F) Assurance of health and safety of person, person's caregivers, workers and others (Identify any known risks, such as, aggression, elopement, aging primary caregivers, drug/alcohol abuse, criminal history, gait hazard, medical conditions, overly friendly with strangers, etc.) Specify preventive and follow up measures if risks are exhibited:

_____

_____

_____

_____

3) Justification for add/revision of new plan:

A) Justification for services requested including amount (units and dollars) of service:

a) Supportive Living:

_____

_____

_____

_____

b) Respite Care:

c) Supported Employment:

d.) Adaptive Equipment:

e.) Emergency Response System:

f.) Environmental Modifications:

g.) Specialized Medical Supplies:

h.) Supplemental Support:

i.) Community Transition Services:

j.) Service Coordination:

k.) Transitional Case Management:

_____

_____

_____

_____

l.) Consultation (Specify types):

_____

_____

_____

_____

m.) Crisis Intervention:

_____

_____

_____

_____

B) Explanation of any increase/decrease services from prior to current year:

a) Explanation if there is a request for more services:

_____

_____

_____

_____

b) Explanation if there is a request for fewer services:

_____

_____

_____

_____

C) Explanation for any new services requested:

_____

_____

_____

_____

D) Explanation of how transportation is used (must be non-medical), miles used in current plan, explanation and justification of how miles will be used, changes requested, and progress toward outcome:

a) Explanation if there is a request for more miles:

_____

_____

_____

_____

E) Is Direct Care staff related to waiver participant? Yes ☐ No ☐

If yes, please state relationship. _____

TREATMENT PLAN

Member's Goals (Must be specific, measurable, achievable, relevant and time bound)	Activities (How goals will be met)	Target Date	Identify the Service Provider	Expected Outcomes (Specify any Service Barriers)

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TREATMENT PLAN

Member's Goals (Must be specific, measurable, achievable, relevant and time bound)	Activities (How goals will be met)	Target Date	Identify the Service Provider	Expected Outcomes (Specify any Service Barriers)

a. Service Coordinator/ Direct Care Supervisor Name _____

b. Date: _____

c. Service Coordinator Phone Number: _____ Ext. _____

d. Service Coordinator E-Mail Address: _____

e. Service Coordinator Fax Number: _____

Physician LEVEL OF CARE CERTIFICATION/ Prescription			
A. DIAGNOSIS: (Please check all that apply):			
☐ Intellectual Disability ☐ Cerebral Palsy ☐ Epilepsy ☐ Autism	☐ Medical Diagnosis (if applicable) _____ _____ _____ _____ _____ _____	Mental Illness (explain) _____ _____ _____ _____ _____ _____ _____	Other (explain) _____ _____ _____ _____ _____ _____ _____
B. PROGNOSIS:			
C. SPECIAL ORDERS:			
D. MEDICATION: Is any psychotropic medication used for behavior? ☐ Yes ☐ No			
E. I have examined the patient within the past 30 days, and I have reviewed the Plan of Care (check one). ☐ I certify the waiver services and level of care listed in the plan. ☐ I disagree with the CES services an care listed in the treatment plan. ☐ I disagree with the following service(s) listed in the plan:			
Physician's Name (Printed):	Address:	Telephone:	
Physician's Signature:	Date:		