



Individual Service Plan

Waiver Type:

Member's Name		SID #
Original Service Plan Date	Updated	Termination Summary Date

Assessment	Date of Home Visit
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INTRODUCTION:

Name:	DOB:
Address:	
Phone number:	Marital status:
Resides with:	Employment:
Income:	Source:
Insurance:	Drives: <input type="checkbox"/> Yes <input type="checkbox"/> No
Interpreter needed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: Phone #:
POA: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: Phone #:
Emergency contact: Name:	Phone #:

MEDICAL INFORMATION:

Diagnosis:	
Physicians/Providers	How Often Seen

Medications:
Who sets up: Self: <input type="checkbox"/> Other: <input type="checkbox"/>
Comment:
Hospitalizations since last service plan:
Critical incidents since last service plan:
Have you had any recent injuries due to your medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Explain:

LEVEL OF CARE:

Date of last LOC certification:	LOC determined:
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HEALTH STATUS/ADLS:

Assistance required:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Dressing:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Bathing:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Meals:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Feeding self:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Toileting:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Transfers:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Minor wound care:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Finances/scheduling:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:
Transportation:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain:

Medication management:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain:
Housekeeping:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain:
Laundry:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain:
Communication:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain:
Shopping:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain:
Assistive devices:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, explain:

ADDITIONAL COMMENTS:

Please use this section for any additional information that is pertinent to the care of this member that is not stated elsewhere.

Comments:

TEAM COMMUNICATION:

All services were mutually agreed upon by all parties. Service worker will communicate eligibility/activation of specific services as well as any modifications to the service plan with all parties and providers.

1.	Goal:		
	Objective:		
	Action Steps	Start Date	Complete Date
2.	Goal:		
	Objective:		
	Action Steps	Start Date	Complete Date
3.	Goal:		
	Objective:		
	Action Steps	Start Date	Complete Date
4.	Goal:		
	Objective:		
	Action Steps	Start Date	Complete Date
5.	Goal:		
	Objective:		
	Action Steps	Start Date	Complete Date
6.	Goal:		
	Objective:		
	Action Steps	Start Date	Complete Date

SAFETY AND CRISIS PLAN:

Phone available at all times:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Capable of contacting 911:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Caretakers capable of assisting:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Knows what to do in case of a fire, tornado, earthquake, or other natural emergency:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Capable of getting out of the home unassisted:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Home is handicapped accessible:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Barriers during emergency situations:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Explain:		

Service (formal and informal)	Funding Source	Name of Provider and Number (any pay source):	Service Frequency (units, days per month)	Rate	Service Effective Dates Where Applicable
					From: To:

Natural supports:

Responsibilities

Provider Agency:

Member and Family:

Department of Human Services:

Reassessment/Termination

Annual Level of Care to be determined by Iowa Medicaid Enterprise in correspondence with the member's medical team and the Department of Human Services.

Signatures

I certify that the above information is true and correct to the best of my knowledge.

Worker's Name	Supervisor's Name	
Worker's Signature		Date
Supervisor's Signature		Date

Please check: I agree I disagree

Member's Signature	Date
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