DPHHS SLTC: 170 06.2014

State of Montana Department of Health and Human Services

AB-CFC/ABPAS SERVICE PLAN

☐ Intake ☐ Annual ☐ Amendment ☐ Temporary Authorization ☐ High Risk ☐ Other					
MPQH Profile Date Span: MPQH Total Profile Bi-Weekly Units (15 Minutes = 1 Unit):					
SERVICE PLAN SCHEDULE Consumer Name:				Medicaid ID Number:	
AM/PM	ADL Tasks	Frequency Week One	Frequency	Week Two	Comments
					+
AM/PM	IADL Tasks	Frequency Week One	Frequency	Week Two	Comments
AM/PM	Skill Acquisition	Frequency Week One	Frequency	Week Two	Comments
Total ADL (Jnits:	Total IADL Units:	Total Skill	Acquisition Units:	Total Bi-Weekly Units:
COMMENTS AND COPERAL INCORPORAÇÃO COPUMOS SU ANTIGODOS					
COMMENTS AND SPECIAL INSTRUCTIONS FOR SERVICE PLAN IMPLEMENTATION:					
ACTION PLAN (Utilized when consumer preferences cannot be met. Indicate agency plan and associated time line to address the situation)					
TEMPORARY AUTHORIZATION/AMENDMENT ☐ Change In Condition ☐ Change In Task ☐ Change In Task Frequency ☐ High Risk ☐ Addition Of Skills Acquisition					
DESCRIBE ADL/IADL CHANGE: ☐ Short Term ☐ Permanent					
DESCRIPTION DESCRIPTION DE CHIMINENC					
TEMPODAD	V ALITHODIZATION Chart	Date: End Da	+	Total Time:	Date Faxed to MPQH:
TEIVIPORAK	Y AUTHORIZATION Start	Date: End Da	te:	rotal rime:	Date Faxed to MPQH.
CONSUMER My Plan Addresses My Personal Assistance Needs, Including Health And Welfare.					
CONSUMER	SIGNATURE		DATE	☐ Concur	☐ Do Not Concur
CONSONIEN	Sidil Wilding		5,112	Concur	2 bo Not coned.
PROVIDERS					
☐ This Service Plan Does Not Require Completion Of A Risk Negotiation Form ☐ I Agree with the Amendment Request					
AB PROVIDE	ER SIGNATURE AG	GENCY	DAT	E ☐ Concur	☐ Do Not Concur
DI AN EACH I	TATOR SIGNATURE AG	ENCY	DAT	F Concur	☐ Do Not Concur
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Distribution: Consumer, PAS/CFC Provider, Plan Facilitator					