DPHHS: SLTC 170
06.2014

State of Montana
Department of Health and Human Services

SD-CFC/SDPAS 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	HMA 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/HMA Units	Total IADL Units	Total Skill Acquisition Units	Total Bi-Weekly Units

COMMENTS AND SPECIAL INSTRUCTIONS FOR SERVICE PLAN IMPLEMENTATION:

TEMPORARY AUTHORIZATION/AMENDMENT ☐ Change In Condition ☐ Change In Task ☐ Change In Task Frequency ☐ High Risk ☐ Addition Of Skills Acquisition

Describe ADL/IADL/HMA Change ☐ Short Term ☐ Permanent

TEMPORARY AUTHORIZATION Start Date: End Date: Total Time: Date Faxed To MPQH:

CONSUMER My Plan Addresses My Personal Assistance Needs, Including Health And Welfare.

CONSUMER/PERSONAL REPRESENTATIVE	**DATE**	☐ Concur ☐ Do Not Concur

PROVIDERS

☐ This Service Plan Does Not Require Completion Of A Risk Negotiation Form ☐ I Agree With The Amendment Request

SD PROVIDER SIGNATURE	**AGENCY**	**DATE**	☐ Concur ☐ Do Not Concur
PLAN FACILITATOR SIGNATURE	**AGENCY**	**DATE**	☐ Concur ☐ Do Not Concur

Distribution: Consumer/PR, PAS/CFC Provider, Plan Facilitator