Provisional Plan of Care

Name of person receiving services:
Medicaid #:
Case Manager Name:
Funding: ☐ HCBS Child ☐ HCBS Adult ☐ CTS ☐ Aux
Is this an enhanced rate? Yes ☐ No ☐
Is the participant transitioning from an ICF? Yes ☐ No ☐

Case Management Provider:
Start Date:

Community Support Provider:
Start Date:

Residential Services (address is required even if residential supports are not provided)
Funding: **Ownership:**
Room and Board Funding:

Street Address:
County:
Type of Residential service: Choose an item.
What is the capacity? Is this a new residential setting? ☐Yes ☐No
Does this create a capacity change in new address: ☐Yes ☐No If yes, please describe and attach names of all people affected by change:
Start date:

Day Hours (Segregated)
Category: Choose an item.
Non Paid Activities Choose an item.
Paid Employment: Choose an item.
Funding: Choose an item.

Number of non-paid hours :
Number of paid hours
Total number of hours:
Wage per hour:
Start Date:

Supported Employment
Category: Choose an item.
Setting: Choose an item.
Type of Paid Employment: Choose an item.
Wage Payer: Choose an item.
Funding: Choose an item.

Number of hours:
Wage per hour:
Start Date:

Prevocational
Type of Paid Employment: Choose an item.
Funding: Choose an item.

Number of non-paid hours :
Number of paid hours
Total number of hours:
Wage per hour:
Start Date:

Other Services
Funding:

☐ Speech, Hearing & Language	☐ Medical Equipment and Drugs	☐ Other Medical
Start Date:	Start Date:	Start Date:

SCR APPROVAL

New CSP: ____ ______________

Signature/ Title **Date**

New CM: ____ ______________

Signature/ Title **Date**