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TEXAS Health and Human Services

Form 3608
May 2022-E

Home and Community-based Services (HCS) and Community First Choice (CFC) Services

Individual Plan of Care (IPC)

Individual Name *(Last, First, MI)*	Medicaid No.	IPC Begin Date	IPC End Date	IPC Effective Date
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Address *(Street, City, State, ZIP Code)*		**Date of Birth**	**Age**	**Level of Need**
Iusto rerum nemo doloribus ipsum		Doloremque et [illegible]	[illegible]	Culpa ratione nec [illegible]
Client Assignment and Registration (CARE) ID No.	**Program Provider**	**Program Provider Component Code**	**Program Provider Contract No.**	
Incidunt optio minim repellendus	Nihil quia saepe nesciunt [illegible]	[illegible]	[illegible]	
Financial Management Services Agency (FMSA)	**FMSA Component Code**	**FMSA Contract No.**	**Residential Type**	
August, 18 2022			◯ Host Home/Companion Care ◯ Own Home/Family Home ◯ Supervised Living ◯ Residential Support Services	
Location Code	**County of Service**			
koderlabs koderlabs, koderlabs soicansc jascljk new york, NY 52000				

IPC Type

Check the IPC type that describes the reason for completing Form 3608.

- ☐ Initial (Enrollment) – IPC Meeting Required
- ☐ Renewal – IPC Meeting Required
- ☐ Transfer: Contract/Service Delivery Option – IPC Meeting Required
- ☐ Revision to Reflect Person-Directed Plan (PDP) Change – IPC Meeting Required koderlabs
  - ☐ Meets Emergency Criteria §9.166(d) *(Check this box if revision is due to an emergency.)*
- ☐ Revision to add/change requisition fee only – No IPC meeting is required.
- ☐ Revision to change support management – No IPC meeting is required, but all parties must sign the IPC.
- ☐ Revision to increase/decrease an existing Home and Community-based Services (HCS) or Community First Choice (CFC) service. This option may not be used if the increase or decrease requires a new outcome, because the Service Planning Team and provider must meet to revise the PDP. The IPC effective date for an IPC increase/decrease must be on or after the date the provider notified the service coordinator (SC) in writing of the need to increase or decrease a current HCS or CFC service.

Non-HCS/CFC Services Provided by Family and Other Funding Sources

Type of Service	Funding Source	No. of Hours Per Day	No. of Days Per Week	Name of Provider
12				20
				12
	12	1		1

Individual Name *(Last, First, MI)*	Medicaid No.	IPC Begin Date	IPC End Date	IPC Effective Date

HCS Services

* Indicate need to increase or decrease an existing HCS service by entering an **I (increase)** or **D (decrease)**.

Provider Service	I/D*	Authorized Units	Provider Service	I/D*	Authorized Units
Adaptive Aids (15)			Nursing - Specialized RN (13C)		
Adaptive Aids - Requisition Fee (41)			Occupational Therapy (7)		
Audiology (35)			Physical Therapy (8)		
Behavioral Support (43A)			Pre-enrollment MHM Assessment (16A)		
Cognitive Rehabilitation Therapy (61)			Residential Support Services (46)		
Day Habilitation (10C)			Pre-enrollment MHM (16B)		
Dental (5A)			Pre-enrollment MHM Requisition Fee (41BA)		
Dental Requisition Fee (41E)			Respite Hourly (11X))		
Dietary (34)			Social Work (36)		
Employment Assistance (54)			Speech/Language Pathology (9)		
Host Home/Companion Care (18A)			Supervised Living (47)		
Minor Home Modifications (16)			Supported Employment (37)		
Minor Home Modifications - Requisition Fee (41B)			Transition Assistance Services (53)		
Nursing - LVN (13A)			Transition Assistance Services Fee (53A)		
Nursing - Specialized LVN (13D)			Transportation SHL(48)		
Nursing - RN (13B)					

Consumer Directed Service (CDS)	I/D*	Authorized Units
Cognitive Rehabilitation Therapy (61V)		
Employment Assistance (54V)		
Financial Management Services (FMS) Monthly Fee (63V)		
Nursing - LVN (13AV)		
Nursing - Specialized LVN (13DV)		
Nursing - RN (13BV)		
Nursing - Specialized RN (13CV)		
Respite Hourly (11XV)		
Support Consultation (57V)		
Supported Employment (37V)		
Supported Home Living (58V)		
Transportation SHL(48V)		

If the individual is receiving nursing services from both an HCS provider and through the CDS option, indicate below the nursing services delivered by the HCS provider.

Provider Service	I/D*	Authorized Units
Nursing - LVN Other (13A)		
Nursing - Specialized LVN Other (13D)		
Nursing - RN Other (13B)		
Nursing - Specialized RN Other (13C)		

Are any services staffed by a relative or guardian? ◯ **Yes** ◯ **No**

Are any services determined as critical, requiring a service back-up plan? ◯ **Yes** ◯ **No**

CFC Services

* Indicate the need to increase or decrease an existing CFC service by entering **I (increase)** or **D (decrease).**

CFC Provider Service	I/D*	Authorized Units	CFC CDS Service	I/D*	Authorized Units
Personal Assistance Services/Habilitation (10CFC)			Personal Assistance Services/Habilitation (10CFV)		
Emergency Response Services (20CFC)			CFC Financial Management Services (63CFV) Monthly Fee		
Total CFC Provider Services			CFC Support Consultation (57CFV)		
			Total CFC CDS Services		

Service Coordinator Response

For proposed service increase/decrease IPC revisions:

Return this form to the provider within two business days after the provider submits this notification of needed change to the SC.

◯ SC agrees with the IPC revision. No IPC meeting is required.

◯ IPC meeting is needed.*

Reason:

* Before checking this box, the SC contacts the provider and discusses any questions or concerns regarding the requested revisions. After the discussion, if the SC determines that an IPC meeting is needed, the SC checks the "IPC meeting is needed" box, includes the reason for the meeting, signs, prints name and returns this form to the program provider. The SC then schedules a meeting to occur with the individual/LAR and the program provider as soon as possible but no later than 14 calendar days.

Printed Name _____ **Signature – Service Coordinator** _____

For certifications completed during enrollment and renewals:

Check applicable option below.

☐ Individual/LAR was informed upon enrollment of the individual's rights and responsibilities.

☐ Individual/LAR was informed upon enrollment of the process for filing a complaint and reporting allegation of abuse, neglect or exploitation.

☐ Individual/LAR has been informed upon enrollment and annually of the individual's option to transfer to other program providers as chosen by the individual as often as desired.

Individual Name *(Last, First, MI)*	Medicaid No.	IPC Begin Date	IPC End Date	IPC Effective Date

Service Planning Team: By signing below, you indicate your agreement that the HCS/CFC services for this individual are necessary to protect the individual's health and welfare in the state plan, other governmental programs, private insurance or the individual's natural supports; are the most appropriate type and amount to meet the individual's needs; are cost effective; and are necessary to enable community integration and maximize independence.

HCS Program/CFC Provider/Individual/Legally Authorized Representative (LAR) Signature

Printed Name | **Signature – Provider Representative** | **Date**

Printed Name | **Signature – Individual/LAR** | **Date**

☐ **Individual/LAR participated by phone on:** **Date**

(1) If the individual/LAR participates in person and agrees with the IPC, the **individual/LAR** signs, prints his name and enters the date of the IPC meeting. If the agreement is obtained by phone, the **provider** checks the box and enters the date of agreement. The provider then sends a copy of the form to the individual/LAR for signature.

(2) For an IPC revision that adds/changes a requisition fee only, the **provider** enters “requisition fee only” in the individual’s signature line and enters the IPC effective date as the signature date.

(3) For an IPC revision that documents a change in support management, the program **provider** obtains the **individual's LAR's** signature and indicates the date on the form when support management is changed. A copy of the form is faxed to the SC for signature. The effective date of the IPC remains the same and this change is not entered into the HHSC data system.

HHSC Review and Authorization *(if required)*

Signature – HHSC Authorized Representative | **Date**

Local Authority/Service Coordinator (SC) Signature

Local Authority Name:

(1) When the SC participates in the IPC meeting in person, the **SC** signs, prints his name and enters the date (on the signature line above) on the day of the meeting.

(2) When the SC participates in the IPC meeting by phone, the **provider** writes “participated by phone” on the SC signature line, prints the SC’s name and enters the date of the meeting.

(3) For an IPC revision that increases/decreases an existing HCS/CFC service and does not require an IPC meeting, the **provider** writes “notified SC” on the SC signature line, prints the SC’s name and enters the date this form was submitted to the SC. (Submission of this form to the SC serves as notification of an IPC revision that does not require an IPC meeting.)

(4) For an IPC revision that adds/changes a requisition fee only, the **provider** enters “requisition fee only” in the SC signature line and enters the IPC effective date as the signature date.

Printed Name | **Signature – Service Coordinator** | **Date**