Stand-Alone Home and Community-Based Plan of Care

Case Number:	PA Number:

1. Client Name:	2. Medicaid ID#:	3. Certification Date:
4. Medical DX Problems:		
5. County:	6. Provider Number:	
7a. Primary Diagnosis Code:	7b. Primary Diagnosis Description:	
8. Personal Goal(s):		

9. Problems/Needs	10. Service Needed	11. Service Objective

12. Service			13. Frequency/Units						14. Provider Name/Phone Number	15a. Service Date	15b. Begin Date	16. End/Change Date
Waivered HCPCS/Rev Code	Type	Description	Hrs/ Day	Days/ Wk	Hrs/ Month	Visits/ Wk	Visits/ Month	Units				

17. Service			18. Frequency/Units						19. Provider Name/Phone Number	20a. Service Date	20b. Begin Date	21. End/Change Date
Non-Waivered HCPCS/Rev Code	Type	Description	Hrs/ Day	Days/ Wk	Hrs/ Month	Visits/ Wk	Visits/ Month	Units				

22. POC must be signed and dated by the client and/or caregiver:

The signature below affirms that the client/caregiver participated in the development of this Plan of Care including input and selection of services to meet the needs of the client/caregiver.

Client/Caregiver Signature:	Date Signed:

Client/Caregiver Signature:	Date Signed:

23. Quarterly reviews must be dated and initialed by both Case Managers:	
Indicate the date of last quarterly review and associated Case Managers' names:	
The Case Managers named below affirm that the client/caregiver participated in the development of this Plan of Care.	Caregiver's name if not indicated previously:
1st Case Manager's Name: 1st Case Manager's Signature:	Last Quarterly Review Date:
	Last Quarterly Review Date:
2nd Case Manager's Name: 2nd Case Manager's Signature:	Last Quarterly Review Date:
	Last Quarterly Review Date: