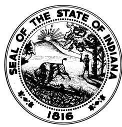

PLAN OF CARE / COST COMPARISON BUDGET FOR THE AGED AND DISABLED WAIVER

State Form 42822 (R3 / 3-96) HCBS 1D / 2D
Approved by State Board of Accounts, 1994

This state agency is requesting disclousure of your Social Security number in order to expedite processing of your Plan of Care. Disclosure is voluntary and you will not be penalized for failure to disclose SSN per IC -4-1-8.

CENTRAL OFFICE USE ONLY		
OMPP	Date	Initials
MWU	Date	Initials
Retuned	Date	Initials

☐ Initial Plan of Care ☐ Re-Entry - Previous Termination Date ______ ☐ Update Plan of Care ☐ Annual Plan of Care

Last name	First name	Middle initial
Address *(Number, street)*		
City, State, Zip code		Date of birth
Medicaid number		Medicaid eligibility date
Social Security number – –		Area agency on aging number

Level of care *(please check one)*	Level of care - current approval date	Level of care - previous approval date
☐ A ☐ B ☐ C ☐ D ☐ E ☐ F ☐ G ☐ H	Date:	Date:

Diagnosis 1 From 450B	Diagnosis 2 From 450B
START DATE WAIVER EFFECTIVE DATE:	**MEDICAID FACILITY DISCHARGE DATE:**

Recommendation

Plan of care - effective from to

A. HOME AND COMMUNITY - BASED CARE COSTS

1. Plan of care information:

a. Case management ______ (1/4 hr.) Units auth. / mo. ______ x Unit cost $ ______ = Mo. cost $ ______

b. Homemaker ______ (1 hr.) Units auth. / mo. ______ x Unit cost $ ______ = Mo. cost $ ______

c. Attendant Care / HHA / HSA - Other ______ (1 hr.) Units auth. / mo. ______ x Unit cost $ ______ = Mo. cost $ ______

/ IDDARS - ILS ______ (1/2 hr.) Units auth. / mo. ______ x Unit cost $ ______ = Mo. cost $ ______

d. Respite Care / Attendant ______ (1 hr.) Units auth. / mo. ______ x Unit cost $ ______ = Mo. cost $ ______

/ Home Health Aide ______ (1 hr.) Units auth. / mo. ______ x Unit cost $ ______ = Mo. cost $ ______

/ LPN ______ (1 hr.) Units auth. / mo. ______ x Unit cost $ ______ = Mo. cost $ ______

/ RN ______ (1 hr.) Units auth. / mo. ______ x Unit cost $ ______ = Mo. cost $ ______

/ IDDARS - ILS ______ (1/2 hr.) Units auth. / mo. ______ x Unit cost $ ______ = Mo. cost $ ______

/ Other ______ (1 hr.) Units auth. / mo. ______ x Unit cost $ ______ = Mo. cost $ ______

e. Adult Day Care ______ (1 hr.) Units auth. / mo. ______ x Unit cost $ ______ = Mo. cost $ ______

f. Meals - one (1) per day ______ (meal) Units auth. / mo. ______ x Unit cost $ ______ = Mo. cost $ ______

g. Home Mod. *(describe)* ______ Unit cost $ ______ = Mo. cost $ ______

h. Adaptive Aides and Devices 1 *(describe)* ______ Unit cost $ ______ = Mo. cost $ ______

Adaptive Aides and Devices 2 *(describe)* ______ Unit cost $ ______ = Mo. cost $ ______

Case Management Agency	**Total A.1 -** Waiver Service Costs	$
Case Manager I.D. Number (4 digits)	**Total A.2 -** Other Medicaid Cost	$
Case Manager Authorization Number (9 digits)	**Total A.5 -** Total HCBS Cost	$
	Total B.7 - Facility Cost Factor	$

Date budget was completed

2. OTHER MEDICAID SERVICES

a. Physician ____________ 3 mo. payment history $ ________ ÷ 3 = Estimated mo. cost ________
b. Pharmacy ____________ $ mo. payment history $ ________ ÷ 3 = Estimated mo. cost ________
c. Therapy ____________ $ mo. payment history $ ________ ÷ 3 = Estimated mo. cost ________
d. Lab / X - ray ____________ $ mo. payment history $ ________ ÷ 3 = Estimated mo. cost ________
e. Supplies ____________ $ mo. payment history $ ________ ÷ 3 = Estimated mo. cost ________
f. Durable medical equipment ____________ $ mo. payment history $ ________ ÷ 3 = Estimated mo. cost ________
g. Transportation ____________ $ mo. payment history $ ________ ÷ 3 = Estimated mo. cost ________
h. Other: ____________ $ mo. payment history $ ________ ÷ 3 = Estimated mo. cost ________
i. Other: ____________ $ mo. payment history $ ________ ÷ 3 = Estimated mo. cost ________
j. Other: ____________ $ mo. payment history $ ________ ÷ 3 = Estimated mo. cost ________

			Total A.2 - Other Medicaid Cost $
3. Total of lines	**A.1** $	**A.2** $	= $ **A.3**
4. Minus Recipient Spend-Down Amount			- $ **A.4**
5. Total Home and Community Care Costs			= $ **A.5**

B. NURSING FACILITY INSTITUTIONAL COSTS

1. NF / I per diem $ ________ x 30 days
or
NF /S per diem $ ________ x 30 days = $________ **B.1**

2. Other Medicaid services:

a. Physician ____________ 3 mo. payment history $ ________ ÷ 3 = Estimated mo. cost ________
b. Pharmacy ____________ $ mo. payment history $ ________ ÷ 3 = Estimated mo. cost ________
c. Lab / X - ray ____________ $ mo. payment history $ ________ ÷ 3 = Estimated mo. cost ________
d. Transportation ____________ $ mo. payment history $ ________ ÷ 3 = Estimated mo. cost ________
e. Other: ____________ $ mo. payment history $ ________ ÷ 3 = Estimated mo. cost ________
f. Other: ____________ $ mo. payment history $ ________ ÷ 3 = Estimated mo. cost ________
g. Other: ____________ $ mo. payment history $ ________ ÷ 3 = Estimated mo. cost ________

			Total B.2 - Other Medicaid Cost $
3. Total of lines	**B.1** $	**B.2** $	= $ **B.3**
4. Minus Recipient Liability Reduction			- $ **B.4**
5. Total Nursing Facility Costs			= $ **B.5**
6. Waiver Program Factor			X .90 **B.6**
7. Nursing Facility Cost Factor			= $ **B.7**

C. DOCUMENTATION OF PAYMENT HISTORY

Please document the Monthly Payment History / method used to determine costs in A.1 and B.2, (month and year).

D. COST COMPARISON DETERMINATION

1. Cost Comparison Data Indicates:

a. If line **A.5** $ _______________ is **less than** line **B.7** $ _______________, then the recipient is **eligible** for Home and Community- Based Waiver Services and must be offered the choice of Nursing Facility Instutional Care or Home and Community Based Services.

☐ Recipient is **eligible** for Home and Community-Based Waiver Services.

b. If line **A.5** $ _______________ is **greater than** line **B.7** $ _______________, then the recipient is **not eligible** for Home and Community- Based Waiver Services.

☐ Recipient **is not eligible** for Home and Community-Based Waiver Services.

E. DESCRIPTION

Please describe how the Plan of Care provides adequate coverage to ensure the health and welfare of the recipient. For Update Plan of Care, explain reasons(s) for the change(s).

F. FREEDOM OF CHOICE

A Medicaid Waiver Services case manager has explained the array of services available to meet my needs through the Medicaid Home and Community - Based Services Waiver. I have been fully informed of the services available to me in a Nursing Facility institutional settting. I understand the alternatives available and have been given the opportunity to choose between waiver services and institutional care. As long as I remain eligible for waiver services, I will continue to have the opportunity to choose between waiver services and institutional care.

1. Choice of Waiver Services:

☐ At this time, I have chosen to receive waiver services in a home and community-based setting, rather than in an institutional setting.

Signature of Recipient / Guardian	Date

2. Choice of Institutional Services:

☐ At this time, I have chosen to receive services in an institutional setting, rather than in a home and community-based setting.

Signature of Recipient / Guardian	Date

G. CHOICE OF PROVIDERS

If the receipient chooses to receive waiver services, they have the right to select any approved waiver service provider(s).

☐ I have been informed of my right ot choose any certified waiver service provider when selecting waiver service providers.

Signature of Recipient / Guardian	Date

H. EMERGENCY BACKUP PLANS

Describe how medical needs, supervision, behavior issues, etc., will be covered during an emergency.

I. NOTES

J. SIGNATURES

Signature of Case Manager	Case Manager's I.D. number	Date

K. STATE AGENCY PLAN OF CARE DETERMINATION

☐ Approved ☐ Disapproved	Signature of Authorized Waiver Unit Representative	Date