



Medically Dependent Children Program
Individual Plan of Care (IPC) Service Review

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|--|------------------------------------|---|-----------------------------------|--------------|
| Individual's Name | | Reason for Contact <input type="checkbox"/> 3/30 Day <input type="checkbox"/> ≤ 6 months | | Medicaid No. |
| Type of Individual Contact <input type="checkbox"/> Telephone <input type="checkbox"/> Face-to-Face | Date of Individual Monitor Contact | Type of Caregiver Contact <input type="checkbox"/> Telephone <input type="checkbox"/> Face-to-Face | Date of Caregiver Monitor Contact | |
| Persons Participating in the Review | | | | |

Medically Dependent Children Program (MDCP) Providers Utilized During the Review Period

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|----------------------------------|
| Respite |
| Flexible Family Support Services |
| Adaptive Aids |
| Minor Home Modifications |
| Financial Management Services |
| Transition Assistance Services |
| Employment Assistance |
| Supported Employment |

1. a. Have MDCP services been implemented and provided in accordance with the IPC? Yes No

If No, explain:

b. Have MDCP services met your needs, goals and preferences as identified in the IPC? Yes No

If No, explain:

2. a. Have third-party resources been implemented and provided in accordance with the IPC? Yes No N/A

If No, explain:

b. If yes, did the third-party resources meet your needs, goals and preferences as identified in the IPC?..... Yes No

If No, explain:

c. Have you accessed third-party resources, including health services? Yes No

If No, explain:

3. Are you satisfied with the implementation of MDCP services? Yes No

If No, explain:

4. Did the use of MDCP services and third-party resources reasonably assure the individual's health and welfare? Yes No N/A

If No, explain:

5. Have you exercised free choice of providers?..... Yes No N/A

If No, explain:

6. For services delivered by a Home and Community Support Services (HCSS) provider:

a. Has the HCSS provider had to implement the service backup plan? Yes No

b. If yes, was the backup plan effective? Yes No

If No, explain:

Consumer Directed Services (CDS) Addendum N/A

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|---|---|
| 7. MDCP services delivered through the CDS option: | 8. Employee Type(s): |
| <input type="checkbox"/> Respite | <input type="checkbox"/> Nurse <input type="checkbox"/> Attendant |
| <input type="checkbox"/> Flexible Family Support Services | <input type="checkbox"/> Nurse <input type="checkbox"/> Attendant |
| <input type="checkbox"/> Employment Assistance | |
| <input type="checkbox"/> Supported Employment | |

9. For services delivered through the CDS option:

Has the Financial Management Services Agency (FMSA) provided assistance and delivered Financial Management Services to your satisfaction? Yes No

If No, explain:

10. Were the services delivered by your employee according to the program service authorization? Yes No

If No, explain:

11. Have you had problems managing your employees?..... Yes No

If Yes, explain:

12. Did you report any problems to your FMSA? Yes No

If Yes, explain:

13. Did the CDS option meet your needs?..... Yes No

If No, explain:

14. a. Have you had to implement your backup plan?..... Yes No

If Yes, complete Item 14b. If No, skip to Item 15.

b. If yes, was the backup plan effective?..... Yes No

If No, explain:

15. Did you receive, at a minimum, a quarterly report from your FMSA?..... Yes No

If No, the case manager must follow up with the FMSA.

16. Do you understand the information on the budget you received from the FMSA? Yes No

If No, explain:

17. Are you on target with your budget? Yes No

If No, explain:

18. Did the FMSA report any concerns or problems to you?..... Yes No

If Yes, explain:

Transition Assistance Services (TAS) N/A

19. Were the services and items delivered according to the program service authorization?..... Yes No

If No, explain:

If No, the case manager must follow up with the TAS provider.

Case Manager Notes