Individual Status Summary

Individual Name		Medicaid No.	Care ID No.
Date of Birth	Region	Waiver Cost Limit	Projected Cost of Services
Waiver Program Provider Name	Waiver Program Provider Representative	Waiver Program Provider Telephone No.	
Comp Code	Contract No.	Waiver Program Provider Representative Email	
Contracted Case Manager	Contracted Case Manager Telephone No.	Contracted Case Manager Email	

Individual Health and Safety

1. What types of assistance does this individual need to complete his or her activities of daily living and who provides these services currently?
2. What services are needed that cause the service plan to exceed the cost limit for the identified waiver program and why are they necessary?
3. Does the individual have an array of services and a provider arrangement able to meet his needs, except for costs?
4. What community resources, informal supports and service options are currently available to the individual?
5. What other agency programs, community resources or service options have been explored or considered?
6. What types of alternative living arrangements have been explored?

Caregivers Status

1. What impact would requiring the primary caregiver to assume more responsibility for services have on the health and well-being of the caregiver?
2. What impact would reduced or lost employment of the primary caregiver have on the financial stability of the individual's natural support system?

Print Name _____ Signature _____ Date _____