Texas Department of Aging
and Disability Services

Form 3671-C-Alternate
June 2013-E

Community Based Alternatives

CBA Individual Service Plan – Nursing Service Plan for Consumer Directed Services (CDS) and/or Specialized Nursing or Health Maintenance Activities (HMAs)

		This Space for DADS Use Only
1. Applicant/Individual Name	2. Medicaid No.	3. Effective Date
4. DADS Case Manager		5. Provider Vendor No.

I. Grand Totals (For DADS Use Only)

A. PAS Hours and HMA (Delegated Nursing Hours)	B. HCSSA-Contracted Provider Direct Nursing Hours (SC13) ☐ SPEC (SC 13C)	C. HCSSA-Contracted Provider Mandatory Direct Nursing Hours	D. HCSSA-Contracted Provider Specialized LVN Hours (SC 13D)	E. CDS Nursing Hours (SC 13V) ☐ SPEC (13CV)	F. CDS Specialized LVN Hours (SC 13DV)

II. Nursing Tasks and Health Maintenance Activities

Important: **Column G** – Use RN column to calculate CDS hours unless Specialized Nursing hours apply, then use both, as applicable. **Column H** – Use RN column to calculate HCSSA-Contracted Provider hours unless Specialized Nursing hours apply, then use both, as applicable.

A. Nursing Tasks	**B. AFC Level**	**C. Hours per Month as Needed**	**D. Hours Delegated and HMA Hours to ☐ PAS ☐ AFC Provider**	**E. Hours Performed by Informal Support**	**F. Hours Performed by Medicare/Other**	**G. CDS Nursing Hours ☐ Specialized**		**H. Direct Nursing Performed by HCSSA Contracted Provider ☐ Specialized**	
						LVN	**RN**	**LVN**	**RN**
1. Administration of oral medications or administration of medications through permanently placed feeding tubes, SL or topically	II								
2. Feeding through permanently placed gastrostomy tube	II								
3. Sterile procedures	II								
4. Non-sterile procedures	I/II								
5. Invasive procedures	II								
6. Care of broken skin involving a wound other than minor abrasions or cuts	II								
7. Elimination	II								
8. Collecting, reporting and documenting data	I								
9. Reinforcement of health teaching planned and/or provided by RN	I								
10. Ambulation, position, turning	II								
11. Other (specify)									
12. Totals									

(THIS BLOCK FOR DADS USE ONLY) **13. 13a. 20. and 20a.** **Number of months remaining in current ISP year x**	20a.	20.	13a.	13.
(THIS BLOCK FOR DADS USE ONLY) **14. 14a. 21. and 21a.** **Subtotal =**	21a.	21.	14a.	14.
15. 15a. 22. and 22a. **For ISP changes, enter the number of Section II nursing hours already authorized from start of current ISP year through date of request for change +**	22a.	22.	15a.	15.

16.	**16. Number of nursing hours needed to develop specifications (HCSSA-Contracted Provider only)**	**17. Number of nursing hours needed to provide Orientation (HCSSA-Contracted Provider only) +**	17.
(convert hours to a dollar amount and transfer to Form 3671-1, Item 41-C, Column 20.)		**18. Number of RN hours needed to complete the annual reassessment (HCSSA-Contracted Provider only)**	18.

(THIS BLOCK FOR DADS USE ONLY) **19. 19a. 23. and 23a.** **Direct nursing hours by HCSSA-Contracted Provider CDS nurse needed this ISP year =**	23a.	23.	19a..	19.

III. Nursing Services Related to Delegation/Training

A. Delegation/Training Activities	B. Total Annual Hours Needed for Each Activity
1. Initial Delegation Activities	
2. Ongoing Delegation Activities	
3. Training of Family Members/Informal Support Providers	
4. Total Annual Hours Requested for Delegation/Training Activities	

IV. Mandatory Direct Nursing Services to be Authorized (For DADS Use Only.)

A. Hours to be Authorized by Program Requirements	B. Number of Hours Authorized
1. Ten hours to allow direct nursing provision to prevent service breaks for individuals in their own homes who have delegated nursing tasks	
2. Four hours for the HCSSA nurse to decide if tasks will be delegated to the AFC Level I or II provider	
3. Three hours for crisis intervention for all individuals except those in AFC homes run by nurses	
4. Four hours annually for an RN to perform the Semiannual Nursing Assessment for all individuals	
5. Total Number of Hours Authorized for Program Requirements	

V. Recommendations

1. Can applicant/individual be left unsupervised for up to three hours at a time? ☐ Yes ☐ No

2. RN's Recommendation for AFC and PC 3 Level ☐ Meets PC 3 ☐ Does Not Meet PC 3
☐ **Level I** ☐ **Level II** ☐ **Level III**

VI. Optional Weekly Schedules - Initial Weekly Schedule for Nursing Visits (See Form 2060-A for PAS schedule.)

Total Visits/Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Comments:

Ongoing Weekly Schedule for Nursing Visits (Complete only if there is an anticipated schedule change.)

Total Visits/Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Comments:

Ongoing Weekly Schedule for Nursing Visits (Complete only if there is an anticipated schedule change.)

Total Visits/Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Comments:

Certification by Interdisciplinary Team Members: The waiver services identified above for this applicant/individual are necessary to prevent nursing facility placement and are appropriate to meet the needs of the applicant/individual in the community.

Signature – HCSSA Nurse Assessor _____ Date _____

Signature – Applicant/Individual/Responsible Party _____ Date _____

Signature – DADS Case Manager _____ Date _____

Signature – HCSSA Representative (if required) _____ Date _____

Signature – Informal Support (if required) _____ Date _____

Signature – Informal Support (if required) _____ Date _____

☐ Applicant/individual/responsible party and HCSSA representative signatures on Form 3671-2, Individual Service Plan, at initial certification and annual redetermination.