Texas Department of Aging and Disability Services

Community Based Alternatives

Nursing Service Plan

Form 3671-C
June 2013-E

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

I. Grand Totals (Section I for DADS Use Only)

A. PAS Hours and HMA (Delegated Nursing Hours)	B. Direct Nursing Hours (SC 13)	C. Number of Program-Required Direct Nursing Hours

II. Nursing Tasks

A. Nursing Tasks and Health Maintenance Activities (HMA)	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 Hours Delegated and HMA to PAS	H. Direct Nursing Performed by HCSSA Contracted Provider
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. Number of months remaining in current ISP year x**	
(THIS BLOCK FOR DADS USE ONLY) **14. Subtotal =**	
15. For ISP changes, enter the number of Section II nursing hours already delivered/scheduled to be delivered from the start of the current ISP year through the date of request for change +	
17. Number of nursing hours needed to provide orientation +	
18. Number of RN hours needed to complete the annual reassessment +	
(THIS BLOCK FOR DADS USE ONLY) **19. Direct nursing hours by HCSSA nurse needed this ISP year =**	

	16. Number of nursing hours needed to develop specifications

(Convert hours to a dollar amount and transfer to Form 3671-1, Item 41-C, Column 20.)

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 (Section IV 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 waiver 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, Addendum to Form 2060 for Personal Assistance Services, 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 Representative _____ Date _____

Signature – HCSSA Representative (if required) _____ Date _____

Signature – Informal Support (if required) _____ Date _____

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

Signature – Informal Support (if required) _____ Date _____