

**CARE PLAN**

|  |   |   |   |
|--|---|---|---|
| PAGE ____ OF ____<br><br><b>CONSUMER:</b> _____<br><b>SOCIAL SECURITY NUMBER:</b> _____<br><b>CASE MANAGER:</b> _____<br><b>PROVIDER:</b> _____<br><b>WORKER ID:</b> _____ | <b>CARE PLAN DATE:</b><br><br>_____                 | <b>DESIRED OUTCOMES:</b><br>____ Prevent acute episode or nursing home placement. Short Term(ST), Long Term (LT)<br><br><b>PROVIDER:</b><br>Non-DOEA Funded Source: (1) Family and Friends, (2) Local Government, (3) Faith Based, (4) Other Non-profit /Association<br><br>DOEA Funded Source: (1) OAA, (2) MW, (3) ALW, (4) CCE, (5) HCE, (6) ADI, (7) SHINE, (8) Other (Specify)<br><br><b>ANTICIPATED SERVICE IMPACT ON HEALTH CONDITIONS:</b> (1) improve (2) maintain (3) decline (4) unknown | <b>DOEA-FUNDED MONTHLY CARE PLAN COST:</b><br><br><b>ANNUALIZED DOEA-FUNDED CARE PLAN COST:</b><br><br><b>NON-ANNUALIZED DOEA-FUNDED CARE PLAN COST:</b><br><br><b>CO-PAY MONTHLY AMOUNT (circle CCE or ADI):</b><br><br><b>ANNUALIZED CO-PAY AMOUNT:</b><br><br><b>ANNUALIZED NON-DOEA RESOURCE:</b><br><b>NON-ANNUALIZED NON-DOEA RESOURCE:</b><br><br>Care Plan Total: |
| <b>HEALTH CONDITIONS AND SERVICE IMPACT:</b><br>(a) _____<br>(b) _____<br>(c) _____<br>(d) _____   | <b>CARE PLAN REVIEW:</b><br>_____<br>_____<br>_____ |   |   |

| # | Date | Problems/Gaps | Service/Activity | Frequency & Duration Needed: Began (B) Ended (E) | Non-DOEA (ND) / DOEA (D) Planned | Provider: Non-DOEA (ND) DOEA (D) | Date Service: Began (B) Ended (E) Problem: Resolved (RS) Revised (RV) | Unit Cost/ Individual Purchase | Monthly Cost/ Value |
|---|------|---------------|------------------|--|----------------------------------|----------------------------------|---|--------------------------------|---------------------|
|   |      |               |                  |  |                                  |                                  |   |                                |                     |
|   |      |               |                  |  |                                  |                                  |   |                                |                     |

I have participated in developing this care plan through discussions regarding my assessed needs, and the services and service providers available to help meet those needs. I understand that the amount of assistance I receive is dependent upon my ability and preference. I understand I am entitled to a grievance review if my services are reduced, changed, or terminated. For Medicaid Waiver services, I accept the services from my choice of enrolled providers, instead of nursing home placement. I understand under Medicaid Waiver, in addition to a grievance review, I am further entitled to a fair hearing. I authorize the provider to release information concerning the services I receive under all programs to the Florida Department of Elder Affairs.

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| CONSUMER/RESPONSIBLE PARTY: | CAREGIVER: | DATE: | CASE MANAGER: | DATE: |
|-----------------------------|------------|-------|---------------|-------|