



PLAN OF CARE FOR: C.H.O.I.C.E.
 WAIVER **OTHER**
 IPAS Only **PASRR / MI** or **PASRR / DD**

State Form 45994 (R3 / 7-01) BAIS 0019
 Approved by State Board of Accounts, 2001

* THIS STATE AGENCY IS REQUIRING DISCLOSURE OF YOUR SOCIAL SECURITY NUMBER PER IC 4-1-8-1. THE INFORMATION OBTAINED ON THIS FORM IS CONFIDENTIAL UNDER STATE AND FEDERAL REGULATIONS. THIS INFORMATION WILL NOT BE RELEASED EXCEPT AS PERMITTED OR REQUIRED BY LAW OR WITH THE CONSENT OF THE APPLICANT.

Last name				First name				Middle initial	
Medicaid number							Date plan completed		
Social Security number *						Area agency on aging number			

PROBLEM STATEMENT

GOAL / OBJECTIVE

PLAN OF CARE - EFFECTIVE FROM: _____ **TO:** _____

SERVICE	PROVIDER	FUNDING SOURCE	FREQUENCY	TOTAL UNITS	COST PER UNIT	TOTAL COST	MONTHLY COST	START DATE	END DATE

C.H.O.I.C.E. PROGRAM

I have reviewed the services contained in this plan, and I choose to accept this plan and the services explained to me.

I have reviewed the services contained in this plan, and I choose to accept this plan and the services explained to me. I hereby agree to notify the case manager of any changes in my income or any changes that may affect the plan of care or my monthly C.H.O.I.C.E. cost share percentage of _____, which equals \$ _____.

Signature of Client		Date
Signature of Client Representative	Relation	Date
Signature of Case Manager	C.M. Code #	Date
Signature of AAA		Date
Signature of Physician (<i>Medically Frag. Child Waiver Only</i>)		Date
Signature of IDDARS Service Coordinator (<i>D.D. Waiver only, BDDS Placement Authority</i>)		Date

First Quarter	Second Quarter	Third Quarter
Initials: _____ Date: _____	Initials: _____ Date: _____	Initials: _____ Date: _____