HOME & COMMUNITY-BASED SERVICES FOR PHYSICAL DISABILITIES
PLAN OF CARE

SECTION I.

Consumer:	SS #:	Medicaid #:	
Address:	City:	Zip:	County Code:
TCM: (IL Counselor):	Phone #:	Consumer DOB:	Consumer Phone #:
Last Assessment Date:	LTC Score:		

SECTION II.

Waiver & Non waiver Services (Specify)	Service Providers	Provider Number	Frequency and Duration	Monthly Cost	Annual Cost	Implem. Date
		Total Monthly Waiver Costs:				
			Total Annual Waiver Costs:			

SECTION III. Monthly costs: $ + **$505.00** =

Monthly Waiver Costs Acute Care Cost Total Monthly Cost of Plan of Care

Section VI.

I, will / will not Self-direct my personal attendant.

My signature on this form certifies that I agree to and helped develop this plan of care.

Consumer Signature and Date TCM (ILC) Signature and Date