

**HOME & COMMUNITY BASED SERVICES TBI WAIVER
PLAN OF CARE**

Section I.

Consumer _____ Social Security # _____ Medicaid # _____
Address _____ City _____ Zip _____ Consumer Phone _____
Case Manager _____ CM Phone _____ Consumer DOB _____ Co. Code _____

Section II.

Goal Statement: _____
Date Referral Received _____ Initial Contact _____ Assessment Completed _____

Section III.

Waiver & Non-waiver Services (Specify Procedure codes)	Service Providers	Provider Number	Frequency and Duration	Monthly Cost	Annual Cost	Implementation Date
1.						
2.						
3.						
4.						
5.						
6.						

Total Monthly Waiver Costs: _____
Total Annual Waiver Costs: _____

Section IV. _____

I, _____, agree to and helped develop this Plan of Care.

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

(circle)

Consumer Signature

Date

TBI-TCM Signature

Date