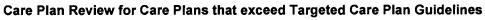
CARE PLAN PROTOCOL REVIEW FORM

Care Plan Review for Care Plans that exceed Targeted Care Plan Guidelines

| West Central Florida Area Agency on Aging, Inc. |
|--|
| aaa |
| |

| Case Mana Agency: | igement | | | | | Case Manager: | | | | |
|--|--------------|------------------|------------------|------------------------------|---------------------------------|--------------------------|-----------------|--------|----------|---|
| Client: | | | | SSN: | | | Ris | k Scor | e: | |
| Medicaid #: | | | Assessment Da | ate: | | | Priority Score: | | | |
| Current Monthly Care Plan Cost: | | | _ | Current | | t Annual Care Plan Cost: | | | | |
| Proposed N | nonthly Car | re Plan Cost: | | | Proposed Annual Care Plan Cost: | | | | | |
| # of clients | on waitlist | ahead of client: | | □ Special Exception Request: | | | | | | |
| Authorization request for: Care Plan review MW – Semi – Annual or Annual Assessment exceeds Statewide Targeted Guidelines | | | | | | | | | | |
| ☐ Car | | | | | | | | | | |
| ☐ Care Plan review CCE, ADI, HCE, LSP – Initial Assessment exceeds PSA 6 Targeted Guidelines | | | | | | | | | ; | |
| ☐ Car | e Plan Incr | ease CCE, AD | I, HCE, LSP – ex | ceeds F | SA 6 Tar | geted Guidelines | ; | | | |
| | | · | | | | • | | | | |
| Current Ser | vices (inclu | ide frequency a | | | | | | | | |
| 1. | | | ! | 5. | | | | | | |
| 2. | | | (| 6. | | | | | | 1 |
| 3. | | | 1. | 7. | | | | | | 1 |
| 4. | | | 1 | 8. | | | | | | 1 |
| | | | | | | | | | _ | |
| A - - - - - - - - - - | enina Da | | - the meanaged a | | es alaa s | | | | | |
| Additional S | ervices Re | quested (Attaci | h the proposed a | nnuai ca | are plan c | OSI | | | | ٦ |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| How Long are Services needed (i.e. short-term day/month, annual, ongoing): | | | | | | | | | | |
| How Long are Services needed (i.e. snort-term day/month, annual, ongoing): | | | | | | | | | | |
| | | | | | | | | | | |

CARE PLAN PROTOCOL REVIEW FORM





| | | | |) | | | | |
|--|--|-------------------------------------|--------------------------|-----|--|--|--|--|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| localdination for Addition | al Cardana | | | | | | | |
| Justification for Addition | iai Services: | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| Check All That Apply: | | | | | | | | |
| □ Dementia | ☐ Hx of Falls | ☐ Caregiver in Crisis | ☐ Med Waiver APPL | | | | | |
| □ Incontinent | □ Lives Alone | □ Nutrition Score 5.5+ | Client Age: | | | | | |
| | | | | | | | | |
| For SGR clients: Is the client Medicaid Waiver Eligible? □ Yes □ No | | | | | | | | |
| | | - | does not most level of C | | | | | |
| If no, v | why not? □ over | assets □ over income □ | does not meet Level of C | are | | | | |
| If no, v | | assets □ over income □ | does not meet Level of C | are | | | | |
| If no, v | why not? □ over | assets □ over income □ | does not meet Level of C | are | | | | |
| If no, v If yes, | why not? □ over what is the status of the | assets □ over income □ application? | does not meet Level of C | | | | | |
| If no, v If yes, Case Manager Signatur | why not? over what is the status of the | assets □ over income □ application? | | | | | | |
| If no, v If yes, Case Manager Signatur | why not? over what is the status of the grade of the gr | assets □ over income □ application? | | | | | | |
| If no, volume of the state of t | why not? over what is the status of the grade of the gr | assets □ over income □ application? | | | | | | |
| If no, v If yes, Case Manager Signatur | why not? □ over what is the status of the | assets □ over income □ application? | | | | | | |
| If no, voltage of the state of | why not? over what is the status of the grade of the gr | assets □ over income □ application? | | | | | | |

Medicaid Waiver Funding Approval Request



| Date of Request: | | | ed Adult Waiver ng for the Elderly Waiver |
|---|--------------|------------|--|
| Client Name: | | SS# | |
| ☐ Client has Medicaid # _ Client must apply for Me | edicaid waiv | er program | _ |
| Annualized Care Plan Cost | : \$ | | |
| Monthly Care Plan Cost: | \$ | | |
| Anticipated MW Enrollment | : Date: | | |
| Risk Score: | | | |
| Case Manager | Printed | Date | Lead Agency |
| Authorizing Supervisor Sigr | nature | Date | Lead Agency |
| * Medicaid Waiver Specia slot to open the client and authority. | | | |
| *Authorized WCFAAA MWS | S Signature | <u> </u> | Date |
| □ Pending | | | |

Serving Hillsborough, Manatee, Polk, Highlands, and Hardee Counties.

A private, non-profit corporation funded in part by Federal and State Revenue through the Florida Department of Elder Affairs.

5905 Breckenridge Parkway * Suite F * Tampa, Florida 33610-4329 * Phone: 813-740-3888 * Fax 813-623-1342 *

www.wcfaaa.org