Appendix D-5

INDEPENDENT CARE WAIVER ADDRESS STATUS FORM

COMPLETE WITH ANNUAL REVIEW AND/OR CHANGE OF ADDRESS

Member's Name:				Medicaid ID:			
Date Completed:							
Current Street Address:							
Apt. No:							
City:		State:		Zip:		County:	
Previous Street Address:							
Apt. No.							
City:		State:		Zip		County	

Member's Phone No.: _____ Date Member Moved: _____

Living Setting:

Private Home: ☐ ALS: ☐

Assisted Living: ☐

Licensed PCH: ☐ Group Home: ☐

Other: ☐

Member's support system, emergency contact or responsible party information:

Name:		**Relationship to Member:**	
Phone:		**Alternate phone:**	
Street address:			
City:		**Zip:**	
County:			

EQUIPMENT AND SUPPLY SHEET

Equipment LIST FOR: **DATE:**

Wheelchair Accessories		**Respiratory Equipment**		**Assistive Devices for Increased Function:**		**Miscellaneous:**	
Manual Wheelchair	☐	ventilator	☐	Specialty Phone	☐	Electrical stimulation unit	☐
Power Wheelchair	☐	In-exsufflator (cough assist)	☐	Mouth stick	☐	Portable Ramps	☐
Tilt in space wheelchair	☐	Suction machine	☐	Plate Guard	☐	Augmented communication devices	☐
Wheelchair Cushion	☐	Ambu- bag	☐	Specialty Utensils	☐	reacher	☐
Wheelchair Lap Tray	☐	other	☐	Over the Stove Mirror	☐	Shoe horn	☐
Lift Chair	☐		☐		☐	sponge	☐
Mobility Assistance Devices		**Bathroom Equipment**		**Beds/ mattresses**		Dressing stick	☐
Quad cane	☐	Tub grab bars	☐	Hospital Bed	☐	Sock aid	☐
standard Cane	☐	Raised toilet seat	☐	Specialty mattress	☐		☐
Side Walker/ hemi walker	☐	Bedside commode chair	☐	Safety bed rails	☐		☐
Lofstrand/ forearm crutches	☐	Drop arm commode	☐	Other:	☐		☐
Regular Crutches	☐	Upright shower chair	☐	Over the bed table	☐		☐
Rolling walker	☐	Shower stool	☐	**Transfer Devices**			☐
Walker without wheels	☐	Reclining shower chair	☐	Sliding board	☐		☐
Walker platform attachment	☐	Bath transfer bench	☐	Hoyer lift	☐		☐
scooter	☐	Bath tub safety rail	☐	Gait belt	☐		☐

ICWP SUPPLY LIST FOR: **DATE:**

SUPPLY ITEM	PER MONTH	PER YEAR	COST PER UNIT	TOTAL COST PER YEAR
Gloves			$7.25	$0.00
Adult Briefs/ pullups			$67.59	$0.00
Bladder control pads cs			$55.00	$0.00
Chux			$50.09	$0.00
Wipes- disposable			$5.48	$0.00
Skin Cream:			$14.34	$0.00
Reusable underpads			$22.50	$0.00
Urinal			$7.32	$0.00
Bisacodyl box of 10			$35.00	$0.00
Glycerin box of 4			$6.75	$0.00
Magic bullets box 100			$75.00	$0.00
Fleet enema			$1.75	$0.00
Lubricant *M pays 4ea/mo			$4.44	$0.00
Urinary leg bag			$28.83	$0.00
TF formula case:			$59.00	$0.00
Glycerin swabs			$6.75	$0.00
Toothettes- bx 250			$56.00	$0.00
Sip and puff straws bx 100			$60.00	$0.00
Bibs- disposable cs500			$58.00	$0.00
Bibs- reusable			$12.25	$0.00
Inner cannula bx10			$27.50	$0.00
Trach care kit			$62.00	$0.00
Trach collar tie bx12			$17.86	$0.00
Drain sponge pk50			$8.56	$0.00
Multidose saline bx100			$18.39	$0.00
Barrier spray			$17.14	$0.00
Periwash			$11.95	$0.00
Heel protector			$19.95	$0.00
Elbow protectors			$8.50	$0.00
Skin barrier wipes bx50			$8.39	$0.00
Geomat			$110	$0.00
Reacher			$13.90	$0.00
			$	$ 0.00
			$	$0.00
			$	$0.00
			$	$0.00
			$	$0.00
			$	$0.00
			$	$0.00
			$	$0.00
			$	$0.00
			$	$0.00
			$	$0.00
			$	$0.00
			$	$0.00
			$	$0.00
			$	$0.00
			$	$0.00
Grand Total:			$	$
			$	$

Appendix H 3

ICWP Financial Summary

Name: _____ **Date:** _____

Service Description	Frequency Intensity	Responsible Provider	Per Unit Cost	Yearly Cost
			Grand Total:	$ 0.00

Reference Sheet

Name: _____ Plan of Care Date: _____

This reference sheet will assist you and your provider in addressing your needs.

Your ICWP case manager is: _____
Phone number: _____

Your Emergency Contact Name: _____
Phone Number: _____

Personal Assistance Provider: _____
Phone Number: _____

Your Primary Care Physician: _____
Phone number _____

Supplies and Equipment
Supplies Provider _____
Phone number _____
Equipment Provider: _____
Phone number _____

Hospital for Emergencies: _____
Phone number: _____
Address: _____

Behavior Management: Yes ☐ No ☐
(if yes, see specific plan)

Notes:

APPENDIX F

Georgia Department of Human Resources

Name of Member/Patient/Applicant

Date of Birth

IF AVAILABLE:

ID Number Used by Requesting Agency

ID Number Used by Requesting Agency

AUTHORIZATION FOR RELEASE OF INFORMATION

I hearby request and authorize: _____

(Name of Person or Agency Requesting Information)

_____

(Address)

to obtain from: _____

(Name of Person or Agency Holding the Information)

_____

(Adress)

the following type(s) of information from my records (and any specific portion thereof):

_____

_____

for the purpose of: _____

_____

All information I hereby authorize to be obtained form this agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for:

☐ ***Ninety (90) days unless I specify an earlier expiration date here:*** _____

(date)

☐ ***One (1) year.***

☐ ***The period necessary to complete all transactions on accounts related to services provided to me***

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent. I may withdraw this consent at any time.

_____ _____

(Date) (Signature of Member/Parent/Applicant)

_____

(Signature of Witness) (Title or Relationship to Member) (Signature of Parent or Authorized Representative, where applicable) (Date)

USE THIS SPACE ONLY IF MEMBER WITHDRAWS CONSENT

_____ _____

(Date this consent is withdrawn by member) **(Signature of Member)**

Form 5450 (Rev. 2-80)

Independent Care Waiver Program

Community Care Path Signature Sheet

Member Name:_____ DOB: _____

Case Manager Name:_____ Signature:_____

Date: _____

Medicaid #: _____

By signing and initialing the lines below we are acknowledging that my plan of care and goals have been discussed between the member/caregiver and case manager during the quarterly visits conducted per DCH/ICWP policy and we are in agreement.

First Quarter:_____ Date: _____ CM Initials: _____

Second Quarter:_____ Date: _____CM Initials: _____

Third Quarter:_____ Date: _____CM Initials: _____

Fourth Quarter:_____ Date: _____CM Initials: _____

***Obtain signatures every quarter and forward to GMCF with Annual Renewal. Enter the Carepath and Quarterly information into the web portal.

APPENDIX C-1

CONSUMER DIRECETD CARE OPTION

MEMORANDUM OF UNDERSTANDING

Rev. 10/05

Member_____ Medicaid Number_____

Purpose:

It is the intent of this agreement to provide an assurance that members understand the expectations and guidelines of the Consumer Directed Service option under the Independent Care Waiver Program (ICWP). The members must follow specific guidelines in order to ensure compliance with the Plan of Care. Failure to follow these guidelines may result in a member returning to the traditional option or termination from the program. Signing this agreement indicates that you understand and will abide by the terms and conditions for participation in the Consumer Directed Care option as implemented by the Georgia Division of Medical Assistance. The following does not intend to address all of the conditions of participation, therefore please discuss with your case manager if you have any questions or concerns.

In order to be eligible for the Consumer Directed Option service under ICWP the member must meet the following criteria:

1. Medicaid eligible or potentially Medicaid eligible;
2. Be between twenty-one (21) and sixty-four (64) years of age;
3. Have a severe physical disability and/or traumatic brain injury that substantially limits one or more activities of daily living and requires help from another person;
4. Mentally capable to direct own care and demonstrate control over daily schedule and decisions. This does not apply to those with a traumatic brain injury. A member's representative may make decisions for the TBI member. Mentally capable means must be cognitively alert and capable of directing their own services. Cognitively alert means the member displays or exhibits reasoning and perception abilities in their thought processes at the time of assessment and thereafter. Directing their own services means the member must be able to make independent decisions and judgements regarding their care, care choices and overall wellbeing. In addition, members must be able to communicate their decisions and care choices through commonly accepted forms of communication including verbal communication, sign language, or through acceptable

7/1/14

communication assistive devices such as communication boards mediums. Access to and the use of such devices is the sole responsibility of the member.

5. Be mentally stable but in or at risk of hospital or nursing home placement;

6. Does not have a primary diagnosis of a mental disorder including mental illness or mental retardation;

7. Certified for a level of care appropriate for placement in a hospital or nursing home;

8. Be motivated to self-direct care;

9. Be willing to assume responsibility for cost effective use of Personal Support Services;

10. Does not have a history of behavior that is problematic that places self or others at risk;

11. Must have a Primary Care Physician;

12. Must successfully fulfill the training requirements of the Consumer Directed Option by review of the training manual and successfully demonstration of understanding of the training sessions; and

13. Must be willing to sign a Memorandum of Understanding (MOU) which outlines the roles and responsibilities of a Self Directed Consumer.

<u>General Understanding:</u>

1. Georgia Medical Care Foundation (GMCF) or Shepherd Care develops the Initial Plan of Care.

2. Approval is needed in writing from GMCF for all services rendered under this program.

3. The member or his/her representative is responsible for hiring, training, supervising, disciplining, terminating and paying their attendant through the FI.

4. All services must be rendered according to the Individual Plan of Care signed by the member, case manager, FI and the planning team and approved by GMCF and/or ShepherdCare

5. Cost of care must be provided within the allocated budgeted amount. The monies for salaries, taxes and benefits of personal support service provider and the FI agency fee will be funded from the budgeted personal support service hours.

6. The member or his/her representative will have the freedom of choice to choose his or her Fiscal Intermediary, an enrolled Medicaid Provider.

7. The member or his/her representative will be responsible for staffing/schedule attendants (s) as well as developing a back up plan should the primary attendant not be available.

8. A member may not participate in more than one Medicaid Waiver Programs at the same time.

9. The Utilization Review team will make in-home visits as needed and required.

10. The member is aware that if he/she is admitted to a hospital he/she cannot continue to receive PSS hours and will not be paid during the hospital stay. Caregivers will not be paid during the period an ICWP member is hospitalized.

11. The member must be responsible for maintenance, proper use and replacement of the fax machine.

12. The **member is responsible** for any cost associated with backgrounds checks that **exceed 5** per Plan of Care year.

13. The **member will be responsible** for paying any employee, if the background check has not been confirmed by the FI.

Discarge of Members:

Discharge may take place when any of the following occurs:

1. GMCF in consultation with the case manager and other providers, determines that the member is no longer appropriate or eligible for ICWP

2. The Utilization Review (UR) staff recommends discharge (10 day notice is required).

3. The member has not received ICWP personal support services for sixty (60) consecutive days.

4. The member has behavior that is disruptive, illegal, threatening, and /or dangerous to self or others.

5. The member refuses to comply with treatment/agreed upon plan of care.

6. The member chooses to be discharged or enters long-term facility.

7. The cost to serve member exceeds the allocated budgeted amount.

8. The member knowingly and freely commits fraudulent activities.

9. Case Manager notifies GMCF review nurses of member's failure to follow the following polices:
    - Failure to meet the following critical carepath goals for two consecutive quarters:
        - Failure to maintain maximum control over daily schedule and decisions
        - Failure to assume responsibility for cost effective use of medical services and supplies
        - Exhibition of problem or symptomatic behavior which places the ICWP participant at risk of social isolation, neglect, or physical injury to themselves or others
    - Failure to stay within budget for two consecutive months
    - Use of the State Backup plan for at least two occasions for two consecutive months
    - Preventable decline in health outcomes for two consecutive quarters.

10. GMCF review nurse will send a denial for continued placement in Consumer-Directed Services and return the member to Traditional Services.

Members May reapply for the Consumer Directed Option:

When a consumer is moved back into the traditional option there is no loss of services. After one year the consumer will be eligible to reapply for Consumer-Directed option.

11. Additional terms

As an ICWP consumer/ representative, it is your responsibility to be actively involved in achieving goals related to good health and community living. Goals identified for all participants in ICWP are:

1. Maintain maximum control over daily schedules and decisions.

2. Participate socially and be connected and involved in community activities of your choice.

3. Assume responsibility of cost effective medical services and supplies.

4. Be responsible for behavior so that it will not place you at risk of social isolation, neglect or physical injury to yourself or others.

5. Maintain a diet that is balanced and appropriate for decreasing risk of further disability.

6. Participate in interventions that maintain skin in a healthy condition, avoiding breakdowns

7. Understand and observe medication regimen.

8. Participate in interventions of daily living without interruptions due to cognitive or physical impairments (self or informal caregiver report, observation by case manager, provider reports, etc).

9. Maintain bowel and bladder program that promotes skin integrity, cleanliness and positive health status.

10. Performs transfers and mobility safely and when needed.

It is the responsibility as ICWP case managers to:

1. Respond to phone calls and requests in a timely manner

2. Respect your choices throughout the development and maintenance of your individual community plan.

3. Provide you with options and information in order for you to make informed decisions.

4. Meet with you and your significant other and notify you of any changes in your service.

5. Take responsibility to initiate termination of ICWP services after a 30 day notice is given if any of the following activities are taking place; use of drugs or other harmful substances, consumer or household involvement in any type of illegal activity, lack of effort or concern in maintaining you physical health or emotional health, lack of effort or concern in actively participation in your life, or abuse of any services provided by ICWP.

Mutual Responsibilities:

The term of this agreement is for one year from the year of approval date, and must be renewed annually or as warranted by mutual written consent of the member and the case manager.

As a recipient of the ICWP, you may be assessed intermittently, but at least annually to determine if your care can be managed under the policy and fiscal limitations of the ICWP.

As a member of the Consumer Directed option, I understand that I, or my documented representative, assume the responsibility of Employer and all the related duties required of my Member-Directed Providers (MEPs) or attendants. This process has been explained to me and all of my questions have been answered.

This_____day of_____20_____

_____	_____
Print Name of Member/Legal Guardian	Signature of Member Date Legal Representative
_____	_____
Print Name of Case Manager	Signature of Case Manager Date

APPENDIX B

MEMBER RIGHTS AND RESPONSIBILITIES

Member's rights include:

1. The right of access to accurate and easy-to-understand information.
2. The right to be treated with respect and to maintain one's dignity and individuality.
3. The right to voice grievances and complaints regarding treatment or care that is furnished, without fear of retaliation, discrimination, coercion, or reprisal.
4. The right of choice of an approved provider.
5. The right to accept or refuse services.
6. The right to be informed of and participate in preparing the care plan and any changes in the plan.
7. The right to be advised in advance of the provider(s) who will furnish care and the frequency and duration of visits ordered.
8. The right to confidential treatment of all information, including information in the member record.
9. The right to receive services in accordance with the current plan of care.
10. The right to be informed of the name, business telephone number and business address of the person/agency supervising the services and how to contact that person/agency.
11. The right to have property and place of residence treated with respect.
12. The right to review member's records on request.
13. The rights to receive care and services without discrimination.

Member's Responsibilities include:

1. The responsibilities to notify case manager/service provider(s) of any changes in care needs.

2. The responsibility to treat provider staff in a courteous and respectful manner, as well as cooperate with and respect the rights of the caregivers providing care.

3. The responsibility to be as accurate as possible when providing information on health history and personal care needs.

4. The responsibility to participate actively in decisions regarding individual health care and service/care plan development.

5. The responsibility to comply with agreed upon care plans.

6. The responsibility to notify the member's physician, providers, and/or caregiver of any change in one's condition.

7. The responsibility to maintain a safe home environment and to inform providers of the presence of any safety hazard in the home.

8. The responsibility to be available to provider staff at agreed upon times services are scheduled to be rendered.

By signing this form, member has read and understands member rights and responsibilities.

This _____ day of _____ 20_____

_____ _____

Print Name of Member/Legal Guardian Signature of Member
Legal Representative

_____ _____

Print Name of Case Manager Date Signature of Case Manager Date

APPENDIX I

Independent Care Program
FREEDOM OF CHOICE (Statement of Informed Consent)

It is the policy of the State of Georgia that participants have the option to receive appropriate services in the setting of choice. Further, it is the policy of the State to recognize the participant's individual dignity; providing safeguards to protect rights, health, and the welfare of recipients. **Rev. 10/2015**

Based on these beliefs the State of Georgia assures that potential participants and their authorized representative(s) will be afforded an opportunity to make an informed choice concerning services. Once an individual is determined to be likely to require the level of care provided in a nursing facility or hospital the individual or his/her authorized representative will be (1) informed of any feasible alternative available under the waiver, and (2) given the choice of either institutional or home and community-based services, and (3) that the substance of the information provided will make one reasonable familiar with service options, their alternatives, and possible benefits and hazards, and (4) the disclosure of said information is designed to be fully understood and appears to be fully understood.

Verification

I have verified that the participant or his/her authorized representative have been informed about their choices in the manner outlined above.

_____ _____

Case Manager Date

Acceptance

I and/or my authorized representative have been informed of my choices and have chosen to participate in the Home and Community Based Services Program.

_____ _____ _____ _____

Participant Date Authorized Representative Date

_____ _____

Witness Date

Refusal

I and/or my authorized representative have been informed of my choices and have chosen to refuse waiver services.

_____ _____ _____ _____

Participant Date Authorized Representative Date

_____ _____

Witness Date

Member name: _____

Appendix D-4

RENEWAL PARTICIPANT ASSESSMENT FORM

Care plan due date:	

Identifying Information

Member Name _____
Last First Middle Initial Suffix

Address: _____
Apartment#

_____
City State Zip County

Phone #: _____Cell# _____

Date of Birth _____ Age: _____ ☐ Male ☐ Female

Have you moved in the past year? ☐ Yes ☐ No

If yes; when did you notify DFCS? _____

Living Arrangements at the time of the Renewal Assessment:

☐ Lives Alone ☐ With Other Family Member ☐ With Paid Help (not ICWP PSS)
☐ With Spouse/Significant other ☐ With a Friend ☐ ALS (Alternative Living Services)

As compared to 1 year ago, Member now lives with other persons (e.g. moved in with another or other person moved in with individual). ☐ Yes ☐ no

Comments:

Medical Information

Current Diagnosis:

Member name: _____

Medication List:

Skilled care duties required:

☐	Tracheostomy Care	☐	Suctioning	☐	Medication administration	☐	Catheter Care
☐	Vent	☐	Wound Care	☐	Tube feeding set up/ administration	☐	Accucheck/ injections
☐	Other:						

EVALUATION

What is the Member's condition compared to the last annual plan care year?

☐ Stable ☐ Improved ☐ Declining

Functional Potential:

☐ Member believes he/she is capable of increased functional independence

☐ Caregivers believe Member is capable increased functional independence

☐ Good prospects of recovery for current disease of conditions, improved health status expected

☐ None of the above

Significant Changes in Last Year as reported by the ICWP member:

☐ Hospitalizations ☐ Functional Decline ☐ Caregiver Status change

☐ New Diagnosis ☐ Loss of Loved One ☐ Any Sentinel Event

Comments:

Member name: _____

STATUS:

1. What was the date of the last physician visit? _____
2. Were any new physician's orders received this annual period? ☐ yes ☐ no
   If yes, please describe:

   _____

   _____
3. Were there any emergency room visits or hospitalizations during this annual period? ☐ yes ☐ no
   If yes, please provide the dates and diagnosis: _____

   _____
   a. Did you, the Case manager, submit a variance? ☐ yes ☐ no
4. Is the individual in jeopardy of moving from their home to a facility to get the care they need? ☐ yes ☐ no

Risk factors:

1.	Does member have a history of nursing facility placement in the past year?	☐ Yes ☐ no
	If yes, what were the reasons?	
2.	Does the member have a progressive disease?	☐ Yes ☐ no
	If so, state the disease:	
3.	Has the member fell 2 or more time in the past year?	☐ Yes ☐ no
	If so, has a fall safety program been implemented?	☐ Yes ☐ no
	If the member has fallen, what were the contributing factors?	
4.	Does the member have urinary incontinence?	☐ Yes ☐ no
5.	Does the member have bowel incontinence?	☐ Yes ☐ no

If Incontinent, what devices does member use?

☐ Diaper/ pull-up/ brief	☐ Indwelling cath	☐ Bowel program
☐ Chux	☐ Supra pubic cath	☐ Ostomy
☐ Urinal	☐ Self-cath	☐ Dialysis
☐ Condom cath	☐ Ileostomy/ ileoconduit	☐ Other: _____

Comments:

Member name: _____

SKIN:
Does member have a wound? ☐ yes ☐ no

If yes, where is it located and what stage is it? _____

_____

_____

If yes, where is the wound being treated:

☐	Home Health	☐	Wound Clinic
☐	Doctor's office	☐	Informal Caregiver
☐	Other:		

Please attach wound care notes. The notes should include location, stage of wound, current treatment plan, progress being made on treatment. If skilled PSS care for wounds has been approved, then submit notes from the PSS provider detailing the additional care aides are providing.
Have you included these notes in a separate attachment? ☐ *yes* ☐ *no*

Comments:

Primary Modes of Locomotion:

☐	No assistive device	☐	wheelchair
☐	Cane	☐	activity does not occur
☐	walker/crutch scooter	☐	Other:

Comments:

Member name: _____

Memory Issues:

Based on your personal knowledge, does the member appear to have difficulties in remembering things?

☐ No issues	☐ Yes, there are issues
☐ No personal knowledge	☐ Member is non-verbal

If yes, would you classify memory difficulty as (choose one):

☐ Short-term memory problems that, with occasional reminders, do no cause difficulty in the person performing self-care tasks.

☐ Memory lapses that result in the person frequently not performing self-care tasks without reminders?

☐ Memory lapses resulting in the inability to perform routine tasks on a daily basis?

☐ Comments: _____

Behavior Issues:

Are there any behavior issues that may impact their ability to continue living in the community?	☐ Yes	☐ No
If yes, describe:		

Is the member:		
Smoking without supervision?	☐ Yes	☐ No
If yes, interventions:		
Suspected alcohol abuse?	☐ Yes	☐ No
If yes, interventions:		
Suspected drug abuse?	☐ Yes	☐ No
If yes, interventions:		
Comments:		

Personal Assistance Services Needed:

☐	Meal prep	☐	Bathing	☐	Routine hair care	☐	exercise
☐	Feeding/eating	☐	shaving	☐	Routine skin care	☐	laundry
☐	Oral care	☐	grooming	☐	shopping	☐	Community outings
☐	transfers	☐	dressing	☐	cleaning		
☐	Assist with self-administered medication			☐	Other:		
Comments:							

Member name: _____

ENVIRONMENTAL:

SAFETY Hazards:		**None**		
	Inadequate floor/ roof/ windows		Unsafe gas/electric appliance	lack of safety devices
	inadequate heating		inadequate cooling	Unsafe floor coverings
	inadequate stair railings		Other:	
Comments:				

Sanitation Hazards:		**None**		
	No running water		inadequate sewage disposal	no schedule trash pick-up
	Contaminated water		inadequate/improper food storage	cluttered/soiled living area
	No toileting facility		no cooking facility	insects/ rodents present
	Other:			
Comments:				

Social functioning:

In the past year has there been a decline in the member's level of participation in social, religious, occupational or other preferred activities?

	No		Decline, but individual is not distressed		Decline, and individual is distressed
	Other:				

Isolation:

How often is the member alone during the day?

	Never or Seldom		About 1 hour		Long periods of time		All the time

Is the member involved in community activities (ex: church, shopping, social activities)?

	yes		no

Comments:

Member name: _____

Informal Caregiver:

Does the member have an informal support system?	☐ yes	☐ no
If yes, was the informal support person present for your renewal visit?	☐ yes	☐ no
If yes, did the person sign the support attestation form?	☐ yes	☐ no

If you answered "no" to any of the above questions, then explain:

Informal Caregiver Status (check all that apply):

☐ Caregiver is unable to continue in caring activities (e.g. decline in health of care giver makes it difficult to continue).

☐ Primary caregiver is not satisfied with support received from family and friends (e.g. other children of individual).

☐ Primary caregiver expresses feelings of distress, anger or depression.

☐ Caregiver expresses feelings of frustration with current PSS staffing

☐ No issues

☐ Other: _____

How often does the Member receive assistance from the Primary Informal caregiver?

☐ Several time during the day and night	☐ once daily	☐ 1-2 times per week
☐ Several times during the day	☐ 3 or more times per week	☐ less often than weekly

LIST MEMBER'S INFORMAL SUPPORT:

1. _____
   a. Lives with Member? ☐ Yes ☐ No
   b. Relationship to Member: ☐ child ☐ spouse ☐ friend/neighbor ☐ parent
      Other: _____

2. _____
   c. Lives with Member? ☐ Yes ☐ No
   d. Relationship to Member: ☐ child ☐ spouse ☐ friend/neighbor ☐ parent
   Other: _____

By signing below, I agree that I will continue to follow the Independent Care Waiver program's policies and procedures. I agree that if I have concerns or questions about the program, I will seek clarification from my case manager. If I am utilizing the Consumer Directed care option, I agree to follow the CDC's policy and procedures as well as maintain my budget as approved.

_____ _____

Client/Representative Signature Date

Member name: _____

Narrative Summary:

_____ _____

Case Manager Signature Date