Texas Department of Aging
and Disability Services

Form 3608
February 2014-E

Home and Community-based Services

Individual Plan of Care (IPC)

Individual Name (Last, First, MI)	Medicaid No.	IPC Begin Date	IPC End Date	IPC Effective Date
Address (Street, City, State, ZIP)	Date of Birth	Age	Level of Need	CARE ID No.
Program Provider	Provider Component Code		Provider Contract No.	
Financial Management Services Agency (FMSA)	FMSA Component Code		FMSA Contract No.	
Residential Type ☐ Foster/Companion Care ☐ Own Home/Family Home ☐ Supervised Living ☐ Residential Support Services			Location Code	County of Service

IPC Type (check one)

Requires service planning team (SPT) and provider to hold an IPC meeting:

☐ Initial (Enrollment) ☐ Renewal ☐ Transfer: Contract/Service Delivery Option ☐ Revision to Reflect Person-Directed Plan (PDP) Change

☐ **Meets Emergency Criteria §9.166(d)** (Check this box if revision is due to an emergency.)

or

Does not require SPT and provider to hold an IPC meeting:

☐ Revision to increase/decrease an existing Home and Community-based Services (HCS) service. This option may not be used if the increase or decrease requires a new outcome, because the SPT and provider must meet to revise the PDP. The **IPC effective date** for an IPC increase/decrease must be on or after the date the provider notified the service coordinator (SC) in writing of the need to increase or decrease a current HCS service.

Reason for increase/decrease:

☐ Revision to add/change a requisition fee only.

Non-HCS Services Provided by Family and Other Funding Sources

Type of Service	Funding Source	No. of Hours Per Day	No. of Days Per Week	Name of Provider

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IPC Service Information

Indicate need to increase or decrease an existing HCS service by entering an I (increase) or D (decrease) in the column next to the service.

Provider Service	I/D	Authorized Units	Provider Service	I/D	Authorized Units	Consumer Directed Service (CDS)	I/D	Authorized Units
Adaptive Aids (AA)			Nursing – LVN (NUL)			Cognitive Rehabilitation Therapy (CRTV)		
Adaptive Aids – Requisition Fee (AAR)			Nursing – Specialized LVN (NULS)			Employment Assistance (EAV)		
Audiology (AU)			Nursing – RN (NUR)			Financial Management Services (FMS) Monthly Fee		
Behavioral Support (BES)			Nursing – Specialized RN (NURS)					
Cognitive Rehabilitation Therapy (CRT)			Occupational Therapy (OT)			Nursing – LVN (NULV)		
Day Habilitation (DH)			Physical Therapy (PT)			Nursing – Specialized LVN (NULSV)		
Dental (DE)			Residential Support Services (RSS)			Nursing – RN (NURV)		
Dental Requisition Fee (DER)			Respite Hourly (REH)			Nursing – Specialized RN (NURSV)		
Dietary (DI)			Social Work (SW)			Respite Hourly (REHV)		
Employment Assistance (EA)			Speech/Language Pathology (SP)			Support Consultation (SCV)		
Foster/Companion Care (FC)			Supervised Living (SL)			Supported Employment (SEV)		
Minor Home Modifications (MHM)			Supported Employment (SE)			Supported Home Living (SHLV)		
Minor Home Modifications – Requisition Fee (MHMRE)			Supported Home Living (SHL)					

Totals from CARE Screen C62 (for all services)	
CDS Estimated Annual Total	
Program Provider Estimated Annual Total	
IPC Estimated Annual Total	

Are any services staffed by a relative or guardian? ☐ **Yes** ☐ **No**

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Service Planning Team: By signing below, you indicate your agreement that the HCS services for this individual are necessary to protect the individual's health and welfare in the community; are not available to the individual through any other source, including the Medicaid state plan, other governmental programs, private insurance or the individual's natural supports; are the most appropriate type and amount to meet the individual's needs; are cost effective; and are necessary to enable community integration and maximize independence.

HCS Program Provider/Individual/Legally Authorized Representative (LAR) Signature

Signature – Provider Representative _____ Printed Name _____ Date _____

Signature – Individual/LAR _____ Printed Name _____ Date _____

☐ Individual/LAR participated by phone on: _____ Date

(1) If the individual/LAR participates in person and agrees with the IPC, the **individual/LAR** signs, prints his name and enters the date of the IPC meeting. If the agreement is obtained by phone, the **provider** checks the box and enters the date of agreement. The provider then sends a copy of the form to the individual/LAR for signature.

(2) For an IPC revision that adds/changes a requisition fee only, the **provider** enters "requisition fee only" in the individual's signature line and enters the IPC effective date as the signature date.

DADS Review and Authorization (if required)

Signature – DADS Authorized Representative _____ Date _____

Local Authority/Service Coordinator (SC) Signature

Local Authority Name: _____

Signature – Service Coordinator _____ Printed Name _____ Date _____

(1) When the SC participates in the IPC meeting in person, the **SC** signs, prints his name and enters the date (on the signature line above) on the day of the meeting.

(2) When the SC participates in the IPC meeting by phone, the **provider** writes "participated by phone" on the SC signature line, prints the SC's name and enters the date of the meeting.

(3) For an IPC revision that increases/decreases an existing HCS service and does not require an IPC meeting, the **provider** writes "notified SC" on the SC signature line, prints the SC's name and enters the date this form was submitted to the SC. (Submission of this form to the SC serves as notification of an IPC revision that does not require an IPC meeting.)

(4) For an IPC revision that adds/changes a requisition fee only, the **provider** enters "requisition fee only" in the SC signature line and enters the IPC effective date as the signature date.

Service Coordinator Response
(For proposed service increase/decrease IPC revisions only)

Check one of the options below and return this form to the provider within two business days after the provider submits this notification of needed change to the SC.

☐ SC agrees with the IPC revision. No IPC meeting is required.

☐ IPC meeting is needed.*

Reason: _____

* Before checking this box, the SC contacts the provider and discusses any questions or concerns regarding the requested revisions. After the discussion, if the SC determines that an IPC meeting is needed, the SC checks the "IPC meeting is needed" box, includes the reason for the meeting, signs, prints name and returns this form to the program provider. The SC then schedules a meeting to occur with the individual/LAR and the program provider as soon as possible but no later than 14 calendar days.

Signature – Service Coordinator _____ Printed Name _____