

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services
PLAN OF CARE/PRIOR AUTHORIZATION FOR WAIVER SERVICES

Member Name: _____ **Medicaid Member ID#:** _____

Identification of Needs/Outcomes/Services/Providers

NEED(S)	OUTCOMES/GOAL(S)	OBJECTIVES/INTERVENTION(S)	SERVICE CODE	PROVIDER NAME/#

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Member Name: _____ **Medicaid Member ID#:** _____ **Date Services Start:** _____

Support Spending Plan

Traditional Waiver Services

Service Code A	Provider Name and Number B	Units per Week C	Units per Month D	Cost per Unit E	Cost per Week (Column CxE) F	Total Cost Monthly (4.6xColumn F) G
						Total Cost per Month \$

Consumer Directed Services

Service Code A	Description of Service B	Employee Providing the Service C	Units per week D	Units per Month (Column D x 4.6) E	Hourly Wage F	Number of Hours per Month G	Sum of Wages Times Hours H	Administrative Costs I	Total Monthly Amount J
									Total Cost Per Month \$

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Member Name: _____ Medicaid Member ID #: _____

List each provider/employee name, address and telephone number:

Provider/Employee Name	Provider Number	Address	Phone Number

Clinical Summary:

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Emergency Back-up Plan (CDO only)

I certify the information contained above is accurate and that I have made an informed choice when selecting the providers/employees to provide each service.

Member/Guardian Signature

Date

Case Manager/Support Broker Signature

Date

Representative Signature (CDO)

Date

Plan of Care/Support Spending Plan **Approved** **Denied**

QIO Signature/Title

Date