**Individual Plan Signature Sheet Date of meeting:**

|  |  |
| --- | --- |
| **Name:** | **DOB:**       **Sex:**       **DDS#:** |
| Provider Name: | Home: (   )    -     Cell: (   )    - |
| Address: | PRRP Name: |
| City/State/Zip:     ,      , | PRRP Email:      @     . |
| Medicaid #:       Medicare #: | Private Insurance: |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **All items marked in yellow highlight will auto fill from data sources upon accessing and printing the Signature Sheet.**  **All items marked in blue highlight must be filled out prior to or at the meeting.**   |  |  | | --- | --- | | **Class member?** |  | | **Annual Notifications - Given to individuals/guardians at IP or sent prior, Check box**  **New 1 page form** | | | | **Other Notifications (Maintained in individual’s DDS Case Management File. Check box to verify)** | | | | | * HIPAA Notification (at initial visit or change of guardian)  **is there one on file?** | | | | | * Legal Liability Notification (at initial visit or change of guardian)  **is there one on file?** | | | | | * Voter Registration Notification (annually, at initial visit, after 17th birthday or new address) **An ED-682 must be done every year per federal law and kept in record. If person requests assistance to register, CM must** **provide that assistance or ensure person gets the help they need to register.** | | | | | * Notification of Regional Advisory Council  **This info is contained within the 1 page notification form but must also be checked off on the Signature Sheet separately.** * Medicaid (verified as current in MedOps Report/Waiver Maintenance screen) | | | | | * type       date implemented       next redetermination date | | | | |  | | | | | **Type of DDS Waiver:** | | | | | **LON Date**       **Residential LON Composite:**       **Behavior:**       **Day LON Composite:**       **Behavior:** | | | | | **Residential WL:**  **Category:**       **Service:**      **Day WL:**  **Category:**       **Service:**       **BSP:**  **Is this Accurate? Yes No Explain:** | | | | |  |

**Case Managers must ensure the WL and all other information is accurate. Any changes to WL info must be done thru a PRAT request and it needs to be an action step for the case manager in the Individual Plan. If new LON info is presented at meeting it must be noted here and a new LON completed by case manager as soon as possible. Any corrections of other information needs to be written on this sheet and then entered into the appropriate data source by the case manager.**

***As an individual, family member, guardian, provider or advocate, please contact your Case Manager within two weeks of receipt if you do not agree with this plan as written.***

As an individual, family member, guardian or advocate, you have the right to request a Programmatic Administrative Review pursuant to Policy DDS-7, if you disagree with any portion of the plan. Contact your Case Manager to assist you in your request. **Case Manager:**       phone:       email:

| **Name** | **Signature** | **Relationship** | **Attended Meeting (x)** | **Contact Number**  **Email Address** |
| --- | --- | --- | --- | --- |
|  |  | **SELF** |  | **Update as needed** |
|  |  | **DDS**  **Case Manager** |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |