

Medically Dependent Children Program
Individual Plan of Care (IPC) Service Review

Individual's Name		Reason for Contact <input type="checkbox"/> 3/30 Day <input type="checkbox"/> ≤ 6 months		Medicaid No.
Type of Individual Contact <input type="checkbox"/> Telephone <input type="checkbox"/> Face-to-Face	Date of Individual Monitor Contact	Type of Caregiver Contact <input type="checkbox"/> Telephone <input type="checkbox"/> Face-to-Face	Date of Caregiver Monitor Contact	
Persons Participating in the Review				

Medically Dependent Children Program (MDCP) Providers Utilized During the Review Period

Respite
Flexible Family Support Services
Adaptive Aids
Minor Home Modifications
Financial Management Services
Transition Assistance Services
Employment Assistance
Supported Employment

1. a. Have MDCP services been implemented and provided in accordance with the IPC? Yes No
If No, explain: _____
- b. Have MDCP services met your needs, goals and preferences as identified in the IPC? Yes No
If No, explain: _____
2. a. Have third-party resources been implemented and provided in accordance with the IPC? Yes No N/A
If No, explain: _____
- b. If yes, did the third-party resources meet your needs, goals and preferences as identified in the IPC?..... Yes No
If No, explain: _____
- c. Have you accessed third-party resources, including health services? Yes No
If No, explain: _____
3. Are you satisfied with the implementation of MDCP services? Yes No
If No, explain: _____
4. Did the use of MDCP services and third-party resources reasonably assure the individual's health and welfare? Yes No N/A
If No, explain: _____
5. Have you exercised free choice of providers?..... Yes No N/A
If No, explain: _____
6. For services delivered by a Home and Community Support Services (HCSS) provider:
 - a. Has the HCSS provider had to implement the service backup plan? Yes No
 - b. If yes, was the backup plan effective? Yes No
 If No, explain: _____

Consumer Directed Services (CDS) Addendum N/A

7. MDCP services delivered through the CDS option:	8. Employee Type(s):
<input type="checkbox"/> Respite	<input type="checkbox"/> Nurse <input type="checkbox"/> Attendant
<input type="checkbox"/> Flexible Family Support Services	<input type="checkbox"/> Nurse <input type="checkbox"/> Attendant
<input type="checkbox"/> Employment Assistance	
<input type="checkbox"/> Supported Employment	

9. For services delivered through the CDS option:

Has the Financial Management Services Agency (FMSA) provided assistance and delivered Financial Management Services to your satisfaction? Yes No

If No, explain: _____

10. Were the services delivered by your employee according to the program service authorization? Yes No

If No, explain: _____

11. Have you had problems managing your employees?..... Yes No

If Yes, explain: _____

12. Did you report any problems to your FMSA? Yes No

If Yes, explain: _____

13. Did the CDS option meet your needs? Yes No

If No, explain: _____

14. a. Have you had to implement your backup plan?..... Yes No

If Yes, complete Item 14b. If No, skip to Item 15.

b. If yes, was the backup plan effective?..... Yes No

If No, explain: _____

15. Did you receive, at a minimum, a quarterly report from your FMSA?..... Yes No

If No, the case manager must follow up with the FMSA.

16. Do you understand the information on the budget you received from the FMSA? Yes No

If No, explain: _____

17. Are you on target with your budget? Yes No

If No, explain: _____

18. Did the FMSA report any concerns or problems to you?..... Yes No

If Yes, explain: _____

Transition Assistance Services (TAS) N/A

19. Were the services and items delivered according to the program service authorization?..... Yes No

If No, explain: _____

If No, the case manager must follow up with the TAS provider.

Case Manager Notes

Signature – Case Manager

Date