PAC WAIVER PLAN OF CARE (POC) SUMMARY

Recipient's: Name_____Medicaid ID #_____ Phone #_____ Caregiver_____

POC-Begin:_____ POC-End:_____ LOC Effective Date:_____ Case Management Agency_____

Case Manager:_____ Phone #:_____Physician Name:_____

PROCEDURE CODE	PROCEDURE DESCRIPTION	BEGIN DATE	END DATE	AUTHORIZED PROVIDER NAME & MEDICAID ID #	FREQUENCY WEEK/MONTH	UNIT COST	TOTAL COST/MONTH

Exception Request Approved by:_____ Date:_____ Total PAC Waiver funds per month_____

NON-PAC WAIVER SERVICES PROVIDED BY THIRD PARTIES, MEDICARE, MEDICAID OR OTHER FUNDING SOURCES

SERVICE	PROVIDER	FUNDING SOURCE AND COMMENTS

NOTE: The recipient/representative has been provided with an explanation and a choice of providers for the services in the Plan of Care. The recipient/representative has been given a copy of the Plan of Care on ___/___/___.

The Plan of Care was reviewed by the Care Manager: Signature of Care Manager:_____ Date: _____

Signature of Case Manager _____ Signature of PAC recipient/representative: _____ Date: _____