Department of Medical Assistance Services
Division of Long Term Care

TECHNOLOGY ASSISTED WAIVER ADULT AIDE PLAN OF CARE

Assessment Date: _____

Participant: _____ Medicaid ID#: _____
Provider: _____ Provider ID#: _____

(WRITE THE AMOUNT OF TIME FOR EACH TASK TO THE NEAREST 15 MINUTES)

Aide Categories/Tasks	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1. ADL Bathing							
Dressing							
Toileting							
Transfer							
Assist Eating							
Assist Ambulate							
Turn/Change Position							
Grooming							
Total ADL Time:							
2. Special Maintenance Vital Signs							
Supervise Meds							
Range of Motion							
Wound Care							
Bowel/Bladder Program							
Total Maint . Time:							
4. IADL Meal Preparation							
Clean Kitchen							
Make/Change Beds							
Clean Areas Used by Participant							
Total IADL Time:							
TOTAL DAILY TIME:							

This Section Must Be Completed

Composite ADL Score = (The sum of the ADL ratings that describe this participant)

BATHING SCORE		TRANSFERRING SCORE	
Bathes without help or with MH only	0	Transfers without help or with MH only	0
Bathes with HH or with HH & MH	1	Transfers with HH or with HH & MH	1
Is bathed	2	Is transferred or does not transfer	2
DRESSING SCORE		**EATING SCORE**	
Dress without help or with MH only	0	Eats without help or with MH only	0
Dresses with HH or with HH & MH	1	Eats with HH or HH & MH	1
Is dressed or does not dress	2	Is fed: spoon/ tube/ etc.	2
AMBULATION SCORE		**CONTINENCY SCORE**	
Walks/Wheels without help or with MH only	0	Continent/ incontinent < wkly self care of internal	
Walks/Wheels with HH or HH & MH	1	or external devices	0
Totally dependent for mobility	2	Incontinent weekly or > Not self care	2

LEVEL OF CARE (LOC)	☐ **A** (Score 0 - 6) Maximum Hours of 25/Week	☐ **B** (Score 7 - 12) Maximum Hours 30/Week	☐ **C** (Score 9 + wounds, tube feedings, etc.) Maximum Hours 35/Week
	☐ **D** Exceeds 35 Hours per Week	☐ **E** Exceptions by DMAS	

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Initial Plan of Care hours must be pre-authorized and should not exceed the maximum for the specified LOC category. Documentation must support the amount of hours provided to the participant.

Reason Plan of Care Submitted: ☐ New Admission ☐ ↑ In Hours ☐ ↓ In Hours ☐ Transfer

Reason for change/additional instructions for the aide: _____

_____

_____ _____

Plan of Care Effective Date: _____ Total Weekly Hours: _____

Participant / Caregiver Signature: _____ Date: _____

RN Signature: _____ Date: _____

Participant Notification Regarding the DMAS-97 T

Provider Notification to Participant
This Plan of Care has been revised based on your current needs and available support. If you agree with the changes, no action is required on your part. If you do not agree with the changes, please contact the RN Supervisor who has signed the plan of care to discuss the reason that you disagree with the change.
If the provider agency is unwilling or unable to change the information, and you still disagree, you have the right to an appeal by notifying, in writing, The Appeals Division, The Department of Medical Assistance Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219. The request for an appeal must be filed within thirty (30) days of the time you receive this notification. If you file a request for an appeal before the effective date of this action, _____ (effective date), services may continue unchanged during the appeal process.

Instructions for Completion of the DMAS-97 T

Category/Tasks
Write the amount of time for each task to be done to the nearest 15 minutes. This should be done for each task for each day. Then put the total time for each category, for each day. IADL time for the Tech Waiver is limited to meals, clean up and linens.

Level of Care Determination for Maximum Weekly Hours
Enter a score for each activity of daily living (ADL) based on the participant's current functioning. Sum each ADL rating and enter the composite score under the appropriate category: A, B, C, D, or E. The amount of time allocated under **TOTAL DAILY TIME** to complete all tasks **MUST NOT EXCEED** the maximum weekly hours for the specified LOC of A, B, or C. Check LOC D if the amount of hours per week exceeds 35. Category D can only be used with prior approval from DMAS. Prior-authorization (PA) must be obtained prior to initiating a change outside the authorized LOC category. Check LOC E to request an exception by DMAS. This category can only be used for prior authorizations completed by DMAS.

Provider Notification to Participant
Anytime the RN Supervisor changes the plan of care that results in a change in the total number of weekly hours, the RN must complete the entire front section of this form. If the change the agency is making does not require PA approval, the RN Supervisor is required to enter the effective date on the Provider Agency Client Notification Section which gives the participant their right to appeal. The participant should get a copy of both the front and back of the form.

Participant / Caregiver Signature
The participant's signature is necessary on the original plan of care and for decreases in the hours of care. It is not needed if the hours increase in a new plan of care. The provider may substitute the signature with documentation in the participant's record that shows acceptance of the plan of care.