**Service Proposal Form**

***To Be completed by Providers and Submitted to Case Managers***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Member Legal Name:** Click here to enter text. | | **Date of Birth:**Click here to enter text. | | |
| **EIS #:** Click here to enter text. | | **MaineCare #:**Click here to enter text. | | |
| **MaineCare Service Provider :** Click here to enter text. | | | | |
| **Contact Person:** Click here to enter text. | | **Agency Phone Number:**Click here to enter text. | | |
| **Contact Email:** Click here to enter text. | | | | |
| **Billing Department Contact:** Click here to enter text. | | | **Billing Contact Number:** Click here to enter text. | |
| **Billing Email:** Click here to enter text. | | | | |
| **Service Location:** Click here to enter text. | | | | |
| **Plan Type:** Choose an item. | **Funding Type:** Choose an item. | | | **Date Submitted:** Click or tap to enter a date. |

**HOME SUPPORTS**

**T2016** - Home Support Services (**Agency Per-Diem and Family Centered Home Supports - Section 21 only**)

**S5140 -** Shared Living

**T2017** - Hourly (intermittent) staffing

**T2017QC -** Home Support-Remote Support-Monitor

**T2017QC -** Home Support-Remote Support-Interactive Support

**Proposed Start Date:** Click or tap to enter a date. **Number of Hours Per Week:** Click or tap here to enter text.

**WORK SUPPORTS**

**H2023** – Work Support - Individual

**H2023HQ –** Work Support - Group

**T2019 –** Employment Specialist

**Proposed Start Date:** Click or tap to enter a date. **Number of Hours Per Week:** Click or tap here to enter text.

**Name of Employer:** Click or tap to enter a date. **Individual or Self Employment:** Choose an item.

**COMMUNITY SUPPORTS**

**T2021** – Community Support Services

**Proposed Start Date:** Click or tap to enter a date. **Number of Hours Per Week:** Click or tap here to enter text.

**ASSISTIVE TECHNOLOGY**

**97755 AT** - Assessment (32 units per year or 8 hours)

**T2035 AT -** Transmission (up to $50.00 per month)

**A9279 AT** – Device (up to $6,000.00 per year)

**Proposed Start Date:** Click or tap to enter a date. **Units (If Applicable):** Click or tap here to enter text.

**Devices (If Applicable):** Click or tap here to enter text.

**CAREER PLANNING**

**T2015** – Career Planning

**Proposed Start Date:** Click or tap to enter a date. **Proposed End Date:** Click or tap here to enter text.

**Stage 1** – up to 10 hours

**Stage 2** – up to 25 hours

**Stage 3** – up to 20 hours

**Stage 4** – up to 5 hours

**OTHER SUPPORTS**

**Home Accessibly Adaptations/Repairs (Section 21 and/or Section 29)**

**Respite (Section 29 Only)**

**Speicalized Medical Equipment (Section 21 Only)**

**Non-Traditional Communciaton Consultation (Section 21 Only**

**Non-Traditional Communciaton Assessment (Section 21 Only)**

**Consultation Services (Section 21 Only)**

**Counseling (S21 Only)**

**Crisis Intervention Services (Section 21 Only)**

**Crisis Assessment (Section 21 Only)**

**Transportation**

**Occupation Therapy (Maintenance– Section 21 Only)**

**Physical Therapy (Maintenance– Section 21 Only)**

**Speech Therapy (Maintenance – Section 21 Only)**

**Other:** Click or tap here to enter text.

**Member’s GOALS**

1. **Goal Decription**: Click or tap here to enter text.

**Start Date:** Click or tap to enter a date. **End Date:** Click or tap to enter a date. **Ongiong:** Choose an item.

**Is meeting the goal a Need or Desire:** Choose an item. **If a need, is it an Unmet Need:** Choose an item.

1. **Goal Decription**: Click or tap here to enter text.

**Start Date:** Click or tap to enter a date. **End Date:** Click or tap to enter a date. **Ongiong:** Choose an item.

**Is meeting the goal a Need or Desire:** Choose an item. **If a need, is it an Unmet Need:** Choose an item.

1. **Goal Decription**: Click or tap here to enter text.

**Start Date:** Click or tap to enter a date. **End Date:** Click or tap to enter a date. **Ongiong:** Choose an item.

**Is meeting the goal a Need or Desire:** Choose an item. **If a need, is it an Unmet Need:** Choose an item.

1. **Goal Decription**: Click or tap here to enter text.

**Start Date:** Click or tap to enter a date. **End Date:** Click or tap to enter a date. **Ongiong:** Choose an item.

**Is meeting the goal a Need or Desire:** Choose an item. **If a need, is it an Unmet Need:** Choose an item.

**NARRATIVE (MaineCare Reinbursable Services)**

Write summary of service planning that includes when service planning occurred, who talked with the focus person (and guardian, if applicable) to review previous plan and learn person's goals for upcoming year and how staff will support the person. Briefly describe support activities linked to services above. Include documentation around choice of services. (include type, scope, amount, duration & frequency)

Click or tap here to enter text.