CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS)

ATTENDANT SUPPORT MANAGEMENT PLAN

Client Information					
Client Name:		Medicaid ID #:			
Address:		City:		Zip:	
Phone:		E-mail:			
Authorized Representative's (AR) Contact Information (optional)					
Name:		Relationship to client :			
Address:					
Phone:		City:		Zip:	
E-mail:					
Single Entry Point (SEP) Case Manager Contact Information					
SEP Case Manager Name:		SEP Agency Name:			
Phone:		E-mail:			
Service Model and FMS Selection					
FMS Model (*please circle one*):	AwC	F/EA			
FMS Agency (*please circle one*):	ACES$	Morning Star	PPL		

PART ONE – Disability:

1. My disability limits my ability to do self-care and/or household activities in the following ways:

PART TWO – Needed Attendant Support :

2. I (or my Authorized Representative) have the ability to train my attendants to perform all of the activities listed below:

TASKS	SUN	MON	TUES	WED	THUR	FRI	SAT
Homemaker Services (check all that apply)							
Routine light housecleaning	☐	☐	☐	☐	☐	☐	☐
Meal preparation	☐	☐	☐	☐	☐	☐	☐
Dishwashing	☐	☐	☐	☐	☐	☐	☐
Bed making	☐	☐	☐	☐	☐	☐	☐
Laundry	☐	☐	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐	☐	☐
Estimated hours per day :							
Personal Care Services or Health Maintenance Activities (check all that apply)							
Bathing	☐	☐	☐	☐	☐	☐	☐
Skin care	☐	☐	☐	☐	☐	☐	☐
Hair care	☐	☐	☐	☐	☐	☐	☐
Nail care	☐	☐	☐	☐	☐	☐	☐
Mouth care	☐	☐	☐	☐	☐	☐	☐
Shaving	☐	☐	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐	☐	☐
Feeding	☐	☐	☐	☐	☐	☐	☐
Ambulation	☐	☐	☐	☐	☐	☐	☐
Exercises	☐	☐	☐	☐	☐	☐	☐
Transfers	☐	☐	☐	☐	☐	☐	☐
Positioning	☐	☐	☐	☐	☐	☐	☐
Bladder care	☐	☐	☐	☐	☐	☐	☐
Bowel care	☐	☐	☐	☐	☐	☐	☐
Medication assistance	☐	☐	☐	☐	☐	☐	☐
Respiratory care	☐	☐	☐	☐	☐	☐	☐
Accompanying	☐	☐	☐	☐	☐	☐	☐
Estimated hours per day :							
Protective Oversight (only if authorized by case manager)							
Estimated hours per day :							

PART THREE – Recruiting and Hiring

3. The steps I am taking to find and hire attendant(s) are (check all that apply):

Posting Ads:

Newspaper:	☐	College/University:	☐
Library:	☐	Grocery Store:	☐
On-line web sites (i.e. craigslist):	☐	Local Publications:	☐
Medical Facilities:	☐	Other Bulletin Boards:	☐
Word of Mouth:	☐	FMS Attendant List:	☐
Recruit Current PCP/CNA/Nurse:	☐	Recruit Family/Friends:	☐

Other (please specify): _____

PART FOUR – Limitations on Payment to Family

4**.** _____(Initial) I will hire my spouse (through legal marriage or common law) as an attendant. I understand that my spouse is limited to providing extraordinary care as determined by the SEP case manager and my spouse will not be paid for providing more than 40 hours of care in a seven day work week.

OR

_____(Initial) Not applicable: I will **not** hire a spouse.

5. _____(Initial) I will hire a family member(s) ("family" all persons related to the client through blood, marriage, adoption, or common law) as an attendant(s). I understand that family members and guardians will not be paid for providing more than 40 hours of care in a seven day work week.

OR

_____(Initial) I will **not** hire family member(s) and/or guardian(s) as attendant(s).

PART FIVE – Emergency Back Up Planning

6. The steps I plan to take in an emergency and/or during unexpected situations are :

Late/ No show Attendant:

Life or Limb Emergency:

Unexpected illness or flu:

Other (optional):

Community Wide Disaster (i.e. flood, blizzard, etc.):

PART SIX – CDASS Monthly Budgeting Worksheet:

Monthly Allocation: Total amount available for attendant support services.					=		1
Attendant	**Attendant's Hourly Rate**	**Your Cost Per Hour ***		**Hours Per Week**		**Total Per Week**	
			X		=		a.
			X		=		b.
			X		=		c.
			X		=		d.
			X		=		e.
			X		=		f.
Attendant Care Wages Per Week Total Add (a) through (f)							2
Attendant Care Wages Per Month Total: Multiply Weekly Total (Box 2) by 4.3							g.
Amount Per Month for Health Insurance: **(Note: This is not applicable for clients with the F/EA service model.)** • Do any of your attendants qualify for, and plan to enroll in, employer-sponsored health insurance? _____Yes _____No If so, which ones? _____ You will need to contact your chosen FMS provider to obtain the monthly employer premium. Add (+) to the Attendant Care Per Month							3
Total Monthly Cost for Attendant Care: **Attendant Care Wages Per Month Total (g) plus Amount Per Month for Health Insurance (Box 3)**					=		4

* Refer to the Attendant Wages table.

PART SEVEN – CDASS Start Date (To be completed by Case Manager)

Preferred CDASS Start Date	Alternate Start Date

PART EIGHT- Signatures

Client/ Authorized Representative Signature	Date
Case Manager Signature	Date

Consumer Direct Comments:

Reviewer's Signature	Date

FOR SINGLE ENTRY POINT CASE MANAGER APPROVAL – PLEASE DO NOT WRITE IN THIS SPACE			
Client receives CDASS through (check one):		**Client's certification dates:**	
HCBS- waiver ☐	**CDASS ONLY ☐**	**CDASS Start Date:**	
		End Date:	
Case Manager Approval		**Date Signed**	