



NC DEPARTMENT OF  
**HEALTH AND HUMAN SERVICES**

**PERSON-CENTERED PLANNING**  
**GUIDANCE DOCUMENT**

DRAFT

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## **Purpose Of Person-Centered Planning**

The Division of Mental Health Developmental Disabilities and Substance Abuse Services (DMHDDSAS) has developed new guidelines for Person-Centered Planning (PCP) process. This new guidance focuses on self-advocacy and individual and families' desire for change and creates a new emphasis on self-determination and choice for individuals. The Person-Centered Planning process begins with an individual's vision for a preferred life and will take the concept of self-determination from theory to practice. Individuals have a primary role in person-centered planning and should be provided the opportunity to participate fully in this process.

The purpose of the 2022 PCP Guidance Document is to assist Qualified Professionals who are tasked with developing PCPs in their knowledge and skills related to person-centered planning. While there are many elements to consider in person-centered planning, perhaps the most important thing for the Qualified Professional (QP) or Licensed Professional (LP) who develops the PCP to remember is that it is an ongoing, interactive, team process.

## **Values and Principles Underlying Person-Centered Planning**

This guidance is rooted in the belief that: All people have the right to live, love, work, learn, play, and pursue their dreams in their community. Person-centered planning is a highly individualized process designed to respond to the expressed needs/desires of the individual. The framework of this belief consists of the following values, principles, and processes:

- Builds on the individual's/family's strengths, gifts, skills, and contributions.
- Supports individual empowerment and provides meaningful options for individuals/families to express preferences and make informed choices in order to identify and achieve their hopes, goals, and aspirations. This also provides the opportunity for individuals to identify what they do not want in their treatment.
- Is a framework for providing services, treatment and supports that meet the individual's needs, and that honors goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, mastery, and competence.
- Identifies and develops natural supports and community connections to assist in ending isolation, disconnection, and disenfranchisement.
- All the elements that compose a person's individuality are acknowledged and valued in the planning process, including the individual's expression of their culture, ethnicity, religion, sexual orientation, and gender identity.
- Supports mutually respectful and partnering relationships between individuals/families and providers/professionals acknowledging the legitimate contributions of all parties.

## **Person-Centered Planning Process**

Person-Centered Planning is a process that engages an individual to develop a Person-Centered Plan. This process engages people important to the individual receiving services, as well as people who will provide supports and services to come together and plan the specifics - the "who, what, when, where and why," related to the supports and services that will be offered. The person-centered plan must include the assessment of life domains, an action plan, an enhanced crisis intervention plan, and a signature page. The person-centered plan should be based on a comprehensive assessment that examines the individual's symptoms, behaviors, needs and preferences across the life domains listed below. All life domains need to be

assessed/discussed during plan development, but only those that the individual identifies that they want to work on should be included in the plan.

### Life Domains

Each life domain has a unique purpose that should provide a written picture of what is currently happening, what the individual's vision for a preferred life is for that area, and what the provider is doing to support the individual to move closer to living their preferred life. These domains will inform the development of a person-centered plan with targeted dates for accomplishment.

- **Daily Life and Employment:** What a person does as part of everyday life – school, employment, volunteering, communication, routines, and life skills.
- **Community Living:** Where and how someone lives – housing and living options, community access, transportation, home adaptation and modification.
- **Safety and Security:** Staying safe and secure – finances, emergencies, relationships, neighborhood, well-being, decision making supports, legal rights, and issues.
- **Healthy Living:** Managing and accessing health care and staying well – medical, mental health, behavioral, alcohol, tobacco and other drug use, medication management, life span development, exercise, wellness, and nutrition.
- **Social and Spirituality:** Building/strengthening friendships and relationships, leisure activities, personal networks, community inclusion, natural supports, cultural beliefs, and faith community.
- **Citizenship and Advocacy:** Building valued roles, understanding personal rights, making choices, sexual orientation, self-identification, setting goals, assuming responsibility and driving how one's own life is lived.
- **Other Areas of Importance:** To be utilized in those rare situations when what the individual desires does not fit into one of the life domains listed above.

### Action Plan

The Action Plan section of the PCP includes the individual's long-term goal, short-term goals, and interventions. Action steps and interventions should address various life domains, as relevant to that individual's goals, needs, and strengths. The providers approved for authorized services are responsible for carrying out the plan and meeting the health and personal safety needs of the individual. For each desired long-term goal, the Action Plan will include short-term goal(s) as well as interventions. Below are definitions of each core component of the PCP as well as tips for how to write them. In addition, the PCP template includes additional suggested questions for directly soliciting the person's input around each of these components.

- **Long-Term Goal Development:** Person-Centered Plans capture desired changes and accomplishments. Long-term goals are what motivate people to engage in services and make changes, are personal to that individual, often reflect one or more Life Domains, and typically take time to achieve. Whenever possible, they are written as a brief quote from the individual that captures what is most important to them in their vision of a good/better life. Ideally, long-term goals are oriented toward quality-of-life priorities and not only the management of health conditions and symptoms, e.g., *I want to finish school, get back to church, see my grandkids, get a car, etc.*
- **Short-Term Goals:** help the person move closer to achieving their long-term goals. They

reflect concrete changes in functioning/skills/activities that are meaningful to the person and are proof they are making progress. They are WHAT the person can do differently and achieve in a relatively brief amount of time. Short-term goals build on strengths while also addressing identified needs from the assessment that interfere with the attainment of the valued, long-term life goal(s). Short-term goals are written in SMART language per the below:

- **Specific/Straightforward/Simple:** What the person wants to accomplish should be clear, specific, and simply stated. What is the concrete step or change that they want to make that will be proof that they are overcoming barriers and making progress?
  - **Measurable:** A short-term SMART goal is written in a manner where people involved can reliably determine if it was accomplished. A measurable short-term goal should include how much, how many, and how will I know when it is accomplished.
  - **Achievable:** Goals should challenge the individual to think about how they can accomplish the goal if they have the resources needed. What feels like a reasonable first step so that the short-term goal is possible to achieve? Achievable short-term goals consider a variety of personal and environmental factors such as resources, strengths, barriers, skill level, stage of change and motivation.
  - **Relevant:** Individuals value short-term goals that are relevant to them and align with their long-term goals. Questions to explore include: “Is this getting in the way of a long-term goal that is important to me?” “Is this worthwhile?”, “Is this the right time?”
  - **Time-Limited:** Short-term goals should have a deadline for completion that holds both the provider, individual, and other supports accountable to action steps. The time needed should be based on where the person is currently starting in relation to their desired goal. Timing may be captured by a specific date (e.g., “As of [this date]” or indication of timespan (within 4 months).
- **Interventions:** Whereas short-term goals are WHAT the person concretely hopes to achieve, interventions reflect HOW all team members contribute to help the person get there. Interventions are the specific tasks the provider and individual agree upon and they address a challenge or need while also building on strengths whenever possible. The language of interventions should include: WHO is offering the intervention/support, WHAT specifically it is (e.g., title of service or action), WHEN it is being offered (e.g., once a month for 3 months), and WHY it is needed (i.e., individualized purpose and intent for this specific individual).

### **Crisis Intervention Plan**

A crisis plan includes supports/interventions aimed at preventing a crisis and supports/interventions to employ if there is a crisis. The plan will include the following components:

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- Significant event(s) that may create increased stress and trigger the onset of a crisis
- Early warning signs that indicate possible upcoming crisis? What indicators relating to behavior, speech, and actions to look for?
- Crisis prevention and early intervention strategies that can be effective in helping avoid and/or manage a crisis.
- Strategies for crisis response and stabilization -natural and community supports.
- Specific recommendations for interacting with the person receiving a Crisis Service.
- Diagnosis and Insurance information,
- Name and contact of medical and mental health provider, list of medication including doses and frequency, allergies, and other medical and dental concerns.
- Living situation and planning for any pets and people, etc. in case of a crisis if applicable.
- Employment/ Educational status and plan for notification if applicable, while respecting individual preferences for what is disclosed/not disclosed.
- Preferred method of communication and language.
- Names and contact information of formal and informal support persons for the individual
- If applicable include suicide prevention and intervention plan, behavior plan, youth in transition plan and Psychiatric Advance Directive (PAD).
- Crisis follow-up planning to include:
  - The primary contact who will coordinate care if the individual requires inpatient or other specialized care.
  - Name of the person who will visit the individual while hospitalized. (This information should come from the individual and reflect the individual's preference).
  - Provider responsible to lead a review/debriefing following a crisis and the timeframe.

The crisis plan is an active and living document that is to be used in the event of a crisis. After a crisis, staff should meet with the individual and their natural and professional supports (if applicable) to discuss the crisis plan including identify and address factors that led to the crisis, what worked and did not work and make changes as indicated.

### **Indicators of Person-Centered Planning Implementation**

It is the responsibility of the provider to assure that the Person-Centered Plan is developed utilizing a person-centered planning process. Below are examples of systemic and individual level indicators that would demonstrate that person centered planning has occurred. The methods of gathering information or evidence may vary, and include the review of administrative documents, clinical policy and guidelines, case record review and interviews/focus groups with individuals and their families.

- Systemic indicators would include, but not be limited to:
  1. The provider and LME/MCO quality improvement system actively seeks feedback from individuals receiving services, support and/or treatment regarding their satisfaction, providing opportunities to express needs and preferences and the ability to make choices.

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2. The LME/ MCO quality improvement system outlines a continuous quality improvement plan that ensures the providers adhere to the Person-Centered Planning Guidance document.
  3. The provider staff involved in managing, planning, and delivering support and/or treatment services are trained in state approved person-centered planning training.
  4. The LME/MCO staff involved in managing, and/or authorizing treatment service are trained in state approved person-centered planning training.
- Individual indicators would include, but not be limited to:
    1. The individual was provided with information on his/her right to person-centered planning.
    2. The individual's preferences, choices, culture, and identity were considered in planning process.
    3. Goals were written in the individual's language, with target dates and supports needed to accomplish the goals.
    4. The individual is living in the housing and location of their choice or is in the process of locating such housing.
    5. The individual is competitively working or currently enrolled in school.
    6. The individual is actively engaged in community activities.
    7. The person-centered plan is updated in accordance to changing needs and preferences of the individual receiving services.

### **Person-Centered Plan Required Elements**

Providers can use the PCP template or develop their own template, but it must contain all of the required elements listed in this guidance document. Each PCP is required to contain the following elements:

- Assessment of Life Domains
- Person-Centered Interview Questions
- Action Plan (Long-term goal, short-term goals, interventions)
- Enhanced Crisis Intervention Plan
- Signature Page

**PCP Template – Page 1**



**\_\_\_\_\_’S PERSON-CENTERED PLAN**

<b>Name:</b>	<b>DOB:</b> / /	<b>Medicaid ID:</b>	<b>Record #:</b>
<b>(Non - CAP-MR/DD Plans ONLY)</b> PCP Completed on: / /	<b>(CAP-MR/DD Plans ONLY)</b> Plan Meeting Date: / /      Effective Date: / /		

**Life Domains Assessed during Development of Person-Centered Plan:**

<p><b>Daily Life and Employment</b></p> <p>What a person does as part of everyday life – school, employment, volunteering, communication, routines, and life skills.</p>	<p><b>Community Living</b></p> <p>Where and how someone lives – housing and living options, community access, transportation, home adaptation and modification.</p>
<p><b>Safety and Security</b></p> <p>Staying safe and secure – finances, emergencies, relationships, neighborhood, well-being, decision making supports, legal rights, and issues.</p>	<p><b>Healthy Living</b></p> <p>Managing and accessing health care and staying well – medical, mental health, behavioral, alcohol, tobacco and other drug use, medication management, life span development, exercise, wellness, and nutrition</p>
<p><b>Social and Spirituality</b></p> <p>Building/strengthening friendships and relationships, leisure activities, personal networks, community inclusion, natural supports, cultural beliefs, and faith community.</p>	<p><b>Citizenship and Advocacy</b></p> <p>Building valued roles, understanding personal rights, making choices, sexual orientation, self-identification, setting goals, assuming responsibility and driving how one’s own life is lived.</p>

***What do you want to work on? What would you like to accomplish?***

*Using the assessment of the Life Domains, use this information to determine what is most important to the individual right now? What is their vision of a good life?*

***What strengths do you currently have?***

*These are the individualized, personal attributes, gifts, and skills a person possesses. Avoid what makes a “good client”. Good examples: good sense of humor, artistic, knowledgeable about gardening, good soccer player, stylish. Avoid: shows up for appointments, takes medications as prescribed, smiles a lot, follows directions.*

***What are the obstacles to meeting your goals?***

*Help the individual identify the things that are getting in the way of meeting their goals and the resources they need to meet their goals.*



**PCP Template – Page 2**

**ACTION PLAN**

The Action Plan section of the PCP includes the individual’s long-term goal, short-term goals, interventions, and timeframes.

**Long-Term Goal:**

*“I want to get a car.”*

**Short-Term SMART Goal**

**Goal:** Example: *“I want to save up money to buy a car.”*

**Team:** *Individual will have improved budgeting skills as evidenced by saving \$500 within 6 months.*

**Interventions – Provider(s):**

1. *Psych Rehab Specialist will provide money management supports 2 times weekly for 45-60 minutes to help with: outlining monthly income and spending, developing a monthly budget, and exploring ways to reduce spending and increase savings.*
2. *Peer Support Specialist will help the individuals open a savings account at a bank of his choice within 30 days.*

**Interventions – Individual and/or Natural Support Actions:**

1. *I will bring a copy of my monthly bills within 2 weeks to help inform the budget.*
2. *My cousin agreed to buy me a calculator to help me look at local banking options.*

**Short-Term SMART Goal**

**Goal:** Example: *“I want to manage my symptoms better. It’s hard for me to make all my shifts at work when I’m not feeling well or I end up in the ER and then my check gets cut.”*

**Team:** *The individual will implement improved coping strategies to miss no more than 1 work shift per month for the next 6 months.*

**Interventions – Provider(s):**

1. *The Team will help the individual schedule an appointment with the psychiatric care provider within 30 days.*
2. *The Team will meet with the individual 2-3 times per week to assess how medication is being tolerated.*
3. *The Psychiatric Care Provider will provide medication management 1x every 3 months to help reduce distressing symptoms, including high anxiety which can lead to work absences and ER visits.*
4. *Team Clinician will meet with the individual at least 1 time per week for individual therapy, utilizing CBT, to assist the individual in improving coping skills to better manage anxiety and frustrations.*
5. *Peer Support Specialist will work with the individual to help him complete a Wellness Recovery Action Plan (WRAP) within 30 days to use as a daily wellness toolbox and in the event of crisis.*

**Interventions – Individual and/or Natural Support Actions:**

1. *I will use at least one of my wellness tools from my WRAP (e.g., attending church, walking my dog, listening to music) every day to better manage my stress.*
2. *I will reach out to my cousin for extra support and also my team when I am having a crisis instead of calling 911 or going to the hospital.*

**\*\* Copy and use as many Action Plan pages as needed.\*\***

**PCP Template – Page 3**  
**PLAN SIGNATURES**

**I. PERSON RECEIVING SERVICES:**

I confirm and agree with my involvement in the development of this PCP. My signature means that I agree with the services/supports to be provided.

I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this PCP.

For CAP-MR/DD services only, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with mental retardation instead of participating in the Community Alternatives Program for individuals with Mental Retardation/Developmental Disabilities (CAP-MR/DD).

**Legally Responsible Person: Self:** Yes  No

**Person Receiving Services:** (Required when person is his/her own legally responsible person)

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Print Name)

**Legally Responsible Person (Required if other than person receiving Services)**

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Print Name)

Relationship to the Individual: \_\_\_\_\_

**II. PERSON RESPONSIBLE FOR THE PCP:** The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Person responsible for the PCP) (Name of Case Management Agency)

**Child Mental Health Services Only:**

**For individuals who are less than 21 years of age (less than 18 for State funded services) and who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the person responsible for the PCP must attest that he or she has completed the following requirements as specified below:**

Met with the Child and Family Team - Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**OR** Child and Family Team meeting scheduled for - Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**OR** Assigned a TASC Care Manager - Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**AND** conferred with the clinical staff of the applicable LME to conduct care coordination.

If the statements above do not apply, please check the box below and then sign as the Person Responsible for the PCP:

This child is not actively involved with the Department of Juvenile Justice and Prevention or the adult criminal court system.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Person responsible for the PCP) (Print Name)

**III. SERVICE ORDERS:** **REQUIRED for all Medicaid funded services; RECOMMENDED for State funded services.**

**(SECTION A): For services ordered by one of the Medicaid approved licensed signatories (see Instruction Manual). My signature below confirms the following: (Check all appropriate boxes.)**

- Medical necessity for services requested is present, and constitutes the Service Order(s).
- The licensed professional who signs this service order has had direct contact with the individual.  Yes  No
- The licensed professional who signs this service order has reviewed the individual's assessment.  Yes  No

Signature: \_\_\_\_\_ License #: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Name/Title Required) (Print Name)

**(SECTION B): For Qualified Professionals (QP) / Licensed Professionals (LP) ordering:**

- CAP-MR/DD or
- Medicaid Targeted Case Management (TCM) services (if not ordered in Section A)
- Any state-funded services not ordered in Section A or
- 1915(b)(3) or 1915(i) Option service(s) (if not ordered in Section A)

**My signature below confirms the following: (Check all appropriate boxes.)** Signatory in this section must be a Qualified or Licensed Professional.

- Medical necessity for the CAP-MR/DD services requested is present, and constitutes the Service Order.
- Medical necessity for the Medicaid TCM service requested is present, and constitutes the Service Order.
- Medical necessity for the State-funded service(s) requested is present, and constitutes the Service Order.
- Medical necessity for the 1915(b)(3) or 1915(i) Option service(s) requested is present, and constitutes the Service Order.

Signature: \_\_\_\_\_ License #: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Name/Title Required) (Print Name) (If Applicable)

**IV. SIGNATURES OF OTHER TEAM MEMBERS PARTICIPATING IN DEVELOPMENT OF THE PLAN:**

Other Team Member (Name/Relationship): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Other Team Member (Name/Relationship): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Submission Requirements for an Initial Authorization

- **Assessment of Life Domains**
  - **Person-Centered Interview Questions**
  - **Action Plan** (long-term goal, short-term goals, interventions)
  - **Enhanced Crisis Intervention Plan**
  - **Signature Pages** from the PCP including:
    - ✓ **Person Receiving Services** - Dated signature is required when the person is his/her own legally responsible person.
    - ✓ **Legally Responsible Person** - Dated signature when the person receiving services is not his/her own LRP.
    - ✓ **Person Responsible for the Plan** - Dated signature is required. Completion of each of the required boxes on the signature pages of the PCP by the Person Responsible for the Plan is also required for individuals under the age of 21 (Medicaid) or under age 18 (State) who are:
      - Receiving enhanced services and;
      - Actively involved with the Department of Juvenile Justice and Delinquency Prevention or the Criminal Court System.
    - ✓ **Service Order/Confirmation of Medical Necessity**-Dated signature is required, plus each of the following must be addressed by the licensed professional who signs the service order.
      - Confirmation of medical necessity;
      - Indication of whether or not review of the comprehensive clinical assessment occurred; and
      - Indication of whether or not the LP signing the service order had direct contact with the individual.
- (NOTE):** Check boxes left blank on the signature pages of the PCP will be returned as incomplete by the service authorization agency.
- **Inpatient Treatment Report (ITR) form, or ORF1, or CTCM.**
  - **LME-MCO Consumer Admission and Discharge Form** (required for submission to the LME-MCO).
    - ✓ Prior to service delivery, a **Comprehensive Clinical Assessment** must be completed.

## Authorization & Follow-up Process

When any service is pre-authorized by the service authorization agency:

- ✓ The authorization is in effect for the duration indicated by the service authorization agency.
- ✓ Prior to the end of the first authorization period, the following must be completed and submitted to the service authorization agency for any further authorization to occur:
  - New ITR/ORF-2 / PCPM / CTCM Form / Risk Identification Tool / MR-II (CAP-MR/DD Consumers) / NC-SNAP (DD Consumers)
  - PCP

Prior to service delivery, a Comprehensive Clinical Assessment must be completed. This assessment is not submitted to the service authorization agency.

- **The Comprehensive Clinical Assessment (CCA) may include but is no limited to:**
  - 1) T1023-Diagnostic Assessment
  - 2) 90801-Clinical Evaluation/Intake
  - 3) 90802-Interactive Evaluation
  - 4) 96101-Psychological Testing
  - 5) 96110-Developmental Testing (Limited)
  - 6) 96111-Developmental Testing (Extended)
  - 7) 96116-Neuropsychological Exam
  - 8) 96118-Neuropsychological Testing Battery
  - 9) H-0001-Alcohol &/or Drug Assessment
  - 10) H-0031-Mental Health Assessment
  - 11) Evaluation & Management (E/M) Codes
  - 12) YP830-Alcohol &/or Drug Assessment-non-licensed provider (State \$ only)

## Signature Page

### (Part I) Signature of Person Receiving Services

- The person receiving services is required to sign and date the PCP in Part I indicating confirmation and agreement with the services and supports detailed and confirmation of choice of service provider(s) *if the individual is his/her own legally responsible person.*
- The signature is authenticated when the individual signing enters the date next to his or her signature.
- Do not present the Signature Page to the individual to sign if not attached to a fully completed and dated PCP.
- A provider may not bill Medicaid for services until this signature is acquired if the individual is his or her own legally responsible person.
- All individuals are highly encouraged to sign their own PCPs.

### Minors

- A minor may and/or must sign the plan under the following conditions: If the minor is receiving mental health services as allowed in NC General Statute 90-21, the minor's signature on the plan is sufficient. However, once the legally responsible person becomes involved, the legally responsible person shall also sign the plan.
- For **minors receiving outpatient substance abuse services**, the plan shall include both the staff and the child or adolescent's signatures demonstrating the involvement of all parties in the development of the plan and the child or adolescent's consent/agreement to the plan. Consistent with North Carolina law (NC General Statute 90- 21.5), the plan may be implemented without parental consent when services are provided under the direction and supervision of a physician. When services are not provided under the direction and supervision of a physician, the plan shall also require the signature of the parent or guardian of the child or adolescent demonstrating the involvement of the parent or guardian in the development of the plan and the parent's or guardian's consent/agreement to the plan.
- For an **emergency admission to a 24-hour facility, per NC General Statute 122C-223(a)**, "in an emergency situation when the legally responsible person does not appear with the minor to apply for admission, a minor who is mentally ill or a substance abuser and in need of treatment may be admitted to a 24-hour facility upon his own application." In this case, the minor's signature on the plan would be sufficient.
- For an **emergency admission to a 24-hour facility, per NC General Statute 122C-223(b)**,

“within 24 hours of admission, the facility shall notify the legally responsible person of the admission unless notification is impossible due to an inability to identify, to locate, or to contact him after all reasonable means to establish contact have been attempted.” Once contacted, the legally responsible person is required to sign the plan.

- For an **emergency admission to a 24-hour facility, per NC General Statute 122C-223(c)**, “If the legally responsible person cannot be located within 72 hours of admission, the responsible professional shall initiate proceedings for juvenile protective services.” In this case, the individual designated from juvenile protective services shall sign the plan.

**NOTE:** For minors receiving substance abuse services in a non-emergency admission to a 24-hour facility, both the legally responsible person and the minor are required to sign the plan.

**NOTE:** Within Substance Abuse Non-Medical Community Residential Treatment, Residential Recovery Programs for women and children the Person-Centered Plan shall also include goals for the parent-child interaction.

### (Part I) Legally Responsible Person

#### Person Receiving Services:

I confirm and agree with my involvement in the development of this PCP. My signature means that I agree with the services/supports being provided.

I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this PCP.

For CAP-MR/DD services only, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with mental retardation instead of participating in the Community Alternatives Program for individuals with Mental Retardation/Developmental Disabilities (CAP-MR/DD).

#### Legally Responsible Person: Self: Yes No

**Person Receiving Services:** (Required when person is his/her own legally responsible person)

**The Legally Responsible Person, if not the person to whom the PCP belongs, signs and dates the PCP in Part I confirming:**

- ❖ Involvement in the development of the One Page Plan / PCP, and agreement with the services to be provided.
- ❖ Understanding that he/she has the choice of service providers and may change providers at any time.
- ❖ For CAP-MR/DD services only, understanding that he/she has the choice of seeking care in an ICF-MR facility in lieu of CAP-MR/DD services.
- This signature and the date of the signature are REQUIRED.
- The signature is authenticated when the individual signing enters the date next to his/her signature.
- Do not present the Signature Page to the Legally Responsible Person to sign if not attached to a fully completed and dated PCP.
- A provider may not bill Medicaid for services until this signature is acquired.

**(Part II) Person Responsible For The PCP**

- The QP/LP responsible for the PCP development signs and dates the plan in Part II, confirming involvement and agreement with the services and supports detailed in the PCP.
- This signature and the date of the signature are REQUIRED.
- The date of the QP/LP signature should coincide with the “PCP Completed on” date, or be within 30 days of the MR 2 (for CAP-MR/DD plans only).
- The signature is authenticated when the individual signing enters the date next to his or her signature.
- **For Adults (21 years of age for Medicaid, 18 years of age for State funded services),** the person responsible for the PCP signs and dates the plan in Part II of the Signature page.
- **For Children/Adolescents (less than 21 years of age for Medicaid, less than 18 for State funded services),** who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the **signature of the person responsible for the PCP in Part II of the Signature page attests that he or she has completed the following requirements:**
  - ❖ Met with the Child and Family Team, OR
  - ❖ Scheduled a Child and Family Team meeting, OR
  - ❖ Assigned a TASC Care Manager, AND
  - ❖ Conferred with the clinical staff of the applicable LME to conduct care coordination.

**II. PERSON RESPONSIBLE FOR THE PCP:** The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

(Person responsible for the PCP)

**For individuals who are less than 21 years of age (less than 18 for State funded services) and who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the person responsible for the PCP must attest that he or she has completed the following requirements as specified below:**

Met with the Child and Family Team - Date: \_\_\_/\_\_\_/\_\_\_

OR Child and Family Team meeting scheduled for - Date: \_\_\_/\_\_\_/\_\_\_

OR Assigned a TASC Care Manager - Date: \_\_\_/\_\_\_/\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

### (Part III) Service Orders

#### For Medical Necessity of MEDICAID Funded Services:

- **A Licensed physician, licensed psychologist, licensed physician assistant or licensed nurse practitioner** must sign the PCP in Part III, **Section A**, indicating all of the following:
  - ❖ That the requested services are medically necessary.
  - ❖ Whether the LP signing has or has not had direct contact with the individual.
  - ❖ Whether the LP signing has or has not reviewed the Comprehensive Clinical Assessment.
- **If not ordered by a LP, a Qualified Professional (QP) must order CAP-MR/DD services, Medicaid funded Targeted Case Management (TCM) services, or 1915(b)(3) or 1915(i) Option service(s) are medically necessary, in Section B.** The signature confirms one or both of the following:
  - ❖ The requested CAP-MR/DD services are medically necessary.
  - ❖ The requested Medicaid-funded TCM services are medically necessary.
  - ❖ 1915(b)(3) or 1915(i) Option service(s) are medically necessary.
- In all cases, the signature and the date of the signature are REQUIRED.
- The signature is authenticated when the designated professional signing enters the date next to his/her signature.
- The signature serves as the Service Order for services contained in the PCP.
- Do not present the signature page to the LP to sign if not attached to a fully completed and dated PCP.
- A provider may not bill Medicaid for services until this signature is acquired.
- The annual review of medical necessity is due upon the annual rewrite of the PCP, based on the “PCP Completed On” Date, or, for CAP-MR/DD Plans only, the Effective Date.

***(NOTE: Check boxes left blank on the signature pages of the PCP will be returned as incomplete by the Medicaid vendor.)***

***(NOTE: DHHS shall report the failure of a licensed professional to comply with the above requirements to the licensed professional’s occupational licensing board).***

#### For Medical Necessity of STATE Funded Services:

- The process above [Medical Necessity of Medicaid Funded Services] is RECOMMENDED for verifying medical necessity and ordering of State funded services.
- Utilizing the process above will prevent the possibility of services being provided without a service order should the individual move from State funded services to Medicaid.
- If a licensed professional listed above does NOT confirm medical necessity, it is then RECOMMENDED that the **QP responsible for the plan** sign the person-centered plan in **Part III, Section B on the Signature page**, confirming that medical necessity criteria have been met for the services included in the plan. **If not confirming medical necessity, the QP must still sign as the person responsible for the PCP in Part II of the Signature page.**
- One of these signatures (in Part III, Section B; or Part II) and the date of the signature are REQUIRED. The signature is authenticated when the designated professional signing

enters the date next to his or her signature.

- A signature in Part III, Section B serves as the Service Order for State-funded services contained in the PCP.
- The signature is authenticated when the individual signing enters the date next to his or her signature.
- The annual review of medical necessity is due upon the annual rewrite of the PCP, based on the “PCP Completed On” Date, or, for CAP-MR/DD Plans only, the Effective Date.

### **Update/Revision Assessment Of Life Domains And Person-Centered Profile**

- PCPs must be reviewed and updated if the person’s needs change, if a goal has been completed, if there is a change in provider and/or based on the documented target date in the Short-Term SMART goal(s).
- If any review results in a new service being added or new goal(s) being added, the PCP must be revised to reflect the new changes.
- At a minimum, a new PCP must be developed annually.
- Any time the PCP is updated/revised, a new Signature page must be completed that reflects the dates of the changes.

### **Update/Revision of Signature Page**

#### **For Medicaid funded services:**

- **When the Update/Revision include a new service(s)**, a licensed physician, licensed psychologist, licensed physician assistant or licensed family nurse practitioner must sign and date the new Signature Page indicating that requested service(s) are medically necessary, indicating whether the LP had face to face contact with the individual and whether the LP reviewed the Assessments. **The dated signature serves as the Service Order(s).**
- This signature and the date of the signature are REQUIRED. The signature is authenticated when the individual signing enters the date next to his/her signature.
- Do not present the revised Signature Page to the LP to sign if not attached to a fully completed and updated PCP.

#### **For State funded services:**

- **When the Update/Revision includes a new service(s)**, it is RECOMMENDED that a licensed physician, licensed psychologist, licensed physician’s assistant or licensed family nurse practitioner sign the new Signature Page indicating that the services contained in the plan are medically necessary. This signature serves as a Service Order and will prevent the possibility of services being provided without a service order should the individual move from State-funded service to Medicaid.
- If the recommended signatures above are not obtained, it is then RECOMMENDED that the **person responsible for the plan/clinical home** sign the new Signature Page indicating the medical necessity has been met and ordering the service(s). *(NOTE: The person responsible for the plan/clinical home must sign the update/revision even if the service(s) is ordered per the Medicaid requirement above. In this case, the signature confirms involvement and agreement with the services and supports detailed in the update/revision but does not constitute the service order.*