_____'S PERSON-CENTERED PLAN

Name:	DOB: / /	Medicaid ID:	Record #:
(Non - I/DD Plans ONLY) **PCP Completed on: / /**	**(I/DD Plans ONLY)** **Plan Meeting Date: / /** **Effective Date: / /**		

Life Domains Assessed during Development of Person-Centered Plan:

Daily Life and Employment	Community Living
Safety and Security	**Healthy Living**
Social and Spirituality	**Citizenship and Advocacy**

What do you want to work on? What would you like to accomplish?
What strengths do you currently have?
What are the obstacles to meeting your goals?

Name: **DOB:** **Medicaid ID:** **Record #:**

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:

Short-Term SMART Goal
Goal:
Interventions – Provider (s):
Interventions – Individual and/or Natural Support Actions:

Short-Term SMART Goal
Goal:
Interventions – Provider (s):
Interventions – Individual and/or Natural Support Actions:

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

Name: **DOB:** **Medicaid ID:** **Record #:**

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 I/DD services only, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with Intellectual/Developmental Disabilities (I/DD) (instead of participating in the Community Alternatives Program for individuals with Intellectual/Developmental Disabilities (I/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:

- I/DD or
- Medicaid Tailored Care Management (TCM) services (if not ordered in Section A)
- Any state-funded services not ordered in Section A 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 I/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(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: __/__/____