**Section 1: Plan of Care Cover Page**

Frequency, Duration and Scope of Services

|  |  |  |  |
| --- | --- | --- | --- |
| Recipient Name: |  | Medicaid #/CIN: |  |

Natural support/services from family, friends, neighbors, attorneys, landlord, church, clubs, other:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Relationship (check if primary caregiver)** | **Address (indicate “same” if lives with Recipient)** | **Home Phone** | **Work Phone** | **Service** | **Frequency** | **Paid**  **Yes** | **Paid No** |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

Other Services needed by the client (list should include prescriptions, labs, primary care): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BH HCBS support/services:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service Code** | **Provider** | **Unit(s)** | **Per** | **Total units monthly** | **Start Date** | **End Date** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**Section 2: Person-Centered Plan of Care Addressing Goals, Preferences and Needs**

Recipient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEDICAID #/CIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location of Meeting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The team may utilize information collected during the Eligibility Assessment to complete the following:

|  |  |
| --- | --- |
| These are my goals: |  |
| I want to spend my time doing: |  |
| My strengths are: |  |
| Through the evaluation it was identified that I have the following clinical and support needs: |  |
| Are there any recommendations by my medical and behavioral health providers that I need help with: (such as help managing my medications, or help with handling my money)? |  |
| I would prefer that when I receive services the following is taken into account by the providers: |  |
| I want to live at: |  |
| If I want to move, the following action steps were identified: |  |
| I want the following people involved in the development of my Plan of Care: |  |

|  |  |
| --- | --- |
| **Goal #1** | **Target Date** |
| **Past Efforts (Things that I have tried in the past to reach my goal)** | |
| **Objectives (These are measurable actions or steps I want to take in order to reach my goal)** | |
| **Potential Barriers (Things that make it hard for me to reach my goal)** | |
| **Strategies (Things that I will do to reach my goal)** | |
| **Supports Needed (Who will help me reach my goal) (Indicate if Paid Provider or natural support and the frequency)** | |
| **Goal #2** | **Target Date** |
| **Past Efforts** | |
| **Objectives** | |
| **Potential Barriers** | |
| **Strategies** | |
| **Supports Needed (Indicate if natural support or Paid Provider and frequency)** | |
| **Goal #3** | **Target Date** |
| **Past Efforts** | |
| **Objectives** | |
| **Potential Barriers** | |
| **Strategies** | |
| **Supports Needed (Indicate if natural support or Paid Provider and frequency)** | |
| **Goal #4** | **Target Date** |
| **Past Efforts** | |
| **Objectives** | |
| **Potential Barriers** | |
| **Strategies** | |
| **Supports Needed (Indicate if natural support or Paid Provider and frequency)** | |

Section 3: Risk Mitigation Strategies

|  |  |  |  |
| --- | --- | --- | --- |
| Recipient Name: |  | Date: |  |

**Crisis Prevention**

It is often helpful to be aware of events, feelings, thoughts and sensations that are early warning signals for an emotional crisis. If I begin to experience them, I can use the following plan.

What are my triggers (what people, places, or things upset me); how do I know when I am upset?

|  |
| --- |
|  |

What activities can I do to feel better (for example, take a walk, listen to music, or watch TV)?

|  |
| --- |
|  |

Who can I call for support?

|  |
| --- |
|  |

**Back-Up Plan**

**If there is an emergency, call 911.** A back-up plan assists in locating help in an emergency situation or if regularly scheduled worker(s) cannot provide you care, services, or supports. The back- up plan will indicate: whom I will call, including service needs, and phone numbers, plans for service animals or pets, and plans for preparing for a disaster.

I will talk with back-up workers about their availability and my care needs before an emergency comes up. I understand that I may only get my most serious needs met in an emergency.

I will call/contact one of the individuals listed below if my regularly scheduled worker(s) does not report for his/her scheduled time. (Examples: provider, friends, family, previous workers, church members, other volunteers).

|  |  |  |  |
| --- | --- | --- | --- |
| **Service** | **Contact** | **Phone** | **Availability** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Plans for natural disaster or emergency preparedness**

I will call the following in the event of a natural disaster or an emergency.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | **Days/Times Not Available:** | **Phone:** | **Will be able to assist with:** |
|  |  |  |  |
|  |  |  |  |

I will do the following in the event of a natural disaster **(including care of service animals or pets).**

|  |
| --- |
|  |
|  |
|  |
|  |

**Other Situations**

I will call the individuals listed below if my health or welfare is at risk by a dangerous or harmful situation.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | **Phone:** | **Address:** | **Relationship: (relative, doctor, Care Manager, other)** |
|  |  |  |  |
|  |  |  |  |

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |

* + 1. Risk Assessment to Justify an Intervention or Support to Address an Identified Risk

Was any intervention or support to address a risk identified? Yes\_\_\_\_ No\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| If yes, complete the following:   1. Identify the specific and individualized assessed need. 2. Document the positive interventions and supports used prior to any modifications to the person-centered service plan. 3. Document less intrusive methods of meeting the need that have been tried, but did not work. 4. Include a clear description of the condition that is directly proportionate to the specific assessed need. 5. Include a regular collection and review of data to measure the ongoing effectiveness of the modification. 6. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. 7. Include informed consent of the individual or legal representative or guardian. 8. Assure that interventions and supports will cause no harm to the individual.   Include a narrative addressing all items A-F and H if an intervention is utilized:   |  |  | | --- | --- | | A. |  | | B. |  | | C. |  | | D. |  | | E. |  | | F. |  |   By signing below, I agree with the use of this intervention or support to address the identified risk. I will watch and make sure that the interventions and support do not harm me in any way   |  |  |  |  | | --- | --- | --- | --- | | Recipient: |  | Date: |  | | Legal Representative/Guardian: |  | Date: |  | | Care Manager: |  | Date: |  | | Care Manager Supervisor: |  | Date: |  | |

**Section 4: Person-Centered Plan of Care Signature Page**

The Care Manager is responsible for monitoring whether the services in the Plan of Care are being delivered as outlined in the Plan of Care and whether those delivered services meet the needs of the individual on a regular basis. The Care Manager will contact the Recipient routinely to ensure that the Recipient’s goals, preferences, and needs are being met. The Recipient may call the Care Manager at any time to initiate changes or discuss the quality of care of the services listed in the Plan of Care*.* If at any time a provider or the Recipient becomes aware of unnecessary or inappropriate services and supports being delivered, he/she is obligated to contact the Care Manager and request a change in the Plan of Care and/or to report the unnecessary or inappropriate services and supports at the next contact with the Care Manager.

The Care Manager shall maintain confidential records for each Recipient. A Care Manager shall not release any record except: as authorized in writing by the Recipient or the Recipient’s representative, if one has been appointed; as otherwise authorized by law; and as necessary to comply with the requirements of this program.

*The overall Plan of Care will be reviewed or revised for changes in the preferred lifestyle, reached goals or skills, or if the plan is not working or is unresponsive. The overall Plan of Care includes:*

* Section 1: Plan of Care Cover Page
* Section 2: Person-Centered Plan of Care Addressing Goals, Preferences and Needs
* Section 3: Risk Mitigation Strategies

**Commitment to Confidentiality and Support:** *By signing this form, I agree to maintain Recipient confidentiality; I affirm that I participated in the development of this Plan of Care and the Recipient was given choices in selecting providers; I support the goals of the Recipient below; I acknowledge that I understand and approve the content of this Plan of Care; and I have a copy of this Plan of Care.*

**Release of Information:** I consent to the release of information under the BH HCBS program, so I may receive services. I understand that the information included on the Plan of Care will be released to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and service providers listed above to enable the delivery of services and program monitoring.

**Signatures:**

|  |  |  |
| --- | --- | --- |
| **Plan of Care Meeting Attendees (if a provider does not attend meeting, please note)** | Date | Sign and date to affirm receipt of approved Plan of Care and agreement to provide services noted |
| **Recipient:** |  |  |
| **Legal Representative/Guardian:** |  |  |
| **Care Manager:** |  |  |
| **Provider:** |  |  |
| **Provider:** |  |  |
| **Provider:** |  |  |

Recipient Rights for Individuals Receiving Behavioral Health Home and Community Based Services (BH HCBS)

**I qualify for BH HCBS which are essential to my health and welfare and may be provided to me within the program limits. My signature below indicates that I agree with the following:**

☐ I have been informed that I am eligible to receive services

☐ I understand that I may choose to remain in the community and receive the services, as designated in my Plan of Care

☐ I understand that I have the choice of any qualified providers in my plan’s network and I have been notified of the providers available

☐ I understand that I have the right to be free of abuse, neglect, and exploitation and to report of these abuses at any time

☐ I understand I may grieve and appeal at any time and have received information on how to do this

**Please ensure that your Care Manager has reviewed the Plan of Care with you and has provided a copy of this Plan of Care to you before signing.** My choice is to (check one):

☐ Receive BH HCBS as indicated on the attached Plan of Care.

☐ Refuse the recommended services

**Recipient Signature Date**

**Representative Signature Date**

**Care Manager Signature Date**







**Abuse, Neglect, Exploitation**

**Physical Abuse: Non-accidental contact which causes or potentially causes physical pain or harm**

**Psychological Abuse: Includes any verbal or nonverbal conduct that is intended to cause emotional distress**

**Sexual Abuse: Any unwanted sexual contact**

**Neglect: Any action, inaction or lack of attention that results in or is likely to result in physical injury; serious or protracted impairment of the physical, mental or emotional condition of an individual**

**Exploitation: The illegal or improper use of an individual’s funds, property, or assets by another individual. Examples include, but are not limited to, cashing an individual’s checks without authorization or permission; forging an individual’s signature; misusing or stealing an individuals’ money or possessions; coercing or deceiving an individual into signing any document (e.g. contracts or will); and the improper use of guardianship, conservatorship or power of attorney**

**I understand what abuse, neglect and exploitation mean.**

or experience :

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  |  |  |
|  |  |  |