Plan of Care Template

In accordance with Person Centered Service Planning Guidelines

Summary Page

Authorization Period________________ Date Issued________________

Enrollee Name		Date of Birth	
Address			
Phone Number		Preferred Language	
Email Address			

If you have a question or a problem regarding your services, call your care manager below,

____________[**Care Manager Name**]____________ **at (xxx) xxx-xxxx**

Description of Services

Use this area to identify current services received by the enrollee. [Duplicate boxes below as needed].

Name of Service			
Scope/Description of Service			
Unit and Frequency of Service		Provider	
Duration/Authorization Period		Contact Information	
Assessment Identifying Need		Authorizing Entity	
Desired Outcome/Goals			

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Duration/Authorization Period		Contact Information	
Assessment Identifying Need		Authorizing Entity	
Desired Outcome/Goals			

Informal Supports

Identify unpaid supports and their relationship to the enrollee. [Duplicate boxes below as needed.]

Name			
Relationship/Title		Contact Information	
Service(s) Provided/ Support Role			
Unit and Frequency of Service			

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Enrollee Information

Primary Care Manager		Secondary Care Manager	
Organization		Organization	
Primary Care Provider (PCP)			
PCP Contact Information			
Medicaid/CIN #			
Primary Insurance Agency		Secondary Insurance Agency	
Enrollee ID		Enrollee ID	

Residential Setting and Supports

Use this section to confirm that the individuals residential setting meets the HCBS settings rule.

Is the residential address provided a community-based setting?	Yes ☐	No ☐
Enrollee chose where they live now.	Yes ☐	No ☐
Enrollee can participate in the activities they like inside and outside of their home.	Yes ☐	No ☐
Enrollee can go to work if/ when they want to.	Yes ☐	No ☐
Enrollee can go to school if/ when they want or need to.	Yes ☐	No ☐
Enrollee can visit friends and family if/ when they want to.	Yes ☐	No ☐
Enrollee can enjoy food and snacks that they like whenever they want to.	Yes ☐	No ☐
Enrollee can easily move around their home and other places where services are received.	Yes ☐	No ☐
Use the space provided below for additional comments if the answer to any of the questions above is "No".		

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Assessment Information

Include all applicable assessments. [Duplicate boxes below as needed].

[Insert Assessment Name]	Date of Initial Assessment	XX/XX/XXXX	Most Recent Assessment Date	XX/XX/XXXX
	Anticipated Reassessment Date	(Month/Year)		

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	Anticipated Reassessment Date	(Month/Year)		

[Insert Assessment Name]	Date of Initial Assessment	XX/XX/XXXX	Most Recent Assessment Date	XX/XX/XXXX
	Anticipated Reassessment Date	(Month/Year)		

Diagnosis	

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Strengths, Preferences, Unmet Service Needs and Goals

Use this section to describe the strengths, preferences, unmet service needs and goals/desired outcomes (both likes and dislikes) of the enrollee.

Strengths:

Ask the enrollee about the things he or she is good at. Provide responses as well as other known strengths of the enrollee in the space below.

Preferences:

Ask the enrollee about the things he or she likes or strongly dislikes. Provide responses as well as other known preferences of the enrollee in the space below. Include preferences for delivery of services.

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Unmet Service Needs

Identify below the services the individual needs. [Duplicate boxes below as needed].

Service Need		Assessment/Date Identified	
Justification for service			
Reason Need is Unmet			
Plan to Address Need			

Service Need		Assessment/Date Identified	
Justification for service			
Reason Need is Unmet			
Plan to Address Need			

Goals/Desired Outcomes:

Use the space below to identify the health care and social goals/desired outcomes of the enrollee. Goals may be long-term or short-term with measurable outcomes. Where applicable, indicate which unmet service need the goal ties into. Include strategies to achieve desired outcome. [Add boxes for additional outcomes as needed].	
Goal/ Desired Outcome	
Goal/ Desired Outcome	

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Risk Management and Safeguards:
Identify risks to the enrollee's health/wellbeing, potential triggers, enrollee's previous responses to triggers, measures in place to minimize risks, and safeguards. Safeguards detail the support needed to keep the person safe from harm and actions to be taken when the health and welfare is at risk (please refer to guidance for more information)

Risk	
Trigger(s)	
Known Response(s)	
Measure(s) in place	
Safeguard(s)	

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Trigger(s)	
Known Response(s)	
Measure(s) in place	
Safeguard(s)	

Back Up Plan
A plan in place to ensure that needed assistance with be provided in the event that the regular services and supports in the enrollee's person centered service plan are temporarily unavailable. The backup care plan may include electronic devices, relief care, providers, other individuals, services, or settings. Individuals available to provide temporary assistance include informal caregivers such as the enrollee's family member, friend or other responsible adult. Include contact information as appropriate.

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Population Specific Requirements
Include as needed.

Self-Directed Services:

Fill out this box for enrollees getting Self-Directed Services under 42 CFR 441 Sub-parts G, K, and M. If this information is documented in another place, attach attestation to this POC. [Duplicate service description portion for each self-directed service].
☐ **I, _____, choose to self-direct some or all of my services.** ☐ **_____, may also act on my behalf to self-direct some or all of my services.** This means that I have the right to recruit, hire, fire, supervise, and manage my own staff. Alone, or with the help of my supports, I can choose the duties, schedules, and training requirements of my staff. This also includes the right to evaluate staff, decide their rate of pay, and review/approve payment requests. I will follow all laws and regulations when exercising these rights and responsibilities. The services I choose to self-direction are:
Service:
Method of Self-Direction:
Risk Management Techniques:
Process for Transitioning out of Self-Direction:
Financial Management Supports:
Specific Employer Authority Information:
Specific Budget Authority Information (see 42 CFR 441.740(d)):

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Residential Modifications:

Fill out these boxes for special populations receiving services under 42 CFR 441 Subparts G, K, and M. Use the first box to identify modifications to a residential setting. Such modifications described here may relate to a change in: status of written, legal agreements to live in the current setting; privacy; lockable entrance doors with only appropriate staff keeping keys; choice of roommate(s); freedom to furnish/decorate within legal agreements; control of schedules, activities, and food choices; or the ability to receive visitors of the enrollee's choosing at any time. [Duplicate modifications box if needed for multiple modifications].
☐ **I, _____, understand the information below and agree to the use of this(/these) modification(s) required to address my assessed risk(s) and need(s). I know that I can change my mind and will tell my Care Manager if I do.**
Modification:
Specific Individualized Assessed Need:
Positive Interventions and Supports used Before this Modification:
Diagnosis/Condition Related to the Modification:
Method for Collection and Review of Data for Effectiveness:
Timeframes/Limits for Review and Determination of Need for Modification:
Assurance that the Modification Will Cause No Harm:

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Person Centered Service Planning Process Information

Complete the table below with meeting information as appropriate. Include signatures and information indicated in boxes below for all persons responsible for writing and implementing this plan.

Meeting Date		Meeting Time		
Meeting Location				
Was this meeting held at a place and time of the enrollee's choosing?			Yes ☐ No ☐	
Did the enrollee lead the meeting to the best of his or her ability?			Yes ☐ No ☐	
Did the enrollee choose who was at the meeting?			Yes ☐ No ☐	
Name	**Title/Relationship**	**Agency**	**Signature**	**Date**
[e.g. Care Manager]				
[e.g. Provider]				
[e.g. Provider]				
[e.g. Informal Support]				
[e.g. Informal Support]				

Enrollee Acknowledgment:

I have been a part of the Person Centered Service Planning Process to the best of my ability. I agree with what is written in my plan. I understand my rights and/or I have someone I trust who can help me with them. I understand that my plan will be reviewed regularly and that I can ask for it to be reviewed sooner. I agree to this plan being shared with the people that need it to provide my services. I was given a choice of my service providers. I know who to talk to if I want to change my services or my Person Centered Plan of Care.

_____ _____

Enrollee or Designated Representative Signature Date

Attachments to Plan of Care: [Name(s) of Attachment(s)]