

COMPLETE PERSON-CENTERED PLAN

Name: (Preferred Name):	DOB: / /	Medicaid ID:	Record #:
Person's Address: (Street/mailling address) (City/State/Zip)			Telephone #: (Home) ()- - (Work) ()- -
Date of Plan: / /		Allergies: 1. 2. 3.	

Participants Involved in Plan Development

Name (person to whom this plan belongs): Role: <input type="checkbox"/> Participated in @ least 1 planning meeting <input type="checkbox"/> Provided written input <input type="checkbox"/> Telephone participation <input type="checkbox"/> Invited, but no participation <input type="checkbox"/> Other:	Name: Relation/Agency: Role: <input type="checkbox"/> Facilitator of PCP/CFT meetings <input type="checkbox"/> Participated in @ least 1 planning meeting <input type="checkbox"/> Provided written input <input type="checkbox"/> Telephone participation <input type="checkbox"/> Invited, but no participation <input type="checkbox"/> Other:
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Other individuals that I or my family would like to be part of this planning process now or in the future.

Name:

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Personal Dialogue/Interview

Date(s) of Interview(s): / /

(This section must include what is important TO the person to whom this plan belongs. Also include issues related to the person's environment, culture, ethnicity and race as appropriate.) *ADD/REVISE INFORMATION WHENEVER NEW THINGS ARE LEARNED ABOUT THIS PERSON. SIGN NAME (NO INITIALS) AND DATE (NEXT TO THE CHANGE), EACH TIME THIS SECTION IS ADDED TO OR REVISED.*

What has happened in my life this past year? (Include exciting, fun things as well as challenges and concerns):

Long Term Goals: (What are the things I want to accomplish in the next year? What are my hopes/dreams for the future?)

Strengths: (What am I good at doing? What do people admire about me? What are my talents/gifts?)

Preferences: What is important **TO** me: (What are the people/activities/things/places that matter to me in everyday life? What don't I want in my life?)

Needs: (What would I change about my life? What is not working in my life? What do I need in order to be an active part of my community? What do I need to be healthy and safe?)

Supports: What is important **TO** me? (What do others need to know or do to support me best in relationships, in things I like to do, in work or school and ways to stay healthy and safe?)

Name:

DOB:

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Family/Legally Responsible Person/Informal Supports Dialogue/Interview

Date(s) of Interview(s): / /

(This section must include what is important **TO** the person and what is important **FOR** the person from the interviewee's perspective. Also include issues related to the person's environment, culture, ethnicity and race as appropriate.) *ADD/REVISE INFORMATION WHENEVER NEW THINGS ARE LEARNED ABOUT THIS PERSON. SIGN NAME (NO INITIALS) AND DATE (NEXT TO THE CHANGE), EACH TIME THIS SECTION IS ADDED TO OR REVISED.*

What has happened in this person's life this past year? (Include exciting, fun things as well as challenges and concerns):

Long Term Goals: (What are the things the person wants to accomplish in the next year? What are this person's hopes/dreams for the future?)

Strengths: (What is this person good at doing? What do people admire about this person? What are this person's talents/gifts?)

Preferences: What is important **TO** this person: (What are the people/activities/things/places that matter to this person in everyday life? What does the person not want in his/her life?)

Needs: (What would this person change about his/her life? What is not working in this person's life? What does this person need in order to be an active part of the community? What does he/she need to be healthy and safe?)

Supports: What is important **FOR** this person? (What do others need to know or do to support this person best in relationships, in things he/she likes to do, in work or school and ways to stay healthy and safe?)

Name:

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Service/Support Providers Dialogue/Interview

Date(s) of Interview(s): / /

(This section must include what is important **TO** the person and what is important **FOR** the person from the interviewee's perspective. Also include issues related to the person's environment, culture, ethnicity and race as appropriate.) *ADD/REVISE INFORMATION WHENEVER NEW THINGS ARE LEARNED ABOUT THIS PERSON. SIGN NAME (NO INITIALS) AND DATE (NEXT TO THE CHANGE), EACH TIME THIS SECTION IS ADDED TO OR REVISED.*

What has happened in this person's life this past year? (Include exciting, fun things as well as challenges and concerns):

Long Term Goals: (What are the things the person wants to accomplish in the next year? What are this person's hopes/dreams for the future?)

Strengths: (What is this person good at doing? What do people admire about this person? What are this person's talents/gifts?)

Preferences: What is important **TO** this person: (What are the people/activities/things/places that matter to this person in everyday life? What does the person not want in this person's life?)

Needs: (What would this person change about his/her life? What is not working in this person's life? What does this person need in order to be an active part of the community? What does he/she need to be healthy and safe?)

Supports: What is important **FOR** this person? (What do others need to know or do to support this person best in relationships, in things he/she likes to do, in work or school and ways to stay healthy and safe?)

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SUMMARY OF ASSESSMENTS/OBSERVATIONS

ASSESSMENTS COMPLETED <i>(List the Comprehensive Clinical Assessment(s) that have been completed on the individual)</i>	RECOMMENDATIONS FROM ALL ASSESSMENTS	LAST DATE COMPLETED	APPROXIMATE DUE DATE
		/ /	/ /
		/ /	/ /
NC TOPPS (MH/SA only) *(Not a comprehensive clinical assessment)		/ /	/ /
NC-SNAP (DD only) *(Not a comprehensive clinical assessment)		/ /	/ /

ADDITIONAL ASSESSMENTS RECOMMENDED	REASON FOR RECOMMENDATION	APPROXIMATE DUE DATE	DATE COMPLETED
		/ /	/ /
		/ /	/ /

RECOMMENDATIONS FOR SERVICES/SUPPORT/TREATMENT BASED ON ASSESSMENTS	FREQUENCY:	DURATION:	TARGET DATE:	STATE/MEDICAID/HEALTH CHOICE
1.			/ /	
2.			/ /	
3.			/ /	

Symptoms/Observations of this Person:

- 1.
- 2.
- 3.
- 4.
- 5.

	(DSM* Code)	(Diagnosis)	(Diagnosis Date)
Axis I			/ /
Axis II			/ /
Axis III			/ /
Axis IV			/ /
Axis V			/ /

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ACTION PLAN

Long Range Outcome: (Ensure that this is an outcome desired by the individual, and not a goal belonging to others.)

Where am I now in relation to this outcome?

SYMPTOM/OBSERVATION #:

Short Range Goal (Taken from Preferences & Supports Sections - "What's important TO & FOR me")		Support/Intervention to Reach Goal (Taken from Supports Sections)	Who will Provide Support/Intervention/Service?	Support/Service & frequency
Target Date (Not to exceed 12 months.)	Reviewed Date	Status Code	Justification for Continuation/Discontinuation of Goal	
/ /	/ /			
/ /	/ /			
/ /	/ /			
Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued				

SYMPTOM/OBSERVATION #:

Short Range Goal (Taken from Preferences & Supports Sections - "What's important TO & FOR me")		Support/Intervention to Reach Goal (Taken from Supports Sections)	Who will Provide Support/Intervention/Service?	Support/Service & frequency
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/ /	/ /			
/ /	/ /			
/ /	/ /			
Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued				

Name:

DOB:

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Record #:

ACTION PLAN CONTINUATION

Long Range Outcome: (Ensure that this is an outcome desired by the individual, and not a goal belonging to others.)

Where am I now in relation to this outcome?

SYMPTOM/OBSERVATION #:

Short Range Goal (Taken from Preferences & Supports Sections - "What's important TO & FOR me")		Support/Intervention to Reach Goal (Taken from Supports Sections)	Who will Provide Support/Intervention/Service?	Support/Service & frequency
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Target Date (Not to exceed 12 months.)	Reviewed Date	Status Code	Justification for Continuation/Discontinuation of Goal	
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CRISIS PREVENTION/CRISIS RESPONSE

(Use this form or attach your crisis plan.)

Symptoms/behaviors that may trigger the onset of a crisis (Include lessons learned from previous crisis events):

Crisis prevention and early intervention strategies (List everything that can be done to help this person avoid a crisis):

Strategies for crisis response and stabilization (Focus first on natural and community supports. Begin with least restrictive steps. Include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help this person to become stable):

Specific recommendations if person arrives at the Crisis and Assessment Service:

After the crisis, identify strategies for determining what worked and what did not work, and make changes to the plan:

Name:

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CRISIS PREVENTION/CRISIS RESPONSE (CONTINUATION)

Contact List (Include names as applicable, relationship and direct phone numbers or extension.)

First Responder: Telephone #: ()- - Consent/Release of Information: Yes No

Legally Responsible Person: Telephone #: ()- -

Consent/Release of Information: Yes No

(If applicable-Attach a copy of any applicable supporting legal documents)

Date of Legal Document: / /

Natural/Community Supports:

Name: Telephone #: ()- - Consent/Release of Information: Yes No

Name: Telephone #: ()- - Consent/Release of Information: Yes No

Professional Supports:

Name: Telephone #: ()- - Consent/Release of Information: Yes No

Primary Care Physician:

Telephone #: ()- - Consent/Release of Information: Yes No

Preferred Psychiatric Inpatient /Respite Provider:

Telephone #: ()- - Consent/Release of Information: Yes No

Other Professional Supports:

Name: Telephone #: ()- - Consent/Release of Information: Yes No

Name: Telephone #: ()- - Consent/Release of Information: Yes No

All Current Medications (* Update and revise list of medications anytime there is a change)	Dose:	Frequency:	Reason for Change:	Date
1.				/ /
2.				/ /
3.				/ /
4.				/ /
5.				/ /
6.				/ /
7.				/ /
8.				/ /
9.				/ /
10.				/ /

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CRISIS PREVENTION/CRISIS RESPONSE (CONTINUATION)

Advanced Directives: (Advance Directives allow you to plan ahead for care in the event that there are times that you are unable to speak for yourself).

Yes No I have a Living Will.

Yes No I would like one.

Yes No I have a Health Care Power of Attorney.

Yes No I would like one.

Yes No I have an Advanced Instruction for Mental Health Treatment.

Yes No I would like one.

Emergency Contact or Next of Kin:

Relationship to Person:

(Address):

(Street/mailling address)

(City/State/Zip)

Home Phone: ()- -

Work Phone: ()- -

Crisis Plan Distribution List:

1.

2.

3.

4.

5.

6.

7.

8.

9.

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COMMENTS

Comments or Concerns on Plan by the person whose plan this is and/or the legally responsible person:

Steps to address concerns:

SIGNATURES

REQUIRED for Medicaid funded services. RECOMMENDED for State funded services.

My signature below confirms that medical necessity for services requested is present, and constitutes the Service Order(s):

Signature: _____

Date: / /

(Name/Title Required. Must be licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner.)

Annual review of medical necessity and re-ordering of services is due on or before: Date: / /

Person Receiving Services:

- I confirm and agree with my involvement in the development of this person-centered plan. 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 my plan.

Signature: _____

Date: / /

(Required when person is his/her own legally responsible person)

- **The following signatures confirm the involvement of individuals in the development of this person-centered plan. All signatures indicate agreement with the services/supports to be provided.**
- **For state-funded services, if the first signature box on this page is not completed, the signature of *the Person Responsible for the Plan* in this box constitutes the Service Order. Complete the Annual Review date if this is the Service Order.**

Legally Responsible Person Signature: _____

Date: / /

(Required, if other than the individual)

Person Responsible for the Plan Signature: _____

Date: / /

(Required)

Other Team Member Signature: _____

Date: / /

Other Team Member Signature: _____

Date: / /

Annual Review of medical necessity and re-ordering of State-funded services is due on or before: Date: / /

Name:

DOB:

Medicaid ID:

Record #:

PLAN UPDATE/REVISION REQUESTS

Name: (Preferred Name):	DOB: / /	Medicaid ID:	Record #:
Person's Address: (Street/mailling address) (City/State/Zip)			Telephone #: (Home) ()- - (Work) ()- -
Type of Plan: <i>(Check the box that applies)</i> <input type="checkbox"/> Update Revision / / <input type="checkbox"/> Update Revision Including Annual Review of Medical Necessity / /		Allergies: 1. 2. 3.	

Long Range Outcome:

--

Where am I now in relation to this outcome?

--

SYMPTOM/OBSERVATION #:

Short Range Goal (Taken from Preferences & Supports Sections - "What's important TO & FOR me")		Support/Intervention to Reach Goal (Taken from Supports Sections)	Who will Provide Support/Intervention/ Service?	Support/Service
Target Date (Not to exceed 12 months.)	Reviewed Date	Status Code	Justification for Continuation/Discontinuation of Goal	
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Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued				

(Provide signatures on the next page)

Name:

DOB:

Medicaid ID:

Record #:

SIGNATURES

REQUIRED for Medicaid funded services. RECOMMENDED for State funded services.

If this Update/Revision includes a NEW service(s) and/or is the annual review of medical necessity, my signature below confirms that medical necessity for the service(s) requested is present and constitutes the Service Order(s):

Signature: _____

Date: / /

(Name/Title Required. Must be licensed physician, licensed psychologist, licensed physician's assistant or licensed family nurse practitioner.)

Annual Review of medical necessity and re-ordering of State-funded services is due on or before: Date: / /

Person Receiving Services:

- I confirm and agree with my involvement in the development of this update/revision to my person-centered plan. 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 my plan.

Signature: _____

Date: / /

(Required when person is his/her own legally responsible person)

• **The following signatures confirm the involvement of individuals in the development of this update/revision to the person-centered plan. All signatures indicate agreement with the services/supports to be provided.**

• **For State-Funded services, if the first signature box on this page is not completed AND this Update/Revision includes a NEW service(s) and/or is the annual review of medical necessity, the signature of the Person Responsible for the Plan in this box constitutes the Service Order. Complete the Annual Review date if this is the Service Order.**

Legally Responsible Person Signature: _____

Date: / /

(Required, if other than the individual)

Person Responsible for the Plan Signature: _____

Date: / /

(Required)

Other Team Member Signature: _____

Date: / /

Other Team Member Signature: _____

Date: / /

Annual Review of medical necessity and re-ordering of State-funded services is due on or before: Date: / /