

INTRODUCTORY 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.	
<i>(NOTE: Date of plan is the 1st date of contact with the Qualified Professional who will complete the Introductory and/or Complete PCP.)</i>			

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 (List symptoms/observations based on preliminary knowledge):

Short Range Goal		Support/Intervention to Reach Goal		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:

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CRISIS PREVENTION/CRISIS RESPONSE (CONTINUATION)

(Use this form or attach a crisis plan that includes the required elements below.)

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 <i>(* Update and revise list of medications anytime there is a change)</i>	Dose:	Frequency:	Reason for Change:	Date
1.				/ /
2.				/ /
3.				/ /
4.				/ /
5.				/ /
6.				/ /
7.				/ /
8.				/ /

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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.

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

Name:

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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: / /