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

PCP / Updated PCP
Face Sheet

☐ **Initial** ☐ **Annual Plan** ☐ **Update** **Updated PCP Effective Date__________**

PCP Year: __________

____

Clinical Home Agency / Name & Contact Number

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

______________________________’S PERSON-CENTERED PROFILE

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

WHAT PEOPLE LIKE AND ADMIRE ABOUT….
Consumer’s input about self: Treatment team’s input about consumer *(Team members should identify themselves and their role in consumer’s life)*:
WHAT’S IMPORTANT TO….
Consumer’s input: Treatment team’s input:
HOW BEST TO SUPPORT….
Consumer’s input: Treatment team’s input:
ADD WHAT’S WORKING / WHAT’S NOT WORKING
Consumer’s input:

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

Treatment team's input:

Medication / Dosage / Regimen:

ACTION PLAN

The Action Plan should be based on information and recommendations from: **the Comprehensive Clinical Assessment (CCA), the One Page Profile, Characteristics/Observations/Justifications for Goals, and any other supporting documentation.**

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 the process of achieving this outcome? (Include progress on goals over the past years, as applicable).
Provide the following: Treatment, Medical, Psychosocial History and Summary of Assessments that support Diagnosis and Treatment Requests via narrative section.

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL:		
WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
		This column should list actual service and the frequency Ex. PSR 120 units per wk, Level II family type- 1 units per day
HOW (Support/Intervention)		

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Code**	**Progress toward goal and justification for continuation or discontinuation of goal.**
This date cannot exceed 1 yr (365 days) from QP/LP signature whichever was first	/ /		
/ /	/ /		
/ /	/ /		
Status Codes: R=Revised	O=Ongoing	A=Achieved	D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL:

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

WHAT (Short Range Goal)				**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
HOW (Support/Intervention)					
Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Codes**	**Progress toward goal and justification for continuation or discontinuation of goal.**		
/ /	/ /				
/ /	/ /				
/ /	/ /				
Status Codes:	R=Revised	O=Ongoing	A=Achieved	D=Discontinued	

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

CRISIS PREVENTION AND INTERVENTION PLAN

(Use this form or attach your crisis plan.)

Significant event(s) that may create increased stress and trigger the onset of a crisis. (Examples include: Anniversaries, holidays, noise, change in routine, inability to express medical problems or to get needs met, etc. Describe what one may observe when the person goes into crisis. Include lessons learned from previous crisis events):

Crisis prevention and early intervention strategies that were effective. (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):

Describe the systems prevention and intervention back-up protocols to support the individual. (i.e. Who should be called and when, how can they be reached? Include contact names, phone numbers, hours of operation, etc. Be as specific as possible.*)*

Specific recommendations for interacting with the person receiving a Crisis Service:

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.

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

- ☐ 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 CAP-MR/DD services only, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with mental retardation instead of participating in the Community Alternatives Program for individuals with Mental Retardation/Developmental Disabilities (CAP-MR/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).

Boxes must be completed for this to be valid service order

- 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:

- CAP-MR/DD or
- Medicaid Targeted Case Management (TCM) services (if not ordered in Section A)
- **OR recommended** for any state-funded services 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 CAP-MR/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

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: __/__/____