

***** Areas highlighted are prompts added to the form by UM to assist provider of what information should be included in each section. These can be removed once provider completes**



PCP / Updated PCP Face Sheet

Initial Annual Plan Update Updated PCP Effective Date **(Please list the date this PCP update/the new services being requested will start)**

PCP Year: _____

Clinical Home Agency / Name & Contact Number

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

PCP (UPDATE/REVISION)

(For use **ONLY** if a new service or a new goal is added to the PCP during the plan year.)

Name:	DOB: / /	Medicaid ID:	Record #:
Update/Revision Date	/ /		

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).

Include sentence or two about what long term plan is for consumer/family

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 (Summarize past treatment and outcomes), Medical, Psychosocial History and Summary of Assessments that support Diagnosis and Treatment Requests via narrative section. This should be where the clinical information that clearly supports why this level of care is medically necessary and why less restrictive levels of care are not appropriate. Also provide a measurable step criteria ex. Going 30 days without physical aggression/harm to self or others etc- this should be based on the current baseline behaviors of the consumer

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL:			
WHAT (Short Range Goal)	WHO IS RESPONSIBLE	SERVICE & FREQUENCY	
		Make sure the actual service and frequency is listed here (ex. Level II 1 unit per day or PRTF 1 unit per day, Therapeutic Leave 45 day per year, etc.)	
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 should be the same as the end of the annual pcp	/ /		

/ /	/ /		
/ /	/ /		
Status Codes:	R=Revised	O=Ongoing	A=Achieved D=Discontinued

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

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.

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).
- 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: ___ / ___ / ___