Person-Centered Service Plan Template

In accordance with Person-Centered Service Planning Guidelines

Authorization Period_____ Date Issued_____

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/Case Manager:

_____[**Care/Case Manager name**]_____ **at (xxx) xxx-xxxx**

Preferences and Strengths:

Use this section to describe the person's preferences and strengths.

Preferences:

Ask the person about the things they like and dislike. Input their responses as well as any other known preferences of the person. Include any preferences they may have for the delivery of their services.

Strengths:

Ask the person about the things they're good at. Input their responses as well as any other known strengths of the person.

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Goals/Desired Outcomes:

Use the space below to identify the person's health care and social goals/desired outcomes. 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	

Description of Services:

Identify services the person is currently receiving. [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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Desired Outcome/Goals			

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Unmet Service Needs:
Identify any services the person needs but does not have. [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			

Informal Supports:
Identify unpaid supports and their relationship to the person. [Duplicate boxes below as needed.]

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

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

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The person's 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 residence integrated in and does it support full access to the greater community?	Yes ☐	No ☐
Was the residence selected from among options by the person?	Yes ☐	No ☐
Does the residence ensure the person's rights of privacy, dignity and respect, and freedom from coercion and restraint?	Yes ☐	No ☐
Does the residence optimize the person's autonomy and independence in making life choices?	Yes ☐	No ☐
Does the residence facilitate the person's choice about services and who provides them?	Yes ☐	No ☐
Is the residence physically accessible to the person?	Yes ☐	No ☐
Can the person control personal resources?	Yes ☐	No ☐
Did the person participate in the person-centered planning process, leading the process whenever possible?	Yes ☐	No ☐
Did the person choose where they live now?	Yes ☐	No ☐
Can the person easily move around their home and other places where services are received?	Yes ☐	No ☐
Can the person participate in the activities such as work, volunteer, attend school, etc., when they like inside and outside of their home? If not, is there a modification noted	Yes ☐	No ☐

properly below (see Residential and Non-Residential Modifications Section below)? (Note: modifications are only applicable for provider-owned or controlled residential or non-residential settings, not private homes) Yes ☐ No ☐	
Can the person visit friends and family if/when they want? If not, is there a modification noted properly below? Yes ☐ No ☐	Yes ☐ No ☐
Can the person enjoy food and snacks that they like whenever they want? If not, is there a modification noted properly below? Yes ☐ No ☐	Yes ☐ No ☐
For provider-owned or controlled residential settings, is there a lease/occupancy agreement/etc. in place that gives the person the same rights and protections afforded to anyone in that jurisdiction, i.e., no rules are in the written agreement that would not be in a common lease, including the ability to furnish and decorate sleeping or living unit? If not, is there a modification noted properly below? Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐
For provider-owned or controlled residential settings, does the person have privacy in their sleeping or living unit, choice regarding roommate(s), and do only the person and necessary staff have a key/key card/code to their sleeping and/or living unit? If not, is there a modification noted properly below? If not, is there a modification noted properly below? Yes ☐ No ☐	Yes ☐ No ☐ N/A ☐
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)		

[Insert Assessment Name]	Date of Initial Assessment	XX/XX/XXXX	Most Recent Assessment Date	XX/XX/XXXX
	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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Risk Management and Safeguards:
Identify risks to the person's health/wellbeing, potential triggers, the person'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 their 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)	

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

Backup Plan:
A plan in place to ensure that needed assistance with be provided if the regular services and supports in the person'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 a family member, friend or another responsible adult. Include contact information as appropriate.

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Self-Directed Services:

Fill out this box for a person self-directing their services under a 1915(c) or 1915(k) authority such as the Consumer Directed Personal Assistance Program (CDPAP) through the Community First Choice Option or under the state plan but as a waiver enrollee. If this information is documented in another place, attach attestation to this PCSP. [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-direct are as follows:
Service:
Method of Self-Direction (self or designated representative):
Risk Management Techniques:
Process for Transitioning out of Self-Direction:

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Residential and Non-Residential Modifications (applies when a HCBS provider owns or controls the Residential or Non-Residential setting):

Fill out these boxes for special populations receiving HCB services under 42 CFR 441 Subparts G, K, or self-directed 1905(a) State plan services, including the Consumer Directed Personal Assistance Program (CDPAP). Such residential modifications described here may relate to a change in status of written, legal agreements to live in the current setting; privacy; sleeping/living unit having lockable entrance doors with only the person and appropriate staff keeping keys; choice of roommate(s); freedom to furnish/decorate within legal agreements; and for both residential and non-residential settings, control of schedules, activities, and access to food at all times; or the ability to receive visitors of the person's choosing at any time. [Duplicate modifications box if needed for multiple modifications].
☐ **I, _____, understand the information below and agree to the use of the modification(s) required to address my assessed risks and needs. I know that I can change my mind and will tell my Care/Case Manager if I do.**
Modification:
Specific Individualized Assessed Need (Note: a diagnosed disability is not a specific 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. Acceptable methods of agreement with the PCSP from the person or designated representative are: 1) wet signature on the PCSP, either in person or mailed or 2) wet signature on a separate page with language indicating agreement with the current PCSP, either in person or mailed. All attempts to obtain signature should be documented on the PCSP by the care/case manager.

Meeting Date		Meeting Time	
Meeting Location			
Was this meeting held at a place and time of the person's choosing?			Yes ☐ No ☐
Did the person lead the meeting to the best of their ability?			Yes ☐ No ☐
Did the person choose who was at the meeting?			Yes ☐ No ☐

Name	Title/Relationship	Agency	Date
	[e.g., Care/Case Manager]		
	[e.g., Provider]		
	[e.g., Provider]		
	[e.g., Informal Support]		
	[e.g., Informal Support]		

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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 Service Plan.

_____ _____

Enrollee/Recipient or Designated Representative Signature Date

Attachments to Person-Centered Service Plan: [Name(s) of Attachment(s)]