

**HIGHLIGHT AND PLACE NAME HERE**

Date of PSP: \_\_\_\_\_

Date of Dissemination: \_\_\_\_\_



# Personal Support Plan Amendment

- |   |   |
|---|---|
| <input type="checkbox"/> Residential and Vocational/Day Services  | <input type="checkbox"/> Initial          |
| <input type="checkbox"/> Residential Services Only  | <input type="checkbox"/> Annual           |
| <input type="checkbox"/> Vocational/Day Services Only   | <input type="checkbox"/> Review/ Revision |
| <input type="checkbox"/> Self-Directed Services (must also complete the Self-Direct with Employer Authority Plan of Care) | <input type="checkbox"/> Exit             |
| <input type="checkbox"/> Case Management Only   |   |
| <input type="checkbox"/> Other  |   |

This plan is approved. It is person-centered and the individual was involved in its development. The plan was developed based on assessments of the person's needs, vision, preferences and health and safety risk factors. In addition, all services listed on the person's cost plan are identified in actions in this plan of care.

Case Manager Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Montana Department of Public Health & Human Services Developmental Disabilities Program  
111 North Sanders  
Helena, MT 59604-4210  
Phone: 406.444.2995 • Fax: 406 444 0230

*Do not alter this document except where indicated. Mark n/a or otherwise if there is no information for a given section.*

# Personal Support Plan

Name:

Effective Date of Plan:

## PSP Amendment Form

### Reason for the meeting :

Amend Vision/Outcome/Action    Add/Remove Vision/Outcome/Action    Exit PSP    ICP Revisions    Other \_\_\_\_\_

*All changes to Visions, Outcomes or Actions must be made through the Case Manager without exception. Consensus must still be reached among team members. Consensus is indicated by signing the signature page whether at a meeting or routing the proposed changes for agreement.*

### Notes for the meeting:

*If no revisions are needed to address the issues, give details of the team's decision to address the concerns.*

# Personal Support Plan

Name:	Effective Date of Plan:
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## Section VII. Outcomes

### Vision Statement:

**Outcome:** *Written to answer this question: "What do I want to do this year?"*

**Assessment tool/s used:**

Actions (Approach): How do I get there? How will this be accomplished? <i>Include name of provider agency and title of responsible person.</i>	Start Date/Completion Date	Status/Progress

### Quarterly Status:

*Note: Quarterly schedule may be based on the actual date of the PSP or the calendar year. Indicate the schedule for this PSP below.*

Calendar Year <input type="checkbox"/>	Jan-Mar <input type="checkbox"/>	Apr-Jun <input type="checkbox"/>	Jul-Sep <input type="checkbox"/>	Oct-Dec <input type="checkbox"/>
Submitted by:	April 30th	July 30th	October 30th	January 30th
PSP Date <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
<small>Submitted within 30 days of the end of the quarter; fill in quarter date ranges above.</small>				
Updated by:		Agency/Dept:		

### Additional Information:

