SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

COMMUNITY FIRST CHOICE Policy Manual	Section: Forms
	Subject: Agency Based Person-Centered Planning Form Instructions SLTC-200

PURPOSE

The CFC/PAS Person Centered Planning (PCP) Form (SLTC-200) documents the member's goals, services, strengths, needs, preferences and supports through a PCP process. This form provides documentation in the Plan Facilitator and provider agency record that the PCP process was completed. (Please see CSB 1112)

PROCEDURE

The Plan Facilitator develops and completes the PCP form. This form must be completed initially and annually or when a significant change occurs.

The person centered planning process includes the pre-planning documents that must be sent to the individual prior to scheduling the planning meeting. These forms are included in the Community First Choice and Personal Assistance (CFC/PAS) Handbook which includes:

- Information on person centered planning
- Member's Rights and Responsibilities
- Plan Facilitator Responsibilities
- Advocacy Resource Guide
- Conflict Resolution and Grievance Procedures

Prior to completing the PCP form, the Plan Facilitators will review the Handbook information with the individual in order to answer any questions they may have.

Note: Case Manager Plan Facilitator should review the member's waiver service plan for goals, preferences, back-up plans, etc. If sections on this form are relevant to the waiver service plan, the Plan Facilitator (with agreement of member) may choose to reference the relevant section on the CFC/PAS PCP form. If the Case Manager Plan Facilitator references the waiver service plan on the PCP form, the referenced documents must be attached to the PCP form and distributed to both the member and provider agency.

INSTRUCTIONS

TOP SECTION:	Enter member name, date of plan, Medicaid number, date of birth, Provider agency name and Plan Facilitator name.
MID-SECTION:	These individual boxes on the form should be framed around the options available in the CFC/PAS programs. The pre-planning documents can assist with framing the discussion around the member's goals, strengths, scheduling preferences, etc. The information captured in the boxes should be meaningful to the member and related to their need and desires for receipt of these services. Every box must contain member specific information. This information should be captured using the PCP approach.
GOALS:	List out the members goals in relation to CFC services.
STRENGTHS:	List member strengths and skills as they relate to the goals.
SERVICES:	Utilizing the MPQH functional assessment and profile, list the personal assistance tasks individualized to the member. List additional help needed to reach the stated goals.
SUPPORT:	List out the member's support network including family, friends, other services being utilized, etc.
SCHEDULE PREFERENCES:	List the member preferences and choices as they relate to the delivery of services. May require follow up questions to gather the information.

PERSONAL CARE ATTENDANT SKILLS: List the skills the member thinks that their caregivers should possess.

BACK-UP PLAN: Detail the member's back-up plan if a worker doesn't show up. The back-up plan needs to address health and safety issues.

INITIAL/ACKNOWLEDGMENT SECTION: This section needs to be discussed and initialed by the member to acknowledge that they have received and reviewed the information contained in the pre-planning handbook. The Plan Facilitator should ensure that the member understands the documents prior to signing off on this section.

SIGNATURES AND DATES SECTION: This form requires signatures from the member and/or their Personal Representative (PR), the Plan Facilitator and the Provider Agency representative.

Note: If the member has a case management team (nurse and social worker), either of the team members can sign off on this section.

DISTRIBUTION The Plan Facilitator completes the form and distributes copies to the member and the Provider Agency. The Plan Facilitator will maintain a copy of the plan in their records.