

Person Centered Planning Form

Member Name:
Medicaid ID:
CFC Provider Agency:
Plan Date:
DOB:
Plan Facilitator:

Strengths/Interests: What are my talents? What activities do I enjoy?

Goals: Things I would like to work on or achieve this year. My dreams and plans.

Services: What kind of help would make me successful in reaching my goals?

Personal Care Attendant Skill and Important Things to Know:

Back-up Plan

Personal Emergency Response Systems (PERS):

Is PERS authorized on the MPQH profile: YES NO
Has the member received the PERS unit: YES NO
Is the PERS system working: YES NO
Does the member use PERS: YES NO
Is the member appropriate for PERS: YES NO

Comments:

Please initial to acknowledge (only on intake):

I have received and understand my rights and responsibilities and those of my Plan Facilitator:

I have received the Conflict Resolution and Grievance Procedures information:

I have received an Advocacy Resource Guide:

I have received my CFC/PAS Handbook:

Member/Personal Rep. Date:

Plan Facilitator Date:

Provider Agency Date:

Distribution: Copy to-Plan Facilitator; Provider; Member