DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Community First Choice Services (CFCS)/Personal Care Services (PCS) Person-Centered Planning (PCP) Form

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

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

What should my PCA know about my personal needs and preferences?

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

Backup plan:

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

Personal Emergency Response Systems (PERS):

Is PERS authorized on the MP profile?	○ Yes	○ No
Has the member received 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 information about 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.
- ☐ I have received my CFCS/PCS Handbook.

Member/Personal Representative
Date:

Settings Attestation: I have been given a choice of available options regarding where to live and receive services. ○ Yes ○ No

Plan Facilitator:
Date:

Provider Agency:
Date:

Distribution: Copy to Plan Facilitator, Provider, and Member