



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