Rhode Island Person-Centered Plan Template

Overview: This document is the **final** person-centered plan template that will be used under Rhode Island's conflict-free case management (CFCM) initiative. The person-centered plan is a written document that reflects the services and supports that are important to and for a Medicaid home and community-based services (HCBS) participant. All Medicaid HCBS participants must have a person-centered plan. The case manager will work with the Medicaid HCBS participant to develop their person-centered plan and will provide a copy of it to the participant. If necessary, the case manager will work with the participant to develop a version of the plan that is understandable to the participant.

The person-centered plan must be:

1. Reviewed and updated at least annually, when the participant's circumstances or needs change significantly, or when the participant requests a change.
2. Understandable to the participant receiving services and supports, and the individuals important in supporting them.
3. Written in plain language and in a manner that is accessible to participants with disabilities and persons who are limited English proficient.

Section 1. My Information			
Name:		**Date of Birth:**	
Address:			
Marital Status:			
Living Arrangement:		**Living Situation:**	
Preferred Method of Contact:		**Secondary Contact:**	
Preferred Language:		**Communication Accommodations:**	
Veteran Status:		**PACE Enrolled:**	
Medicaid/Medicare MCO Enrollment:			
Health Home Enrollment:			
Employment Status:		**Employment Status Details:**	
Name of Legal Representative:		**Legal Representative Contact Info:**	
Type of Legal Representation (Guardian, Trustee, etc.) :			
Case Manager Name:		**Case Manager Phone #:**	
Case Management Agency:			
Authorized Representative:		**Authorized Rep Contact Info:**	

Section 2. My Person-Centered Planning Meeting and Revisions			
This is information about my person-centered planning meeting and tracks any recent changes that I may have made.			
Planning meeting			
Type of "Person-Centered Plan" :		**Location:**	
Date:		**Time:**	
Who Attended? :			
Plan Effective Date:		**Plan Renewal Date:**	
Plan revisions			
Is this a revision?			
Revision Date		**Reason for my revision (select one of the following):**	
The following sections in my plan were revised:			

Section 3. My Goals	
These are my strengths, preferences, and goals.	
What's Working for Me? (Abilities, Strengths, Preferences, Contributions, etc.):	
What's Not Working for Me? (Unmet needs, Dislikes, etc.):	
What Supports Do I Need?	
Goal(s)	
Goal #1	
Goal #1 - I Want To:	
Goal #1 - Priority Ranking:	
Goal #1 - My expected objective (measurable/observable) I will:	
Goal #1 - Background / barrier(s) to meeting goal:	

Goal #1 - Action Steps:			
Goal #1 - Person Responsible:			
Goal #1 - Start Date:		Goal #1 - End Date:	
Goal #1 - Status of Goal:		Goal #1 - Date of Status Update:	

Section 4. My Choices

These are my choices regarding services, self-direction, and living preferences.

Factors considered when helping me choose services:	
Scope of services I would like to self-direct:	
Living preference(s):	

Section 5. My Services and Supports

These are my paid and unpaid supports

Name of Service:			
Service Description:			
Pathway:			
Service Justified By:			
Start Date:		End Date:	
Unit Type:		Unit Per:	
Units of Measure:		# Of Service Units:	
Provider Name:			
Provider Contact Information:			
Services Change Type:			
Reason for Service Change:			

Informal supports (i.e., unpaid supports)

Informal Support #1			
Informal Support #1 - Name		Informal Support #1 - Contact Phone	
Informal Support #1 - Relationship to Me			
Informal Support #1 - How Does this Person Provide Support?			
Support frequency: Informal Support #1 - Support Frequency			
Add 2nd Informal Support?			

Services and supports declined, not available, or inaccessible

Services and Supports Declined, Not Available, or Inaccessible #1	
Name of service #1:	
Reason for not using #1:	
Describe Reason for Not Using #1	
How is the Need Being Met #1?:	
Add 2nd Services and Supports Declined/Not Available/Inaccessible?	

Section 6. My Assessed Needs (Risks)

#	Assessed Needs	Objectives	Interventions	Mitigation
1				
2				
3				
4				

5				

Section 7. My Backup Plan

These are my supports if my home and community-based service staff are not available

Backup Plan 1

Name of Backup Support #1			
Backup Plan #1			
Backup Phone # 1		**Paid or Unpaid Service? Backup #1**	
Add 2nd Backup Plan?			

Section 8. My Crisis and Safety Plan

These are my action items in case of an emergency

In case of severe weather or tornado, I will:	
In case of fire, I will:	
In case of flood, I will:	
If I am sick or injured, I will:	
If my caregiver is sick or injured, I will:	
If I lose electricity, I will:	
If I lose water, I will:	
If I need to evacuate my home, I will:	
In the event I am unable to care for any children or pets, I will:	
Other unexpected event:	

Section 9. Case Management Monitoring

This is information about meetings with my case manager

I would prefer that my Case Manager check in with me:	
When I meet with my Case Manager in person, I would prefer these meetings happen at:	
Other location(s), describe	
Other things I would prefer that my Case Manager do or not do when monitoring my plan or services:	

Section 10. Review and Approval

Confirmations

Confirmation	**Participant / Legal Representative Initial**
I understand that my case management is to:	
Provide support to me when I develop, implement, and monitor my person-centered plan.	

Ensure that the programs and services I have selected and am eligible for have been arranged for me.	
Assist in identifying any health and safety issues and address them in my person-centered plan.	
Provide regular follow-up and answer any questions that I may have regarding my services	
I agree with what is written in my person-centered plan.	
I acknowledge that I had a choice regarding services and supports and who provides them.	
I agree to my person-centered plan being shared with the people that need it to provide my services.	
I understand that I can request to have changes to my person-centered plan at any time and that I can contact my Case Manager about making changes.	
I understand that my Case Manager will provide a face-to-face visit every 6 months to the full extent possible and a check-in every month or as agreed to in my person-centered plan.	
I understand that my Case Manager will contact my providers ongoing, to assess progress with my goals, and to assist me in making any changes that I may need.	
I understand that I have the right to appeal and to request a hearing about the scope, amount, duration, and process related to Medicaid services.	
I have reviewed my Rights and Responsibilities with my Case Manager.	
I received a written fact sheet on critical incidents and how to report them.	
I understand that I have a choice about where I receive my long-term services, based on my needs and goals.	
I have received information about my options for home and community-based services in a community setting and about care in a healthcare facility.	
I understand that there may be risks involved in living in a community setting. I have been informed about the risks and how to manage risks.	
If I choose to direct my own care, I will select my own services providers or direct care workers. I am aware of the limitations of the provider's role, and I accept responsibility if the provider provides care outside of the limitations of his or her role.	
If I choose to direct my own care, I acknowledge that I will work with a Fiscal Intermediary.	
I understand that by choosing home and community-based services, I will be required to grant reasonable access to my home by services providers or direct care	
I understand that I may have a monthly contribution towards the cost of my services, and that I may lose my services if I do not pay.	
I understand that I can decide at any time that I no longer want to receive home and community-based services and supports.	

The people who have signed below understand and agree to participate in implementing my plan.

Signature	Print Name	Date	Role	Attended PCP Meeting?	Date Person-Centered Plan Was Sent