Member Name: _____
DOB: _____
SID: _____

Chronic Condition Health Home
Person-Centered Care Plan

Section 1: PCCP Information

Type of PCCP: Choose an item
Program Type: Choose an item
Date PCCP Held: _____
PCCP Date Span: _____
Previous PCCP Date Range: _____

Chronic Condition Health Home: _____
Health Home Staff: _____
Health Home Phone Number: _____
Health Home Staff Email: _____
Managed Care Organization: Choose an item

I choose the following people to attend my meeting: _____

Comprehensive Assessment Date: _____

Section 2: My Information

My address (Street, City, State & Zip): _____
Phone Number: _____
Email Address: _____

- If child, do they reside with their parents: _____
- Parent(s) Name: _____
- Parent(s) Contact Information (if different than members): _____

I am currently approved and accessing the following Waiver:

- Identify Community Based Case Manager (CBCM) in My Care Team & Natural Supports section. CBCM should be involved in the PCCP planning.

I have applied for the following Long Term Services and Supports Waivers and I am on a waitlist for:

My strengths are _____

My preferences are _____

My physical health diagnoses include _____

My mental health diagnoses include _____

Section 3: My Risk Factors

The following risks have been identified from my comprehensive assessment, social history, and other records.

Identified Risk Areas	Identified Risk Factors, Needs, Background Information	Measures in Place to Minimize, including Back-Up Plans and Strategies When Needed
Allergies		

Member Name: _____
Medicaid ID: _____

Behavioral Health		
Communication and Language		
Dental/Oral Health		
Developmental Milestones (children only)		
Domestic Violence, Physical, Emotional, Sexual Abuse, Trauma		
Education		
Employment/Volunteering		
Financial/Money Management		
Gambling/Dependence		
Hospitalization/Emergency Room		
Housing		
Legal		
Leisure Activities		
Marital/Dating/Relationships		
Medical/Physical Health		
Medical Support Team		
Medications		
Mental Health		
Preventative Visits		
Self-Care/ADLs/IDLs		
Social, Cultural & Spiritual		
Substance Use or Abuse		
Transportation		
Other		

Section 4: My Goals

I have agreed to the following goals that I developed with my Health Home team.

Goal #1

I want			
My expected objective (measurable/observable: I will			
Background/barriers to meeting goal:			
If I had to rank this goal on how important it is to me or my caregivers, out of all of my goals in this service plan, this one would be: (the most important, the second most important, the third most important, the fourth most important)			
Interventions and supports, including incremental action steps	Person Responsible	Start date	End date

Goal #2

Member Name: _____
Medicaid ID: _____

I want			
My expected objective (measurable/observable: I will			
Background/barriers to meeting goal:			
If I had to rank this goal on how important it is to me or my caregivers, out of all of my goals in this service plan, this one would be: (the most important, the second most important, the third most important, the fourth most important)			
Interventions and supports, including incremental action steps	Person Responsible	Start date	End date

Section 5: My Medical & Behavioral Health Plan

When I experience the following **medical symptoms**, these are the steps I take to manage them

Medical Symptom	What I do to manage on my own	How others can support me

My **behavioral plan** is as follows

- My **baseline mood** is _____
- My **triggers** are _____
- My **early intervention plan** is _____
- The **indicators** that I need help are _____
- Things I can do to **help myself** are _____
- My **coping skills and natural supports** are _____

Section 6: My Care Team & Natural Supports

The following are members of my care team and natural supports that I can utilize for my health and safety plan (include natural supports, guardian, POA, medical professionals, etc.)

Provider Name	Specialty	Address	Phone
	Chronic Condition Health Home		
	Primary Care Physician		
	Hospital For Medical Care		
	Hospital for Mental Health Care		
	Urgent Care Office		
	Dentist		
	Pharmacy		

Member Name: _____
Medicaid ID: _____

	Psychiatrist		
	Counselor		
	Guardian/Parent		
	Power of Attorney (POA)		

*To reach my Integrated Health Home **after hours**, I can reach them by .*

If I suspect that I am being abused, neglected and/or or exploited, I can call the local DHS office or use the toll-free, hot line number, which is answered 24 hours a day, 7 days a week: 1-800-362-2178. I can also talk with IHH staff, my therapist, or other care providers who can support me in making a call. If I am in immediate danger, I can call 911.

Section 7: My Discharge Plan

I understand that my Health Home Services are voluntary and that I can be end them at any time. If I lose Medicaid eligibility, I will not be eligible for Health Home services. If I do not meet with my Health Home Team, my eligibility could be impacted.

My discharge plan for Chronic Condition Health Home Services is:

Section 8: Acknowledgments

Item	Confirmation	Member's / Guardian's Initial
1	I gave input into my assessment, goals and additional information included in this care plan.	
2	I am in agreement with my care plan and I know who to work with on my goals.	
3	I understand the information in this care plan and have had a chance to ask questions and receive clarification.	
4	I understand that I can request to have changes to the service plan at any time and that I contact my Health Home Team about making changes.	
5	I understand that my Health Home Team is responsible for monitoring my goals and overall plan.	
6	I understand that my Health Home Team will review my plan with me at least every 365 days, or sooner at my request.	
7	I was given a choice of providers and choose the providers I want to work with.	

Member Name: _____
Medicaid ID: _____

Section 8: Signature Page

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

Signature	Print Name	Date	Role	Date a copy of the plan was sent/ given	Method plan was provided (e.g. mail, email, etc.)
			Member		
			PCP	N/A	