Member Name: _____
DOB: _____
SID: _____

Integrated Health Home Person-Centered Service Plan

Section 1: PCSP Information

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

Integrated Health Home: _____
Care Coordinator Name: _____
CC Phone Number: _____
CC Email: _____
Managed Care Organization: Choose an item
Comprehensive Assessment Date: _____

I choose the following location for my PCSP meeting: _____
I choose the following date and time for my PCSP meeting: _____
I choose the following people to attend my meeting: _____
I choose _____ to lead my meeting.

Revisions, Only:

Date of Revision: _____
Reason for my revision (select one of the following):

- ☐ I requested because _____
- ☐ My needs changed as follows: _____

The following sections in my PCSP were revised: (select all that are applicable)

- ☐ Section 1: PCSP Information
- ☐ Section 2: My Information
- ☐ Section 3: My Risk Factors & Needs
- ☐ Section 4: My Goals
- ☐ Section 5: My Services & Supports
- ☐ Section 6: My Self-Management Plan
- ☐ Section 7: My Right Restrictions
- ☐ Section 8: My Education & Employment
- ☐ Section 9: Where I live
- ☐ Section 10: Acknowledgment & Signatures

Section 2: My Information

My address (Street, City, State & Zip): _____
Name of facility *(if applicable):* _____
Phone Number: _____
Email Address: _____

I have advanced directives in place: ☐ Yes ☐ No
(This is a written document stating how you want medical decisions to be made if you lose the ability to make them for yourself. It may include a living will, durable power of attorney for health care. The law requires that you sign and date your advanced directive with a witness(es) present.)

My strengths are _____

My preferences are _____

Member Name:_____
Medicaid ID:_____

How you can support me _____

My cultural preferences are _____

My cultural accommodations are _____

My communication preferences are _____

My communication accommodations are _____

My physical health diagnoses include _____

My mental health diagnoses include _____

My Care Team Members
(Include guardian, Power of Attorney, service providers, natural supports, etc.)

Name	Agency/Title	Address	Phone	Present at Meeting
	IHH Name			☐
	Guardian/Parents			☐
	Payee			☐
	MH Advocate			☐
	Court (type):			☐
	Power of Attorney			☐
	School/AEA			☐
				☐
				☐
				☐
				☐

Section 3: My Risk Factors & Needs

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

interRAI & Comprehensive Assessments sections	Identified risk factors, needs, background information	Measures in place to minimize, including back-up plans and strategies when needed
Allergies		
Behavior		
Cognition and Executive Functioning		
Communication/Language		
Cultural		
Developmental Milestones (children only)		

Member Name:
Medicaid ID:

Domestic Violence, Physical, Emotional, Sexual Abuse		
Educational	.	
Employment/Volunteering		
Environmental		
Financial/Money Management		
Gambling/Dependence		
Harm to Self and Others		
Hearing		
Hospitalization/ER Visits		
Housing		
Independent activities of daily living (IADL) and Activities of daily living (ADL)		
Legal		
Leisure Activities		
Medications		
Medical Support Team		
Mental Health		
Nutritional Status		
Physical Health Conditions		
Preventative Visits		
Service Utilization and Treatment		
Social and Family Relationships		
Spiritual		
Stress and Trauma		
Substance Use or Excessive Behaviors		
Transportation		
Vision		
Other		

Section 4: My Goals

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

Goal #1

I want			
My expected objective (measurable/observable: I will			
Background / barrier(s) 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

Member Name:
Medicaid ID:

Goal #2

I want			
My expected objective (measurable/observable: I will			
Background / barrier(s) 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 #3

I want			
My expected objective (measurable/observable: I will			
Background / barrier(s) 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 #4

I want			
My expected objective (measurable/observable: I will			
Background / barrier(s) 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

Member Name:
Medicaid ID:

Section 5: My Services and Supports

My Waiver or Habilitation Services (Medicaid Funded Services)

Provider Responsible / NPI	Name of Service	Service Code & Modifier	Units	Frequency	Rate (CMH Waiver)	Start Date	End Date
NPI:				Choose an item			
NPI:				Choose an item			
NPI:				Choose an item			
NPI:				Choose an item			
NPI:				Choose an item			
NPI:				Choose an item			

Reductions or Terminations to My Services

Effective Date	Service Code & Modifier	Type	Original Units	New Units	Reason	My need is now being met by
		Choose type			Choose Reason	
		Choose type			Choose Reason	
		Choose type			Choose Reason	

My Non Waiver/Habilitation Services and Supports (such as Veteran Benefits, IVRS, AEA, Schools – IEP/504, therapy, doctors, specialist, pharmacy, transportation, etc.)

Service Name	Funding Source	Agency/Person Responsible	Phone Number	Frequency of Service	Start Date (month/yr)

- If I receive speech, physical, or occupational therapy along with day habilitation, my services are being coordinated in this way

Services or Supports that are needed but declined, not available, or inaccessible

Service	Reason for not utilizing	How is the need being met?
	Choose Reason	
	Choose Reason	

My Natural Supports Are _____

Member Name:
Medicaid ID:

Name	Relationship to me	Training or resources needed to provide support	How does this person provide support?
My supports will receive the following training or resources (how, when, where):			
Additional:			

Resources that I use (unpaid services)

Resource / Contact name	Description

My Backup Plan for Services

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

Name	Backup plan / Backup staff	Backup phone number

My Discharge Plan for Services

I understand that waiver and habilitation services are voluntary and can be ended at any time. If I end my waiver or habilitation services, there may be an impact on my Medicaid, as well as, the service and supports for which I qualify. If I lose Medicaid eligibility, I will also lose my waiver and habilitation services. If my level of care changes or I reach all of my goals, I may not qualify for waiver or habilitation eligibility services anymore. If I do not meet with my Health Home Team, my waiver or habilitation eligibility could be impacted. In order to stay eligible for CMH waiver services, I must use at least one unit of service every three months.

My discharge plan for each service I receive is as follows:

Service Name	Discharge Plan

Section 6: My Self-Management Plan

My crisis and safety plan

- 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 _____

Member Name:
Medicaid ID:

- 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 _____

My Medical and Behavioral 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 _____

I have these supports available in the event I need to enact my crisis or safety plan

Provider Name	Specialty	Address	Phone
	Integrated Health Home		
	Primary Doctor		
	Hospital For Medical Care		
	Hospital for Mental Health Care		
	Urgent Care Office		
	Dentist		
	Pharmacy		
	Psychiatrist		
	Counselor		

In the event of a major incident, my care coordinator should be contacted as soon as possible.
An incident report should be completed and sent to the members assigned MCO (by the provider who first became aware of the incident) by midnight of the next business day.

Member Name:
Medicaid ID:

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 Right Restrictions

I know that all of my right restrictions will be reviewed at least quarterly with my Care Coordinator. Any changes to my right restrictions will result in a revision to my plan. I/my guardian agree to these right restrictions and will not cause undue harm.

Restriction	Date Implemented	Reason for Restriction	Past Interventions Tried	Plan to Restore

Comment:_____

Section 8: My Education and Employment

My Education Level Choose Education Level
Comments:_____

I am currently employed ☐ Yes ☐ No

a. My current employer is_____. I started on_____and work these days_____and these hours_____.
b. I am not currently working, but I have the following plans (include any barriers or resources needed)

_____

I am currently volunteering ☐ Yes ☐ No

a. I volunteer at_____. I started on_____and volunteer these days_____for_____hours.
b. If no, I have the following plans to volunteer (include any barriers or resources needed) .

_____

I am currently working with Iowa Vocational Rehabilitation Services ☐ Yes ☐ No

a. My IVRS counselors name is_____ and their contact information is_____. I began working with IVRS (month/year)_____.

I am receiving prevocational or supported employment service ☐ Yes ☐ No

a. I work in the following setting _____

I earn a subminimum wage ☐ Yes ☐ No

a. I was provided with counseling, information, and referral regarding community employment on _____ by _____ with the following provided to me _____.

Member Name:
Medicaid ID:

b. I was **not** provided with counseling, information, and referral regarding community employment because _____.

I am receiving small group employment ☐ Yes ☐ No

a. I work with_____(number) people in my group and_____hours each week.

I am receiving individual supported employment ☐ Yes ☐ No

a. I work_____hours a week and have staff on-site for support_____hours a week.

I receive long term job coaching ☐ Yes ☐ No

a. I work_____hours a week and have staff support_____hours per month.

Section 9: Where I Live

I live in an integrated setting of my choosing ☐ Yes ☐ No

If no, my integration plan is_____

I live (check all that are applicable)

- ☐ A With family or legal guardian
- ☐ B In my own home
- ☐ C In a living unit/apartment rented from a community landlord that is not owned or operated by a Home-and-Community-Based Service (HCBS) provider
- ☐ D In a setting that is located on the grounds of or directly next to a public or private institution
- ☐ E In a setting that is a licensed facility (e.g. residential care, assisted living, other)
- ☐ F In a setting where two or more people receiving Medicaid funded services live together to receive waiver/habilitation services
- ☐ G In a setting where multiple HCBC/habilitation living units are co-located in close proximity to each other within the community
- ☐ H In a setting that is owned or operated by the provider of service

I choose the setting in which I live now. ☐ Yes ☐ No

If no, please explain:_____

I selected the setting where I live among available alternatives. ☐ Yes ☐ No

If no, please explain:_____

What alternative settings were discussed?

_____

I had setting options to choose from. For example, I had the choice to live in a non-disability specific setting or to have a private unit in a residential setting. ☐ Yes ☐ No ☐ N/A

If no, please explain: _____

The setting where I live encourages my own resourcefulness, independence, and freedom in making life choices, including but not limited to daily activities, physical environment, and with whom I choose to interact.

☐ Yes ☐ No If no, please explain:_____

Member Name:
Medicaid ID:

I had a choice regarding services and supports and who provides them. ☐ Yes ☐ No
If no, please explain: _____

The setting where I live supports full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS. ☐ Yes ☐ No If no, please explain:
_____

The setting where I live ensures the right to privacy, dignity and respect, and freedom from coercion and restraint. ☐ Yes ☐ No If no, please explain:
_____

I am receiving home-based habilitation services ☐ Yes ☐ No

- I have_____ waiver members living in my home with me.
- I need_____hours of supervision per day.
- If yes, the living environment is _____

For settings that are E, F, G, and H select in I live, the following question need to be answered:
The living unit entrance doors and my bedroom door are lockable by me. ☐ Yes ☐ No
Staff have access to keys to my living unit. ☐ Yes ☐ No

I have the freedom to furnish and decorate my sleeping or living unit. ☐ Yes ☐ No
If no, please explain: _____

I am able to have visitors of my choosing at any time? ☐ Yes ☐ No
If no, please explain: _____

Member Name:
Medicaid ID:

Section 10: Acknowledgments

Item	Confirmation	Member's / Guardian's Initial
1	I gave input into my assessment, right restrictions, goals and additional information included in this service plan.	
2	I gave consent to the right restrictions that have been identified in my service plan. If I wish to change them, I can request a meeting to review and change. My Care Coordinator will review these with me at least quarterly and document my understanding of them.	
3	I was given a choice of providers and selected the providers I want to deliver my services.	
4	I am in agreement with my service plan and I know who to work with on my goals.	
5	I understand the information in this service plan and have had a chance to ask questions and receive clarification.	
6	I understand that I can request to have changes to the service plan at any time and that I contact my Care Coordinator about making changes.	
7	My Care Coordinator has explained to me how to make a report if I suspect I am being abused, neglected, and/or or exploited.	
8	I understand that my Care Coordinator is responsible for monitoring my service plan.	
9	I understand that my Care Coordinator will meet with me face-to-face at least every 3 months or sooner, if needed. Every month there is not a face-to-face visit, my Care Coordinator will call me or my guardian if I choose.	
10	I understand that my Care Coordinator will contact my providers ongoing, to assess progress with goals, to evaluate changes in need and to make necessary adjustments to the service plan.	
11	I understand that I have the right to appeal and that there is a grievances process. I have the right to appeal any reduction, termination, or denial of services. In the event of a reduction, termination, or denial of services. I will receive a written letter with my appeal rights.	

My care coordinator will contact me on or before_____(date) by_____(method).

My care coordinator will contact_____(provider name) on or before_____(date) by_____(method).

My care coordinator will contact_____(provider name) on or before_____(date) by_____(method).

My care coordinator will contact_____(provider name) on or before_____(date) by_____(method).

Member Name:
Medicaid ID:

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

Signature	Print Name	Date	Role	Date a copy of this service plan was sent/ given & Method (e.g. mail, email, etc.)
			Member	
			Care Coordinator	N/A