

**NORTH CAROLINA
 DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE
 SERVICES
 PERSON-CENTERED PLANNING INSTRUCTIONS
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**DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE
SERVICES
PERSON-CENTERED PLANNING INSTRUCTIONS**

I. OVERVIEW

The State Plan: A Blueprint for Change establishes person-centered planning as fundamental to transformation within the mental health/developmental disabilities/substance abuse service system. Person-centered planning is a process of determining real-life outcomes with individuals and developing strategies to achieve those outcomes. The process supports strengths and recovery and applies to everyone supported and served in the system. Person-centered planning provides for the individual with the disability assuming an informed and in-command role for life planning, service and support and treatment options. The individual with a disability and/or the legally responsible person directs the process and shares authority and responsibility with system professionals about decisions made. In the case of children and youth with mental health needs, the Division recommends the System of Care Child and Family Team process¹.

The key values and principles serving as the foundation of person-centered planning are:

1. Person-centered planning builds on the individual's/family's strengths, gifts, skills, and contributions.
2. Person-centered planning supports consumer empowerment, and provides meaningful options for individuals/families to express preferences and make informed choices in order to identify and achieve their hopes, goals, and aspirations.
3. Person-centered planning is a framework for providing services, treatment and supports that meet the individual's needs, and that honors goals and aspirations for a lifestyle that promotes dignity, respect, interdependence, mastery and competence.
4. Person-centered planning supports a fair and equitable distribution of system resources.
5. Person-centered planning processes create community connections. They encourage the use of natural and community supports to assist in ending isolation, disconnection and disenfranchisement by engaging the individual/family in the community, as they choose
6. Person-centered planning sees individuals in the context of their culture, ethnicity, religion and gender. All the elements that compose a person's individuality are acknowledged and valued in the planning process.
7. Person-centered planning supports mutually respectful and partnering relationships between individuals/families and providers/professionals acknowledging the legitimate contributions of all parties.

The Person-Centered Plan as a Unified Life Plan

The Person-Centered Plan (PCP) is the umbrella under which all planning for treatment, services and supports occurs. Person-centered planning begins with the identification of the reason the individual/family is requesting assistance. It focuses on the identification of the individual's/family's needs and desired life outcomes--not a request for a specific service. The plan captures all goals and objectives and outlines each team member's responsibilities within the plan.

¹ For more information on this process, go to: <http://www.dbhs.state.nc.us/mbddsas/childandfamily/index-new.htm>

II. COMPLETING A PERSON-CENTERED PLAN

A. *The Process*

The planning process may include one or more meetings scheduled by the clinician/case manager. If so, the individual and the legally responsible parties are expected to be there, as are family members of a child and others identified by the individual/family. Discussions in the meetings include information about life goals and aspirations and the services, treatment and supports needed to accomplish them. The individual/family and professionals determine together which services and supports, including natural supports and community resources, and treatments can best meet the person's identified needs. This includes the amount and duration of care necessary to achieve the outcomes.

After the person-centered plan is documented, the primary clinician/case manager for the individual submits the plan to the identified service authorization unit for review. The service authorization unit reviews the person-centered plan to ensure that treatment, services and supports are appropriate to meet individual/family needs and meet medical necessity requirements for specified services.

B. *Required Content*

Every plan must include the following elements:

- Individual needs, preferences, and desired outcomes as identified and prioritized by the individual and/or family.
- Information obtained in the assessment process, including diagnosis and functional status in life domains.
- Potential issues of health and safety, and services and supports to address these issues (a safety net).
- Priority goals and measurable outcomes expressed by the individual/family/legally responsible person.
- Specific strategies, activities, supports, services, and/or treatment to achieve goals and objectives including frequency and duration. All resources, including natural and community, must be included within the plan. Because the person-centered plan is the umbrella under which all planning for support and treatment occurs, all facets of treatment and supports provided must be documented within it. Separate plans should not be developed by other providers, or if they are, they should be referenced and incorporated into the person-centered plan. Potential resources must be addressed including:
 - **Informal Services/Supports** – Every effort should be made to use these resources before paid supports.

Personal Resources

The person's own resources, such as special skills or attributes, should be examined and included in the plan.

Natural Supports

Natural supports include family, neighbors, co-workers, and friends. Existing supports should be included if applicable and new ones explored.

Community Resources

Community resources are those that exist for any community member's use. Examples include church or faith-based organization, Boy's or Girl's Club, YM or YWCA, special interest or civic groups, sports or any other group available to other community members. Opportunities to connect the individual/family to the community must be explored and offered.

- **Formal Services/Supports** – This is paid assistance provided by professionals in the public system.
- Individuals responsible for completing or following through with the activities, strategies, supports, services and/or treatment.
- Documentation of individuals who participated as part of the planning team.
- Documentation of any areas of disagreement and the steps to address the dispute process.

C. Documenting the Person-Centered Plan

For a new consumer, a Person-Centered Plan should be completed within the first thirty days of contact. For consumers currently receiving services, there should be an annual update near the birth date.

PAGE 1

Header (To be completed on each page of the Person-Centered Plan document)

- **Consumer Name:** Enter the consumer’s legal name as indicated on the current Medicaid card.
- **DOB:** Enter the consumer’s date of birth (mm/dd/yyyy).
- **Medicaid ID:** Enter the identification number noted on the consumer’s current Medicaid card.
- **Record #:** Enter the record number assigned to the consumer by the LME.

_____’s **PERSON-CENTERED PLAN:** Enter the consumer’s first and last name.

Plan Meeting Date: This is the date participants meet to develop the plan. Dates spent collecting additional information are not reflected here.

State Funding Only:

Service Authorization By: Enter the signature of the individual authorizing services.

Authorization Date: Enter the date of the above signature.

Person Responsible for Plan: Enter the name of the qualified professional representing the consumer’s *clinical home* and responsible for plan development.

Consumer’s Preferred Name: The name by which the consumer prefers to be known if different from his/her legal name.

Address: Enter the consumer’s current street or mailing address.

City/State/Zip: Enter the city, state and zip code for the street or mailing address of the consumer.

Home Phone: Enter the telephone number for the current residence of the consumer.

Work Phone: Enter the telephone number of the consumer’s worksite, if applicable.

LME (Local Management Entity): Enter the name of the LME responsible for oversight and monitoring of the consumer’s service system.

Primary Care Physician: Enter the name of the physician responsible for the overall medical care of the consumer.

Medicaid County: Enter the name of the county from which the consumer's Medicaid originates.

Medicare/Insurance: Enter the name and policy number for each insurance company providing health coverage to this individual.

CONTACT PERSON(S):

Next of Kin: Enter the consumer's spouse or nearest blood relation. [NC General Statute 122C-3 (24)]

Relationship to the Consumer: Enter how the next of kin is related to the consumer.

Address: Enter the street or mailing address of the next of kin.

City/State/Zip: Enter the city, state and zip code for the street or mailing address of the next of kin.

Home Phone: Enter the telephone number for the residence of the next of kin.

Work Phone: Enter the telephone number of the worksite for the next of kin, if applicable.

Legally Responsible Person:

- When applied to an adult who has been adjudicated incompetent, this is a guardian.
- When applied to a minor, this is a parent, a guardian, a person standing *in loco parentis* (in the place of the parent) or a legal custodian other than a parent who has been granted specific authority by law or in a custody order to consent for medical care, including psychiatric treatment.
- When applied to an adult who is incapable as defined in NC G.S. 122C-72(c) and who has not been adjudicated incompetent, this is a health care agent named in a valid health care power of attorney. [NC G.S.122C-3 (20)]

Telephone: Enter the telephone number where the legally responsible person can be reached

Guardianship: Enter the name of a person appointed as a guardian of the person or general guardian by the court. [NC G.S.122C-3 (15)]

Date of Legal Document: Enter the date noted on the legal guardianship document/s specifying the date of appointment. (A copy of any applicable supporting legal documents must be attached).

Clinical Home Agency: Enter the provider agency serving as the clinical home for the consumer. *Clinical home* is defined as the responsible service provider for person-centered plan development and implementation.

First Responder Contact Name: Enter the name of the individual within the clinical home agency responsible for ensuring first response in case of emergency.

First Responder Work Phone: Enter the work telephone number of the individual responsible for ensuring first response in case of emergency. Designate if after hours number.

First Responder Cell Phone: Enter the cell telephone of the individual responsible for ensuring first response in case of emergency. Designate if after hours number.

First Responder Pager: Enter the pager number of the individual responsible for ensuring first response in case of emergency. Designate if after hours number.

Type of Plan: Check the applicable box. based on whether this plan is the first plan developed for the consumer or an update to a previous plan.

Initial Person-Centered Plan: Due within thirty days of contact with the consumer.

Updated Plan: Plans are updated annually near the consumer's birth date.

Revision: At a minimum, the Plan must be reviewed/revised by the person responsible for the Plan, based on assigned, target dates whenever the consumer's needs change or when a service provider changes.

Residence: Check the applicable type of residence in which the consumer is residing at the time the plan is developed.

Gender: Check if the consumer is male or female.

Ethnicity: Check the appropriate box if applicable for the consumer.

Race: Check the applicable race for the individual if not noted in the "Ethnicity" section.

PAGE 2: Participants Involved in Plan Development

For all individuals receiving services, it is important to include people who are important in the person's life such as family, legal guardian, professionals, friends and others identified by the individual (i.e. employers, teachers, faith leaders, etc.) in the planning process. These individuals can be essential to the planning process and help drive its success. The individual and/or the legally responsible person, identifies who will participate in the planning process, how and to what extent.

Use additional copies of this page if needed to enter information about all participants.

For each person involved in Plan development, record the following:

Name: Enter the name of the individual participating and providing any form of input into the development of the plan.

Relation/Agency: Enter the relationship and agency, if applicable, of each participant.

Role: Check the box or boxes that define each participant's involvement in Plan development.

Other individuals that I or my family would like to be part of my planning process in the future: List the names of individuals the consumer and/or family requests to participate in future planning processes.

PAGE 3: Personal Interview

Information should be provided as outlined in the prompts for each section. The prompts should not be considered all inclusive. The consumer may fill this out. Documentation on this page should reflect information given by the consumer.

Sections to be completed are as follows:

- What has happened in my life this past year?
- Long Term Goals
- Strengths
- Preferences
- Needs
- Supports (What is important **to** the consumer)

PAGE 4: Family, Legally Responsible Person, Informal Supports Interview

Information should be provided as outlined in the prompts for each section. The prompts should not be considered all inclusive. The legally responsible person may fill this out. Documentation on this page should reflect information given by the family member/s, guardian and informal supports plan participants. Sections to be completed are as follows:

- What has happened in this person's life this past year?
- Long Term Goals
- Strengths
- Preferences
- Needs
- Supports (What is important **to** this person.)

PAGE 5: Service/Support Provider Interview

Information should be provided as outlined in the prompts for each section. The prompts should not be considered all inclusive. The person responsible for the plan should fill this out after talking with applicable providers. Documentation should reflect information given by the provider services and supports plan participants. Sections to be completed are as follows:

- What has happened in this person's life this past year?
- Long Term Goals
- Strengths
- Preferences
- Needs
- Supports (What is important **for** this person.)

PAGE 6: Diagnostic Assessment

Diagnostic or other assessments serve as the starting point for developing the person-centered plan. Assessments and the person-centered plan must be completed within thirty (30) days of a service provider being authorized to provide services.

Assessments Completed: List all relevant assessments completed for this individual, including medical and dental evaluations if applicable.

Issues to Address: Enter areas to be addressed for the consumer as indicated in each completed assessment.

Last Date Completed: Enter the most recent completion date for each assessment.

Approximate Due Date: If re-assessment is recommended, enter the projected due date for the re-assessment.

Additional Assessments Recommended: Enter any additional assessments needed based on the information in each completed assessment.

Issues to Address: Enter areas to be addressed by each additional assessment.

Approximate Due Date: Enter the projected completion date for the assessment.

Completed Date: Enter the date of the completed assessment.

Axis: From the *Diagnostic and Statistical Manual of Mental Health Disorders IV-TR* (DSM), enter the Axis number in the first column, the diagnosis code in the second column and the determined diagnosis in the third column.

Recommendations for Services/Supports from Assessments: Use the information in each assessment to determine and enter the specific services, supports and treatment needed to achieve the desired outcome/s.

State/Medicaid: Note whether the service to be used to achieve the outcome is Medicaid or state funded.

Frequency: Indicate how often the service/support will be used to achieve the outcome.

Duration: Indicate how long the service/support will be used to achieve the outcome.

Target Date: Indicate the projected completion date for the service, support or treatment.

Symptoms and Observations of this Person: Enter key symptoms and observations that will result in action plans.

- **Symptoms** are indicators of disorders or disease that cause a decrease in the ability to fully participate in daily activities or impair the ability to achieve a maximum quality of life. They are determined by formal assessments.
- **Observations** involve informally recognizing and noting some fact or occurrence that limits a consumer's functioning.

PAGES 7 and 8: Action Plan

Potential service, support and/or treatment options to meet the goals and needs of the individual/family are identified and discussed in collaboration with professionals in the public system of services. The individual/family/legally responsible person must be fully informed of the rationale, evidence and risks of specific service, support and treatment options in order to make responsible choices based on the options presented.

Care should be taken to assure that purchased or funded supports do not take the place of natural supports and community resources when they are available and appropriate to the need.

Health and safety - In order to protect a person's health, safety and, consequently, the person's freedom, it is necessary to identify health and safety risk factors and to create supports and back up plans aimed at minimizing risk. Risk should be addressed by helping a person look at ways to be safe within the choices made.

Long Range Outcome: In measurable terms, state the goal the person desires to achieve within the year.

Where am I now in relation to this outcome? Briefly describe the consumer's current status, skills and abilities related to the identified long range outcome and the consumer's current level of participation related to this outcome.

Symptom/Observation #: For each symptoms/observation that may prevent the consumer from achieving the Long Range Outcome, enter the following information: (These symptoms/observations should tie back to those noted at the bottom page 6.)

- **Short Range Goal:** Enter a measurable objective needed to achieve the long range outcome based on in the "What's important to and for me" sections of the plan.

- **Support to Reach Goal:** Define the supports/services required to achieve the short range goal based on the “What people need to know or do” section of the plan.
- **Who Will Provide Support/Service?:** Identify the individual/s who will be responsible for implementing and documenting the progress on the goal.
- **Support/Service:** Identify the specific service/support/treatment to be used to address the goal.
- **Target Date:** Enter the date the team projects the consumer can achieve this goal.
- **Reviewed Date:** Enter the date progress towards the goal is reviewed.
- **Status Code:** Based on the progress review, enter the status code. (**Status Codes: R=Revised, O=Ongoing, A=Achieved, D=Discontinued**)
- **Justification for Continuation/Discontinuation of Goal:** If a goal is not achieved at the time of review, provide information justifying the reason the team determines to either continue or discontinue the goal.

Add additional copies of page 8 as needed to address Long Range Outcomes, Symptom/Observation.

PAGE 9 Crisis Prevention/Crisis Response

A crisis includes supports/interventions aimed at preventing a crisis (proactive) and supports/interventions if to employ if there is a crisis (reactive). A proactive plan aims to prevent crises from occurring by identifying health and safety risks and strategies to *head off* a crisis. A reactive plan aims to avoid diminished quality of life when crises do occur by having in place a plan for what to do in the crisis.

Symptoms or behaviors that may trigger the onset of a crisis: Provide detailed information regarding known behaviors the consumer may demonstrate prior to going into crisis, environmental factors that contribute to the onset of the crisis and information learned from previous episodes that may allow a crisis intervention response resulting in de-escalation or crisis diversion. Incorporate information gathered from, the Personal Interview, the Family/Guardian/Informal Supports Interviews and from the Service/Support Provider Interviews.

Crisis prevention and early intervention strategies: Provide a detailed description of strategies that will be used to assist the consumer in avoiding a crisis. Strategies should be based on knowledge, information, and feedback from the consumer and other team members as well as strategies that have been effective in the past. Incorporate information gathered from, the Personal Interview, the Family/Guardian/Informal Supports Interviews and from the Service/Support Provider Interviews.

Strategies for crisis response and stabilization: Provide a detailed description of strategies to be implemented to help the consumer stabilize during a crisis. Strategies should be based on knowledge, information, and feedback from the consumer and other team members as well as effective intervention strategies identified during previous crises. Steps should focus first on natural and community supports, starting with the least restrictive interventions. Incorporate information gathered from, the Personal Interview, the Family/Guardian/Informal Supports Interviews and from the Service/Support Provider Interviews.

Specific recommendations if consumer arrives at the Crisis and Assessment Service: Provide detailed information regarding intervention strategies, including contact information of the First Responder/Clinical Home agency staff responsible for providing first line intervention during a crisis. Incorporate information gathered from, the Personal Interview, the Family, Guardian, Informal Supports Interviews and from the Service/Support Provider Interviews.

Current Medications

Name: List the name of every current medication prescribed for the consumer. This must be kept updated so that in the event of a crisis the information is correct.

Dose: Enter the dosage of each medication.

Frequency: Enter the dosage frequency information as noted on the prescription.

Identify strategies for determining, after the crisis, what worked and what didn't and for making changes in the plan: After each crisis, provide information, as processed and assessed by members of the planning team, regarding effective and ineffective strategies. Make changes to the plan accordingly.

PAGE 10 Crisis Prevention/Crisis Response (Continuation)

Contact List:

Clinical Home Agency: Enter the provider agency serving as the clinical home for the consumer. *Clinical home* is defined as the responsible service provider for person-centered plan development and implementation.

First Responder Contact Name: Enter the name of the individual within the clinical home agency responsible for ensuring first response in case of emergency.

First Responder Work Phone: Enter the work telephone number of the individual responsible for ensuring first response in case of emergency. Designate if after hours number.

First Responder Cell Phone: Enter the cell telephone of the individual responsible for ensuring first response in case of emergency. Designate if after hours number.

First Responder Pager: Enter the pager number of the individual responsible for ensuring first response in case of emergency. Designate if after hours number.

Consent/Release of Information: Indicate yes or no that legal consent to contact the first responder has been signed by the consumer or guardian.

Legally Responsible Person: Enter the name of the legally responsible person.

- When applied to an adult who has been adjudicated incompetent, this is a guardian.
- When applied to a minor, this a parent, a guardian, a person standing *in loco parentis* (in the place of the parent) or a legal custodian other than a parent who has been granted specific authority by law or in a custody order to consent for medical care, including psychiatric treatment.
- When applied to an adult who is incapable as defined in NC G.S. 122C-72(c) and who has not been adjudicated incompetent, this is a health care agent named in a valid health care power of attorney. [NC G.S.122C-3 (20)]

Telephone: Enter the telephone number where the legally responsible person can be reached

Natural/Community Supports

Name: Enter the name of the individual/s providing natural/community supports in the consumer's life to be contacted during a crisis.

Telephone: Enter the telephone number where the identified individuals providing natural/community supports can be reached.

Consent/Release of Information: Indicate yes or no that legal consent to contact the identified natural/community support has been signed by the consumer or legally responsible person.

Professional Supports

Psychiatrist: Enter the name of the psychiatrist providing care to the consumer.

Telephone: Enter the telephone number for the identified psychiatrist.

Consent/Release of Information: Indicate yes or no that legal consent to contact the psychiatrist has been signed by the consumer or legally responsible person.

Primary Care Physician: Enter the name of the physician responsible for the overall medical care of the consumer.

Telephone: Enter the telephone number for the identified primary care physician.

Consent/Release of Information: Indicate yes or no that legal consent to contact the primary care physician has been signed by the consumer or legally responsible person.

Preferred Psychiatrist Inpatient or Respite Provider: Enter the name of the preferred inpatient psychiatric facility or the crisis respite provider as identified by the team.

Telephone: Enter the telephone number for the psychiatric inpatient or respite provider.

Consent/Release of Information: Indicate yes or no that legal consent to contact the preferred psychiatrist inpatient or respite provider has been signed by the consumer or legally responsible person.

Other Professional Supports

Name: Enter the name of the individual/s providing professional supports to be contacted during a crisis.

Telephone: Enter the telephone number of the individual/s providing professional supports.

Consent/Release of Information: Indicate yes or no that legal consent to contact the other individuals providing professional supports has been signed by the consumer or legally responsible person.

Advance Directives: Enter *yes* or *no* to the existence of a living will, health care power of attorney or advance directives for mental health treatment. If the consumer has any of these, attach a copy. If the consumer does not have them, explain them.

Living Will - All competent adults have the right to make decisions in advance about issues such as life support when it is clear that death is imminent or a state of coma becomes permanent. With a living will in place, the legally responsible person can make sure that the person's wishes are honored.

Health Care Power of Attorney - Also known as a *durable power of attorney for health care*, this document can be helpful when the consumer is unable to make medical decisions for him/herself. It may also be referred to as a *health care proxy* or a *medical power of attorney*. It names someone who represents the person's wishes. Unlike the living will, which usually is limited to terminally ill patients, this document applies whenever the person is unable to make medical decisions.

Advance Instruction for Mental Health Treatment - [122C-72 (1)] *Advance instruction for mental health treatment* or *advance instruction* means a written instrument signed in the presence of two qualified witnesses who believe the person to be of sound mind at the time of the signing, and acknowledge that before a notary public. In this document, the person gives instructions, information, and preferences regarding mental health treatment.

Crisis Plan Distribution List: Enter the names of all individuals/agencies receiving copies of the crisis plan.

PAGE 11 Comments and Signatures

Consumer and/or Guardian Comments on the Plan, Concerns, and Disputes:

The outcome of the planning process is intended to be consensus on the plan. A consensus implies that debate has taken place and that the Plan is generally accepted. However, if the consumer/legally responsible person has comments, concerns, or disputes with the Plan, they should be noted here.

Signatures:

Licensed physician, licensed psychologist, licensed physician's assistance or licensed family nurse practitioner: One of the professionals noted here must sign the Plan indicating that requested services are medically necessary. This signature and the date of the signature are REQUIRED. The signature serves as the Service Order for services contained in the Person-Centered Plan.

Individual: The consumer signs and dates the plan indicating confirmation and agreement with the services and supports detailed in the plan and confirmation of choice of service provider(s). This signature is REQUIRED.

Legally Responsible Person: The legally responsible person signs and dates the plan confirming involvement and agreement with the services and supports detailed in the plan. This signature is REQUIRED.

Person Responsible for Plan: The qualified professional representing the consumer's *clinical home* and responsible for the plan development signs and dates the plan confirming involvement and agreement with the services and supports detailed in the plan. This signature is REQUIRED.

Other Team Members: Other team members have the option to sign and date the plan confirming participation and agreement with the services and supports detailed in the plan. Participation is defined on page 2, *Participants Involved in Plan Development*.

PAGE 12 Plan Update/Revision Requests

Enter revised elements of the current approved Person-Centered Plan and substantiate requested revisions. Submit this page with page 1, identifying the submission as a revision.

Plan Update/Revision Requests: Check which type of action this represents.

Long Range Outcome: In measurable terms, state the goal the person desires to achieve within the year.

Where am I now in relation to this outcome? Briefly describe the consumer's current status, skills and abilities related to the identified long range outcome and the consumer's current level of participation related to this outcome.

Symptom/Observation #: For each symptoms/observation that may prevent the consumer from achieving the Long Range Outcome, enter the following information: (These symptoms/observations should tie back to those noted at the bottom of page 6.)

- **Short Range Goal:** Enter a measurable objective needed to achieve the long range outcome based on information gained in the "What's important to and for me" sections of the plan.
- **Support to Reach Goal:** Enter the supports/services required to achieve the short range goal based on information gained in the "What people need to know or do" section of the plan.
- **Who Will Provide Support/Service?** Identify the individual/s who will be responsible for implementing and documenting the progress on the goal.
- **Support/Service:** Identify the specific service/support/treatment to be used to address the goal.

- **Target Date:** Enter the date the team projects the consumer can achieve this goal.
- **Reviewed Date:** Enter the date progress towards the goal will be reviewed.
- **Status Code:** Based on the progress review, enter the status code. **(Status Codes: R=Revised, O=Ongoing, A=Achieved, D=Distinguished)**
- **Justification for Continuation/Discontinuation of Goal:** If a goal is not achieved at the time of review, provide information justifying the reason the team determines to either continue or discontinue the goal.
- **Medication Changes:** Enter any changes to medication or enter *No change*,

Add additional copies of this page as needed to address Long Range Outcomes, Symptom/Observation.

Signatures:

Licensed physician, licensed psychologist, licensed physician's assistance or licensed family nurse practitioner: One of the professionals noted here must sign the Plan indicating that requested services are medically necessary. This signature and the date of the signature are REQUIRED. The signature serves as the Service Order for services contained in the Person-Centered Plan.

Individual Signature: The consumer signs and dates the plan indicating confirmation and agreement with the services and supports detailed in the plan and confirmation of choice of service provider(s). This signature is REQUIRED.

Legally Responsible Person: The legally responsible person signs and dates the plan confirming involvement and agreement with the services and supports detailed in the plan. This signature is REQUIRED.

Person Responsible for Plan: The qualified professional representing the consumer's *clinical home* and responsible for the plan development signs and dates the plan confirming involvement and agreement with the services and supports detailed in the plan. This signature is REQUIRED.

Other Team Members: Other team members have the option to sign and date the plan confirming participation and agreement with the services and supports detailed in the plan.