**WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISOREDER (CSED) WAIVER**
**MASTER PERSON CENTERED SERVICE PLAN (PCSP)**

| **PCSP SERVICE YEAR:** *mm/dd/yr – mm/dd/yr* | **DATE OF MEETING:** Click here to enter a date. | **MONTH THIS PLAN WILL BE REVIEWED:** Click here to enter a date. |
|---|---|---|

**TYPE OF PCSPT MEETING:**

☐ **ANNUAL** ☐ **3-MONTH** ☐ **6-MONTH** ☐ **9-MONTH** ☐ **SIGNIFICANT LIFE EVENT**

☐ **TRANSFER** ☐ **DISCHARGE** ☐ **7-DAY** ☐ **30-DAY**

**DEMOGRAPHICS**

| | |
|---|---|
| **Member Name:**<br>**Address:**<br>**Phone Number:**<br>**Date of Birth:** | **Additional Insurance (if applicable):**<br>**Date of Financial Eligibility:**<br>**Date of Medical Eligibility:**<br>**Anchor Date:** |
| **Legal Representative:** Yes ☐ No ☐<br>If "Yes" Full ☐ Limited ☐<br>Name:<br>Address:<br>Phone: | **Medical Power of Attorney:**<br>Yes ☐ No ☐<br>Name:<br>Address:<br>Phone: |
| **MCO Care Manager Name:**<br>Telephone #, ext:<br>E-mail: | Date of last CANS:<br>Date of last CAFAS/PECFAS:<br>Date of last BASC: |
| **Case Management:**<br>CM Name:<br>CM Provider Agency:<br>CM Telephone #, ext.:<br>CM e-mail: | **Attachments:**<br>☐ Crisis Plan<br>☐ Therapy plan<br>☐ Other: ________________________________ |

| **Non-CSED Waiver State Plan (Medicaid) Services:** (Describe all services the member is receiving not covered under the waiver) | | |
|---|---|---|

**Coordination of Healthcare Needs:**

Name of Primary Care Physician:

Date of Last Annual Physical Exam:

Are there any outstanding medical issue? Yes ☐ No ☐

Does the person who receives services need assistance in scheduling any medical appointments?
Yes ☐ No ☐

For any "yes" answers, describe in Health & Safety Issues area of Evaluation and Assessments Section, below

PARTICIPANT NAME / RECORD ID # MM/DD/YYYY

| **MEETING MINUTES** |
|---|
| **Who attended this meeting? Did any team members attend by phone, and why?** |
| |
| **Summary of what was discussed during this meeting** *(describe specific details including, but not limited to, person-centered items, current events, concerns, anticipated/upcoming changes, unmet needs, input/recommendations, etc.)* |
| |
| **Review of Services** *(list each service authorized and include: total number of units authorized, how many units used to date, and how many units remain for the remainder of the service year)* |
| |
| **Incident Reports** *(List any incidents which have occurred since the last PCSPT meeting; include any trends identified and measures that are being taken to address trends. Ensure that corresponding incident reports are on file and that each incident has been entered into MCO's Incident Management System)* |
| |

| **Meeting Minutes Completed By** | |
|---|---|

| **CIRCLE OF SUPPORT** |
|---|
| **Intimacy: Who can I count on?** |
| |
| **Friendship: Who is a good friend?** |
| |
| **Participation: What people, organizations, or networks am I involved with?** |
| |
| **Exchange: Who are the people paid to be in my life (i.e. staff)?** |
| |
| **Who would I like to participate in developing my plan? (May include anyone I want: professionals, direct care providers, family members, friends, etc.; however, it must include my legal representative – if applicable and a representative of any agency that provides services for me.)** |
| |

| **GOALS AND DREAMS**<br>***Goals and dreams should be carried through the rest of this plan and incorporated into the Service Plans and goals/objectives including responsible persons and/or provider and timelines for making plans happen.*** |
|---|
| **What are my short-term and long-term goals and dreams? My dreams should be positive and possible.**<br>***(Where do I want to live? Ideal job? Who do I want to live with? Dream vacation? What do I want to learn?)* Who is going to help me achieve these goals/dreams?** |
| **Short-term goals:**<br><br>**Long-term goals:** |
| **What do I expect to be different as a result of receiving services and supports? What outcomes do I expect to accomplish with the help of supports?** |
| |
| **What are the things that I like and dislike? What things do I consider pleasant and important? What do I like to do during my leisure time? What community activities do I enjoy?** |
| |
| **What are my strengths? What am I good at?** |
| |

| ***AGREED UPON EXPECTATIONS AND VALUES*** |
|---|
| Talking to the family about their expectations from service providers and other family members. Also discussing family's values.<br><br>What are your expectations for this program? What do you want to gain/improve from your participation? |

| **Evaluation** | **Date of Evaluation** | **Summary of Assessments/Evaluations Results and Recommendations (List all assessments used to develop the service and habilitation plan):** |
|---|---|---|
| Person-Centered Assessment | | SUMMARY OF CURRENT PERSON CENTERED PLANNING TOOL<br><br>Based on my strengths, dreams and goals, my PCSPT has determined that the following services, supports and/or resources are needed: |

| **Evaluation** | **Date of Evaluation** | **Summary of Assessments/Evaluations Results and Recommendations (List all assessments used to develop the service and habilitation plan):** |
|---|---|---|
| CANS | | SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS<br><br>Based on these findings, my PCSPT recommends the following training goals/ programs and/or support activities to be implemented:<br><br>•<br><br>Based on these findings, my PCSPT recommends the following behavioral objectives to be implemented: (delete if n/a)<br><br>•<br><br>Based on my needs as stated above, my PCSPT has determined that the following services, supports and/or resources are needed: |

| Evaluation | Date of Evaluation | Summary of Assessments/Evaluations Results and Recommendations (List all assessments used to develop the service and habilitation plan): |
|---|---|---|
| Health & Safety Issues Identified<br><br>Crisis Planning | Ongoing | SUMMARY OF MOST CURRENT HEALTH AND SAFETY ISSUES AS IDENTIFIED BY THE PCSPT.<br><br>Based on my needs as stated above, my PCSPT has determined that the following services, supports and/or resources are needed: |
| Medical | Ongoing | LIST ALL PHYSICIANS, DATES OF LAST APPOINTMENTS, AND RECOMMENDATIONS.<br><br>Based on my needs as stated above, my PCSPT has determined that the following services, supports and/or resources are needed: |
| Psychological/ Psychiatric (if applicable) | | SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS<br><br>Based on my needs as stated above, my PCSPT has determined that the following services, supports and/or resources are needed: |
| Therapy (PT, OT, ST, etc. – if applicable) | | SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS<br><br>Based on my needs as stated above, my PCSPT has determined that the following services, supports and/or resources are needed: |
| Diagnosis | N/A | |

| Evaluation | Date of Evaluation | Summary of Assessments/Evaluations Results and Recommendations (List all assessments used to develop the service and habilitation plan): |
|---|---|---|
| Case Management Assessment | | SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS<br><br>Based on my needs as stated above, my PCSPT has determined that the following services, supports and/or resources are needed: |
| Therapist Assessment (if applicable) | | SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS<br><br>Based on my needs as stated above, my PCSPT has determined that the following services, supports and/or resources are needed: |
| IEP (if applicable) | | SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS<br><br>Based on my needs as stated above, my PCSPT has determined that the following services, supports and/or resources are needed: |

| Living Arrangement Evaluation | | |
|---|---|---|
| **Family Demographics** including name and relationship to Participant:<br><br>Biological Family (if reunification is the goal) :<br><br>Foster/Adoptive Family: : | **Family Strengths:** | **Family Needs:** |

PARTICIPANT NAME / RECORD ID # MM/DD/YYYY

| Medications that I take | Dosage | Frequency | Reason for taking this medication (applicable diagnosis) | Who will administer? (agency name and staff title or natural support) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**IF PSYCHOTROPIC MEDICATIONS ARE ADMINISTERED, PLEASE INCLUDE A RATIONALE FOR CHANGES OR CONTINUATION OF EACH MEDICATION:**

| **CSED Waiver Services Needed to Support Me<br>Person Centered Service Plan** | | | |
|---|---|---|---|
| **Service Code** | **Service Description** | **Provider (include *name* of staff person)** | **Is this service available/accessible?** |
| | | | ☐ Yes ☐ No |
| **Amount/Frequency:** Service should average _____ units per month & should not exceed ____ units per year. | | | |
| **Duration of Service:** This service should begin on __________ and end on __________. | | | |
| **Plan of Action/Scope of Work to be done to support me.<br>What, specifically, will the provider do to support my needs? What has changed since my last PCSPT meeting?** | | | |
| | | | |

| **CSED Waiver Services Needed to Support Me<br>Person Centered Service Plan** | | | |
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PARTICIPANT NAME / RECORD ID # MM/DD/YYYY

| **CSED Waiver Services Needed to Support Me**<br>**Person Centered Service Plan** | | | |
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<tr><td>Support:</td><td>Who provides this support (name)?</td><td>Is this service available/accessible: ☐ Yes ☐ No<br>If no, indicate what steps will be taken for the service to become available/accessible in Plan of Action.</td></tr>
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<tr><td colspan="3">Duration of Support: This support should begin on __________ and end on __________.</td></tr>
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| Non-CSED Waiver Services and Natural Supports<br>(Volunteer groups, clubs, churches, schools, etc.) | | |
|---|---|---|
| **Support:** | **Who provides this support (name)?** | **Is this service available/accessible: ☐ Yes ☐ No**<br>*If no, indicate what steps will be taken for the service to become available/accessible in Plan of Action.* |
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| --- |
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| --- | --- | --- |
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| | | |

| Discharge Criteria |
| --- |
| Include measurable goals and objectives along with expected time frames for completion:<br><br><br><br>If applicable, describe transition plan: |

| **Person Centered Service Planning Team Signature Sheet** | | |
|---|---|---|
| **Participant Name:** | **Date of Meeting:** Click here to enter a date. | **DATE UPLOADED TO MCO/Atrezzo©:** Click here to enter a date. |

**TYPE OF PCSPT MEETING:**

☐ **ANNUAL** ☐ **3-MONTH** ☐ **6-MONTH** ☐ **9-MONTH** ☐ **CRITICAL JUNCTURE**

☐ **TRANSFER** ☐ **DISCHARGE** ☐ **7-DAY** ☐ **30-DAY**

| **Relationship** | **Signature and Credentials** | **Time Spent in Meeting** **(start/stop times)* | **Agree** | ***Disagree** | **Date this PCSP was sent out** |
|---|---|---|---|---|---|
| Waiver Participant | | | | | |
| Parent/Legal Representative | | | | | |
| Case Manger | | | | | |
| Other Relationship: | | | | | |
| Other Relationship: | | | | | |
| Other Relationship: | | | | | |

***Rationale for Disagreement with the Plan (if applicable)**

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Signature: _______________________________________________________ Date: ____________