

**Person-Centered Plan/Individual Service Plan (PCP/ISP)**

**Quality Check**

Medicaid ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PCP/ISP Review Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beneficiary Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Note: Federal regulations related to Medicaid HCBS programs 1915(c) and 1915(i) states that service plans must be developed using a person-centered planning process that address health and long-term services and support needs in a manner that reflects individual preferences and goals.***

**Section 1: Personal Information** This section contains basic demographic information regarding the individual. Please note, information provided under Person's Name, Preferred Name, Medicaid ID, and Medicaid Certification Period will auto-populate throughout the PCP template, including Section 9-PCP Plan Agreement.

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| **Indicator(s)** | **Yes** | **No** | **N/A** | **Comments** |
| 1. Is the beneficiary’s legal name listed in this section? |  |  |  |  |
| 1. Is the beneficiary’s preferred name listed in this section? |  |  |  |  |
| 1. Is the Medicaid certification period stated in the section? |  |  |  |  |
| 1. Is the beneficiary’s Authorized/Legal Representative listed in the section (if applicable)? |  |  |  |  |

**Section 2: PCP Preparer** This section contains information on the preparer of the PCP. Please note, information provided under PCP Preparer will auto-populate to Section 9-PCP Plan Agreement.

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| **Indicator(s)** | **Yes** | **No** | **N/A** | **Comments** |
| 1. Is the Preparer identified (including their affiliation) in this section? |  |  |  |  |
| 1. Is the contact information for the Preparer stated in this section? |  |  |  |  |

**Section 3: Participants** This section contains the names and associated information of those parties invited by the individual to participate in development of the PCP. Please note, information provided under Name will auto-populate to Section 9-PCP Plan Agreement. The preparer also should note the individual's level of capacity in developing the PCP, and what supports, if any, are necessary.

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| **Indicator(s)** | **Yes** | **No** | **N/A** | **Comments** |
| 1. Is the date of the PCP/ISP meeting and location noted in this section? |  |  |  |  |
| 1. Is there evidence in PCP/ISP of people that were invited to the meeting? |  |  |  |  |
| 1. Is there evidence that the preparer assessed the beneficiary’s independence level regarding the plan completion? |  |  |  |  |
| 1. If assistance is needed in completion of the plan, does the PCP preparer explain what support was needed? |  |  |  |  |

**Section 4: About Me** This section contains a series of questions to be answered by the individual, which will help document the person's gifts, abilities, talents, and skills. If an individual chooses not to answer a specific question, this must be documented in the PCP. All individuals are presumed to have the capacity to actively participate in the planning process.

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| **Indicator(s)** | **Yes** | **No** | **N/A** | **Comments** |
| 1. Does the preparer thoroughly respond to all 5 questions in this section? |  |  |  |  |

**Section 5: Goals** This section contains information on goals the individual would like to accomplish. These goals should be achievable within 12 months, and should be framed as “I will” statements. At minimum, each completed PCP must detail one (1) goal.

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| **Indicator(s)** | **Yes** | **No** | **N/A** | **Comments** |
| 1. Is there a target completion date for each goal? |  |  |  |  |
| 1. Are the “desired results” written in measurable terms (key steps)? |  |  |  |  |
| 1. Are responsible parties identified and their core responsibilities are included in the section? |  |  |  |  |
| 1. Are risks identified? If not, is “none” it noted in this section? |  |  |  |  |
| 1. Does the preparer identify dissention among team members? If not, is “none” noted in this section? |  |  |  |  |

**Section 6: Goal Summary** This section contains a summary of each goal outlined in Section 5, along with information on the key steps and responsible party, the provider the individual is being referred to, the target date for accomplishing the goal, and the plan of action if progress is lacking towards achieving the goal. Information from Section 5 will auto-populate into Section 6 (i.e., Goal, Key Steps, Responsible Party, & Target Date). Fields for Done, Achieved Date, and Update on Status if progress is lacking must be completed by the preparer with the individual and his/her PCP team.

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| **Indicator(s)** | **Yes** | **No** | **N/A** | **Comments** |
| 1. Are all goals included in the “goal summary”? |  |  |  |  |
| 1. Are there key steps/objectives for each goal? |  |  |  |  |

**Section 7: Risk Factors** This section contains information on potential risks and how each identified risk will be addressed by the individual and his/her PCP Team. At minimum, each completed PCP must detail one (1) area of risk. The preparer must also note if the individual has an advance directive and plans for future healthcare decisions.

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| **Indicator(s)** | **Yes** | **No** | **N/A** | **Comments** |
| 1. Does the preparer identify at least one “risk” factor in the PCP/ISP? |  |  |  |  |
| 1. Does the preparer address each risk factor identified? |  |  |  |  |
| 1. Does the PCP/ISP include an emergency back-up plan for disasters, staffing shortage, power outages, etc.? |  |  |  |  |

**Section 8: Specific Services & Recommended** This section contains information on the services (both Medicaid and non-Medicaid) recommended that will help the individual achieve the goals outlined in Sections 5 and 6. The recommended services should include community and natural resources, as well as those services paid for by Medicaid and/or the District of Columbia. For recommended Community Resources, the PCP preparer must provide detail on the scope and nature of this resource in the “Notes” section. In addition, any added detail regarding the individual's preferences on how/when/where the recommended services should be delivered must be detailed under the “Notes” section. Section 8 will be approved by DHCF and/or its designee only if the services recommended clearly relate to the goals and objectives outlined in the PCP.

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| **Indicator(s)** | **Yes** | **No** | **N/A** | **Comments** |
| 1. Does the PCP/ISP identify recommended services (Medicaid, non-Medicaid) needed to achieve the goals in section 5&6? |  |  |  |  |
| 1. Does the preparer indicate the type, source, frequency, start/stop date for each recommended service, as appropriate? |  |  |  |  |

**Section 9: PCP Plan agreement** This section contains signatures by the individual and the PCP Team both agreeing to and attesting to the entirety of the PCP. Until this PCP template is automated, the preparer must print this page of the template and have it available for signature at the time of the PCP team meeting. The case manager must scan and upload a copy of the signed Section 9 with the completed PCP, and is required to maintain Section 9 in his/her files; such files will be subject to inspection and audit by DHCF.

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| **Indicator(s)** | **Yes** | **No** | **N/A** | **Comments** |
| 1. Is the PCP/ISP signed by the beneficiary (if appropriate)? |  |  |  |  |
| 1. Is the PCP/ISP signed by the authorized/legal representative (if appropriate)? |  |  |  |  |
| 1. Is the PCP/ISP signed by the other PCP team members (if appropriate)? |  |  |  |  |
| 1. Was the beneficiary provided information about the Services My Way program? |  |  |  |  |

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| **Summary:** Include any actions taken by the reviewer to correct the issues identified such as returning the PCP to the Case Manager, discussion with the provider and their assigned lead, issuing discoveries or referrals to monitoring team for follow-up. |
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| **Reviewer Name:**  **Reviewed Title:** | **Review Date:** |
| **Signature of Reviewer:** | |