Adult Developmental Services
Personal Plan Face Sheet

Identifiers

Consumer name		**Region:** ☐ **1** ☐ **2A** ☐ **3B** ☐ **2R** ☐ **3C** ☐ **2L**
MaineCare ID #		
EIS ID #		
ISC/CCM name		

Facilitator

Name of person writing this plan	_____
Organization	_____

Plan

Plan start date	_____
Plan end date	

Plan Type ☐ Annual ☐ Review/Other ☐ Interim

***Next Waiver reclassification date** _____ OR ☐ no waiver

***Pre-Planning**

Preplanning start date	(see narrative)
Response Sheet Summary used in Pre-Planning with consumer/guardian	☐ Yes ☐ No
Reportable Events reviewed?	☐ Yes ☐ No ☐ No Reportable Events
IST in past 12 months?	☐ Yes ☐ No

***Routine Health**

Date of most recent:	
Physical exam	_____.
Dental/oral exam by a dentist	_____.
IV sedation for dental/oral procedure? ☐ Y ☐ N	_____.
Vision exam (if needed)	_____.
Hearing exam (if needed)	_____.
Psychotropic meds ☐ Y ☐ N Reviews 1. By psychiatrist? ☐ Y ☐ N 2. By psychiatrist? ☐ Y ☐ N	 ___/___/___. ___/___/___.
Mortuary Trust (age 50+ only) ☐ Yes ☐ No	

Current Medical Providers	
Name	**Specialty**

Developmental Services Grievance Process insert sent to consumer/guardian ☐

Planning Coordinator signature _____ Date ___/___/___.

Action Plan (To be completed by ISC/CCM)

Unmet needs are identified?	☐ Yes (see narrative)	☐ No unmet needs
Plan for assessing consumer satisfaction?	☐ Yes	☐ No
Planning team monitoring schedule:		

This plan accurately reflects the planning process and the person's needs and desires. The recommended services are medically necessary and in compliance with MaineCare rules

ISC/CCM Signature _____ Date___/___/___.

* these items are required for the annual plan only

Revised 6/02/09