Personal Plan Face Sheet Instructions

Consumer Name: Self-Explanatory **EIS ID #** Consumer's ID # from DHHS File, ask Case Manager.

Effective Plan Date:

Effective Plan Date is the plan start date. It is the same every year. The Effective Plan Date is not the same as the Plan meeting which must be held no more than 45 days prior to the Effective Plan date.

Plan End Date:

This must not exceed 365 days from the Effective Plan Date.

Waiver Type: ☐ 21 ☐ 29 ☐ Other Funding Sources *(specify)*

Identify the MaineCare funding source for services. If unsure, contact the Case Manager.

Next Waiver Reclassification Date:

The annual deadline, listed in EIS, for re-authorization for waiver services. The Effective Plan Date must be no more than 6 months prior to the Reclassification Date.

Caseworker Name & Agency: Self-Explanatory

Name of Guardian(s), if applicable: Name of court appointed guardian for the focus person.

Name of Correspondent, if applicable: Name of Volunteer Correspondent (as appointed by OAB)

List names and affiliations/relationships of *other* team members *who participated* in planning:

List people participating in the planning process who are NOT listed above this box.

Name of Medical/Dental Monitor:

The person designated by the planning team as responsible for monitoring the quality of medical and dental services, including routine and acute health care.

Name of Rep Payee:

The person appointed by Social Security or other government agency to receive consumer funds.

Name of Person Reporting Critical Information to Case Manager at Least Monthly or as Changes Occur:

The person identified as responsible for updating critical information and updating the case manager of any changes (monthly or more frequently as changes occur). This is information the case manager needs to enter into EIS.

Name of Advocate:

Enter name of Advocate, see PCP Instruction Manual for more information.

Items in box require further detail be written in narrative:

- Check if participated in the planning process:
  ☐*Consumer* ☐*Guardian(s)* ☐*Caseworker* ☐*Correspondent*
- Type of Guardianship (if applicable) ☐Full Public ☐Limited Public ☐Full Private ☐Limited Private ☐Self
  Does team recommend any changes to guardianship? ☐Yes ☐No
- Reportable Events in last 12 months? ☐Yes ☐No Reviewed in service planning? ☐Yes ☐No
- IST in past 12 months? ☐Yes ☐No Reviewed in service planning? ☐Yes ☐No
- Has employment been discussed? ☐Yes ☐No
  Is person employed? ☐Yes ☐No *Is person underemployed?* ☐Yes ☐No
- Needs/Outcomes are identified ☐Yes ☐No Desires/Outcomes are identified ☐Yes ☐No
- Health and safety needs identified and addressed in service description form(s)? ☐Yes ☐No
- Unmet needs are identified ☐Yes ☐No unmet needs
  If yes, interim plan is included? ☐Yes ☐No
- Did consumer identify any sensitive issues? ☐Yes ☐No
  If yes, were they addressed in another forum? ☐Yes ☐No
- Plan for assessing consumer satisfaction with the plan? ☐Yes ☐No

Was DS Grievance Process Insert given to consumer and guardian(s), if there is guardian(s)? ☐Yes ☐No

Check one of these boxes to verify that the *DHHS Developmental Services Grievance Process Insert* was sent with the completed plan to the consumer and guardian.

Planning team monitoring schedule:

Describe the monitoring schedule determined by the team, see the PCP Instruction Manual.

In boxes below, check each type of MaineCare Service being requested. Check if new, continued or a change in service. A "New" service is one not previously provided. A "Continued" service is one continuing as it is currently being provided. A "Change" in service may include a different provider or frequency.

Check MaineCare Services Member Requested:

SERVICE	NEW	CONTINUED	CHANGE
☐ Home Supports	☐	☐	☐
☐ Community Supports	☐	☐	☐
☐ Work/Employment Specialist Supports	☐	☐	☐
☐ Ancillary Supports	☐	☐	☐
☐ Transportation	☐	☐	☐
☐ Crisis Services	☐	☐	☐
☐ Case Management	☐	☐	☐
☐ Other (specify)	☐	☐	☐
☐ Other (specify)	☐	☐	☐

*****Service Descriptions must be entered into EIS*****

Routine Health:

Examination	Date of most recent	Name of Provider
Annual Medical Exam		
Dental/oral (by dentist) Dental/oral exam by a dentist. This refers only to an exam performed by a dentist. It does not include a dental/oral inspection done as part of the annual medical exam.		
IV Sedation for dental/oral procedure? ☐ Yes ☐ No Y means the person requires IV sedation in order to have a dental/oral procedure N means sedation is not needed.		
Vision (if recommended by doctor) This refers only to an exam performed by an optometrist or an ophthalmologist. It does not include a vision screening done as part of the annual medical exam.		
Hearing (if recommended by doctor) This refers only to an exam performed by an audiologist. It does not include a hearing screening done as part of the annual medical exam.		
Psychiatric meds ☐Yes ☐No Y means the person has one or more psychotropic medications. N means the person has no psychotropic medication. Reviews 1. By psychiatrist? ☐Yes ☐No 2. By psychiatrist? ☐Yes ☐No Enter the dates of the two most recent reviews. Y means the meds were reviewed by a psychiatrist. N means the meds were reviewed by another practitioner.		

Other Medical Providers:

Name of Provider	Specialty
Enter the names of each specialist, if applicable	*Enter the specialty, e.g., "Speech Pathologist", "Neurology", "Internal Medicine", etc*

Required Signatures:

Consumer Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

☐ I approve the plan dated _____. ***I understand that I may revoke my approval of any or all parts of the plan at any time.***

☐ I do **NOT** approve the plan and will get in touch with the case manager to discuss it.

Case Manager Signature: _____ Date: _____

By signing, I agree this plan accurately reflects the planning process and the person's needs and desires. The recommended MaineCare services are medically necessary and in compliance with MaineCare rules.