Behavioral Health Home and Community Based Services (BH HCBS)
PLAN OF CARE

Click here to access the PLAN OF CARE Guidelines document

Please contact the Care Manager at abc@test.com if you need copy of PLAN OF CARE

Care Manager		*Organization*	
POC Meeting Location		*Date*	
Tel #		*Email*	
InterRAI Completion Date			
Next Assessment Due on			

OUTLINE

Section 1: Demographic information

Individual Name		Medicaid #/CIN	
Date of Birth		Gender	
Address		Home Phone #	
Phone #		Email	
Language		Religion	

Section 2: Clinical and Non Clinical Needs/Services at the Time of Assessment

Medical Needs at the time of assessment

Service	Provider Specialty	Provider name	Organization	Address	Work Phone	Email	Service / Diagnosis code	Description	Prescription/ unit	Frequency	Last visit date

Click to add more Clinical/non Clinical needs/services

Behavioral Health Needs at the time of assessment

Service	Provider Specialty	Provider name	Organization	Address	Work Phone	Email	Service / Diagnosis code	Description	Prescription/ unit	Frequency	Last visit date

Click to add more Behavioral Health needs/services

Social Service Needs at the time of assessment

Service	Provider Specialty/ Relation	Provider name	Organization	Address	Work Phone	Email	Service / Diagnosis code	Description	Prescription/ unit	Frequency	Last visit date	Paid/ unpaid

Click to add more Social services needs/services

Section 3: Behavioral Health Home and Community Based Services (BH HCBS) Eligibility

Results of BH HCBS screen:

- ☐ Eligible for Tier 1 BH HCBS only
- ☐ Eligible for Tier 2 BH HCBS (Full array)
- ☐ Not Eligible

Section 4: Recommended Behavioral Health Home and Community Based Services (BH HCBS)

BH HCBS Recommended Providers/Services										
Service	**Provider type/ Specialty**	**Provider name**	**Organization Name & Address**	**Duration**			**Phone**	**Frequency**	**Email**	**Description**
				Start Date	**End Date**	***Note if Continuous Service***				

Click to add more services

Section 5: Interventions

Status	Duration	Start Date	Tests/ Treatment/ Service/ Referral	Service Description	Provider Name	Provider Specialty	Organization	Phone	Email	Address

Click to add more Interventions

Section 6: Goals, Preferences and Strengths

Goal # 1	
Category	**Target Date**
Past Efforts (Things that I have tried in the past to reach my goal)	
Objectives (The outcomes I want to achieve)	
Preferences (I would prefer that when I receive services the following is taken into account by the provider)	
Strengths (My strengths are)	
Potential Barriers (Things that make it hard for me to achieve these outcomes)	
Strategies (Things that I will do to address the barriers and achieve my desired outcomes)	
Support(s) Needed (Who will help me reach my goal) Indicate if supports are to be provided by paid or unpaid provider and the frequency needed	

Click to add more Goals

Section 7: Risk Assessment and Mitigation Strategies

Crisis Prevention

It is often helpful to be aware of events, feelings, thoughts and sensations that are early warning signals for an emotional crisis. If I begin to experience them, I can use the following plan.

What are my triggers (what people, places, or things upset me); how do I know when I am upset?

What activities can I do to feel better (for example, take a walk, listen to music, or watch TV)?

Who can I call for support?

Name	Relation	Contact Info

Back-Up Plan

If there is an emergency, call 911. *A back-up plan assists in locating help in an emergency situation or if regularly scheduled worker(s) cannot provide you care, services, or supports. The back- up plan will indicate: whom I will call, including service needs, and phone numbers, plans for service animals or pets, and plans for preparing for a disaster.*

I will talk with back-up workers about their availability and my care needs before an emergency comes up. I understand that I may only get my most serious needs met in an emergency.

I will call/contact one of the individuals listed below if my regularly scheduled worker(s) does not report for his/her scheduled time. (Examples: provider, friends, family, previous workers, church members, other volunteers).

Service	Contact	Phone	Availability

Natural Disaster

In the event of a natural disaster or an emergency, I will call the following people:

Name	Days/Times Not Available	Phone	Will be able to assist with

In the event of a natural disaster or emergency, I will do the following ***(include securing medications, knowing the location of your nearest emergency department, care of animals or pets, etc.)****:*

Plans for any other Emergency Situations

If my health or welfare is at risk by a dangerous or harmful situation, I will call the following people:

Name	Phone	Address	Relationship (relative, doctor, Care Manager, other)

Risk Assessment to Justify an Intervention / Support to Address an Identified Risk

If a risk is identified address items A – H below:

If risk is identified, complete the following:

A. Identify the specific and individualized assessed need.
B. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
C. Document less intrusive methods of meeting the need that have been tried, but did not work.
D. Include a clear description of the condition that is directly proportionate to the specific assessed need.
E. Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
F. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
G. Include informed consent of the individual or legal representative or guardian.
H. Assure that interventions and supports will cause no harm to the individual.

Include a narrative addressing all items A-F and H if an intervention is utilized:

A.	
B.	
C.	
D.	
E.	
F.	
G.	
H.	

By signing below, I agree with the use of this intervention or support to address the identified risk. I will watch and make sure that the interventions and support do not harm me in any way.

Recipient:		Date:	
Legal Representative/Guardian:		Date:	
Care Manager:		Date:	
Care Manager Supervisor:		Date:	

Section 8: Person-Centered Plan of Care Affirmation / Attestation

The Care Manager and MCO are responsible for monitoring, on a regular basis, whether the services in the Plan of Care are being delivered as outlined in the Plan of Care and whether those delivered services meet the needs of the individual. The Care Manager will contact the Recipient routinely to ensure that the Recipient's goals, preferences, and needs are being met. The Recipient may call the Care Manager at any time to initiate changes or discuss the quality of care of the services listed in the Plan of Care. If at any time a provider or the Recipient becomes aware of unnecessary or inappropriate services and supports being delivered, he/she is obligated to contact the Care Manager and discuss a change in the Plan of Care.

Commitment to Confidentiality and Support:
By signing this form, I agree to maintain Recipient confidentiality; I affirm that I participated in the development of this Plan of Care and the Recipient was given choices in selecting providers; I support the goals of the Recipient below; I acknowledge that I understand and approve the content of this Plan of Care; and I have a copy of this Plan of Care.

Release of Information: I consent to the release of information under the BH HCBS program, so I may receive services. I understand that the information included on the Plan of Care will be released to _____ and service providers listed below to enable the delivery of services and program monitoring. I understand that my Care Manager shall not release my record in the absence of written authorization from me or my representative.

I affirm to share my PLAN OF CARE with following individuals:

Name	Phone	Address	Relationship (relative, doctor, Care Manager, other)

Signature	*Date*	*Print Name*
Individual		
Legal Representative/Guardian		
Care Manager		
Provider (Must sign if present at POC meeting):		
Provider (Must sign if present at POC meeting):		
Provider (Must sign if present at POC meeting):		
Provider (Must sign if present at POC meeting):		
Provider (Must sign if present at POC meeting):		
Provider (Must sign if present at POC meeting):		
Provider (Must sign if present at POC meeting):		

Click to add Signature line

Section 9: Approved / Denied Services

Service		Service Status	
MCO Approval Status	☐ Approved ☐ Denied ☐ Pending	MCO Representative	Name: Representative:
Reason:			

Date service started	Provider Specialty	Provider name	Organization	Address	Work Phone	Email	Service / Diagnosis code	Description	Prescription/ unit	Frequency

Hide Detail

Service		Status	
MCO Approval Status	☐ Approved ☐ Denied ☐ Pending	MCO Representative	Name: Representative:
Reason:			

Date service started	Provider Specialty	Provider name	Organization	Address	Work Phone	Email	Service / Diagnosis code	Description	Prescription/ unit	Frequency

Hide Detail

Click to add service

Recipient Rights for Individuals Receiving Behavioral Health Home and Community Based Services (BH HCBS)

I qualify for BH HCBS which are essential to my health and welfare and may be provided to me within the program limits. My signature below indicates that I agree with the following:

☐ I have been informed that I am eligible to receive services.
☐ I understand that I may choose to remain in the community and receive the services, as designated in my Plan of Care.
☐ I understand that I have the choice of any qualified providers in my plan's network and I have been notified of the providers available.
☐ I understand that I have the right to be free of abuse, neglect, and exploitation and to report of these abuses at any time.
☐ I understand I may grieve and appeal at any time and have received information on how to do this.

Please ensure that your Care Manager has reviewed the Plan of Care with you and has provided a copy of this Plan of Care to you before signing. My choice is to (check one):
☐ Receive BH HCBS as indicated on the attached Plan of Care.
☐ Refuse the recommended services

Recipient Signature	**Date**
Representative Signature	**Date**
Care Manager Signature	**Date**

Abuse, Neglect, Exploitation

Physical Abuse: Non-accidental contact which causes or potentially causes physical pain or harm

Psychological Abuse: Includes any verbal or nonverbal conduct that is intended to cause emotional distress

Sexual Abuse: Any unwanted sexual contact

Neglect: Any action, inaction or lack of attention that results in or is likely to result in physical injury; serious or protracted impairment of the physical, mental or emotional condition of an individual

Exploitation: The illegal or improper use of an individual's funds, property, or assets by another individual. Examples include, but are not limited to, cashing an individual's checks without authorization or permission; forging an individual's signature; misusing or stealing an individuals' money or possessions; coercing or deceiving an individual into signing any document (e.g. contracts or will); and the improper use of guardianship, conservatorship or power of attorney

I understand what abuse, neglect and exploitation mean.

If I believe I am at risk of harm from or experience abuse, neglect, or exploitation, I know that I should contact:

Name:	Phone:	Location
		if at home
		if in the community