Magellan in Wyoming
Suggested Plan of Care (POC) template

Full Name of Youth:

Date of Birth: **Social Security Number:**

<u>Address</u>

Street:

City: **State:** **Zip Code:**

Phone: **Email Address:**

Preferred Language of Communication:
☐ English ☐ Spanish ☐ Other:

Does the Youth/Family Have an Interpreter Available?: ☐ Yes ☐ No ☐ N/A
If “Yes”, please provide their name and contact info:

Is the Child/Youth Currently Receiving Medicaid?:
☐ Yes Medicaid Number: ☐ No, Medicaid Number Pending

Other Insurance (specify): **Group ID:**

PCP: **Address:** **Phone #:**

Psychiatrist *(medication oversight)*: **Address:** **Phone #:**

Dentist: **Address:** **Phone #:**

Optometrist: **Address:** **Phone #:**

Most Current CASII Date: **Date of Entry into High Fidelity Wraparound:**

Name of Legally Responsible Individual:

Relationship to Youth: ☐ Parent ☐ Legal Guardian ☐ Attorney ☐ Other *(please specify):*
(For relationship other than parent, please <u>submit written / legal documentation with plan)</u>

Address *(if different from youth address above):*

Street:

City: **State:** **Zip Code:**

Phone: **Email Address:**

Medical Information

Diagnosis

Mental Health:

Medical/Physical:

Medications *(List ALL medications the youth is currently taking):*

Medication (Dose/Frequency)	Start Date	Diagnosis Target Symptoms	Prescriber	Date of Last Review	Frequency of Ongoing Reviews

Has Youth/Family Given Informed Consent for all Behavior/Psychotropic Medications Currently Being Taken?

- ☐ Yes
- ☐ No *(Check in with family to make sure they understand and agree to meds)*

Assessments/Evaluations

What Assessments Were Reviewed/Completed With the Family?

- ☐ Psychological Evaluation — Date completed:
  (If not available for initial Plan of Care, discuss need and identify specific areas of focus. Complete within 90 days. The psychological evaluation will help identify needs and will provide recommendations.)
- ☐ Strengths, Needs and Cultural Discoveries — Date revised:
- ☐ Functional Assessment — Date completed:
- ☐ Crisis Plan/Behavior Support Plan — Date completed:
- ☐ CANS — Date completed:
- ☐ CASii — Date required:
- ☐ LOC — Date required:
- ☐ Financial Eligibility renewal if 1915(c) waiver — Date required:

Family High Fidelity Wraparound plan

Team Meeting Date(s):

Plan Updated and Reviewed On:

Team Members:

Name	Role	Email and Mailing Address	Phone

Vision/Mission/Strength information

Family Vision:

Team Mission:

Family Strengths *(Add Strengths/Accomplishments at Each Team Meeting. Record Date Added)*:

Date:
Date:
Date:
Date:
Date:

Ground Rules:

Family's Decision Making Process

Prioritized Needs:

Life Domain Information *(Fill out this series of info for every priority need)*

- ☐ Residence
- ☐ Employment
- ☐ Family/Extended Family
- ☐ School
- ☐ Friends
- ☐ Religious Background
- ☐ Physical Health
- ☐ Mental Health
- ☐ Safety
- ☐ Legal

Primary Diagnosis:

Need (Priority Need From Above and From the SNCD):

Start Date:
When you begin to work on this need

Target Date:
When the team thinks it will be finished

Drop Date:
If the family decides to not work on it any more

First Objective *(short term measurable goals for each need, you may have two or three, please add progress each time you update it or if the family drops this objective)*

Start Date:
When you begin to work on this need

Target Date:
When the team thinks it will be finished

Drop Date:
If the family decides to not work on it any more

Strategies/Action Steps: *(How will the objectives be accomplished?)*

Strategy/Action step – (*include measurement strategy*)	Frequency	Start Date	Responsible Person

Meeting Notes, Brainstorming and Possible Barriers:

Second Objective *(please add progress each time you update it or if the family drops this objective)*

Start Date:
When you begin to work on this need

Target Date:
When the team thinks it will be finished

Drop Date:
If the family decides to not work on it any more

Strategies/Action Steps: *(How will the objectives be accomplished?)*

Strategy/Action step – (*include measurement strategy*)	Frequency	Start Date	Responsible Person

Meeting Notes, Brainstorming and Possible Barriers:

Third Objective *(optional) (please add progress each time you update it or if the family drops this objective)*

Start Date:
When you begin to work on this need

Target Date:
When the team thinks it will be finished

Drop Date:
If the family decides to not work on it any more

Strategies/Action Steps: *(How will the objectives be accomplished?)*

Strategy/Action step – (*include measurement strategy*)	Frequency	Start Date	Responsible Person

Meeting Notes, Brainstorming and Possible Barriers:

Recommended service information

Family Care Coordinator (FCC)
Organization:
MIS Number:
Contact Name:

Family Support Partner (FSP)
Organization:
MIS Number:
Contact Name:

Youth Support Partner (YSP)
Organization:
MIS Number:
Contact Name:

Youth and Family Training (YFT): *To be provided by the FSP in small groups of 2-5 (19 units/mo)*
Number of Units Requested:

Short-term Respite: *(a 1:1 service that provides short-term help until natural supports can be put in place (30 units/mo)*
Organization:
MIS Number:
Contact Name:
Number of Units Requested:

Flex Funds
Organization:
Contact Name:
What are the Funds Needed For?
(There is a separate request form to request flex funds. It can be found at www.MagellanofWyoming.com.)

Individual Counseling
Organization:
Contact Name:

Medication Management
Organization:
Contact Name:

Other
Organization:
Contact Name:

Natural/Informal Support Information

Support name	Task	Frequency	Phone

Crisis Plan Information: (*Separate Documents Attached)*

Discharge Information

Natural/Informal Supports and Formal Services to Continue:

Further Recommendations for Natural/Informal Supports and Formal Supports:

Triggers:

Potential Crisis:

Action Steps for Home and School:

Person Responsible:

Contact Name: Contact Phone:

Individual Plan of Care
Signature Page
Family name: ______________________

I have reviewed, understand and agree to follow this plan to the best of my ability:

Print Name & Role	**Signature**
Youth	
Guardian	
Guardian	
FCC	
FSP	
Therapist	
YSP	
Respite Provider	
Other Support	
Other Support	
Other Support	
Other Support	