IOWA
HHS

Member Name:
DOB:
SID:

Integrated Health Home Person-Centered Service Plan

Section 1: PCSP Information

Type of PCSP:
Program Type:
Date PCSP Meeting Held:
PCSP Date Span:
Managed Care Organization:

Integrated Health Home:
Care Coordinator Name:
CC Phone Number:
CC Email:

Comprehensive Assessment and Social History Date:

PCSP Meeting

These must be updated each PCSP meeting:

I choose the following location for my PCSP meeting:
I choose the following date for my PCSP meeting:
I choose the following time for my PCSP meeting:
I choose the following people to attend my meeting:
I choose to lead my meeting: ☐ Yes ☐ No

If no, I choose the following person to lead my meeting:

Revisions, Only:

Revision Meeting Date:

**Reminder to answer the 5 I choose questions above for addendums.*

Reason for my revision (select one of the following):

☐ I requested because
☐ My needs changed as follows:

The following sections in my PCSP were revised: (select all that are applicable)

☐ Section 1: PCSP Information
☐ Section 2: My Information
☐ Section 3: My Risk Factors & Needs
☐ Section 4: My Goals
☐ Section 5: My Services & Supports
☐ Section 6: My Self-Management Plan
☐ Section 7: My Right Restrictions
☐ Section 8: My Education & Employment
☐ Section 9: Where I live
☐ Section 10: Acknowledgment & Signatures

Section 2: My Information

My address (Street, City, State & Zip):
Name of facility *(if applicable):*
Phone Number:
Email Address:

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I have advanced directives in place: ☐ Yes ☐ No

(This is a written document stating how you want medical decisions to be made if you lose the ability to make them for yourself. It may include a living will, durable power of attorney for health care. The law requires that you sign and date your advanced directive with a witness(es) present.)

My strengths are

My preferences are

How you can support me

My cultural preferences are

My cultural accommodations are

My communication preferences are

My communication accommodations are

My physical health diagnoses include (name and ICD-10 code)

My mental health diagnoses include (name and ICD-10 code)

My LOCUS / CALOCUS scores (for members with Habilitation eligibility)

Date of LOCUS/CALOCUS: Actual Disposition: Composite Score:

Dimension	Score	Dimension	Score
Risk of Harm:		Functional Status:	
Medical, Addictive and Psychiatric Co-Morbidity:		Recovery Environment (Level of Stress):	
Recovery Environment (Level of Support):		Treatment and Recovery History:	
Engagement and Recovery Status:			

Corresponding home-based habilitation tier:
If requesting a lower tier, rationale and how member's needs will be met at the lower tier:

Section 3: My Risk Factors & Needs

The following risks and needs have been identified from my HCBS state approved standardized assessment tool, comprehensive assessment, social history, and other records.

State approved assessment & Comprehensive Assessments Areas	Identified risk factors, needs, background information	Measures in place to minimize, including back-up plans and strategies when needed
Communication/Language		
Awareness/Memory		
Hearing		
Vision		

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Speech		
Social/Family Relationships		
Cultural		
Spiritual		
Leisure Activities		
Marital/Dating Status		
Developmental Milestones (children ONLY)		
Dental		
Fall Risk		
Behavioral Health		
Mental Health		
Harm to self/others		
Hospitalization/ER Visits		
Preventative Visits		
Allergies		
Physical Health		
Nutrition		
Toxin Exposure		
Domestic Violence, Physical, Emotional, Sexual Abuse, Trauma		
Medications		
Medical Support Team		
Substance Use or Excessive Behaviors		
Gambling/Dependence		
Independent activities of daily living (IADL) and Activities of daily living (ADL)		
Caregiver/Natural Supports/Family Relationships		
Transportation		
Employment/Volunteering		
Education		
Housing		
Financial/Money Management		
Legal		
Stress		
Other		

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Section 4: My Goals

I have agreed to the following goals that I developed with my team.

Goal #1

I want			
My expected objective (measurable/observable): I will			
Background / barrier(s) to meeting goal:			
If I had to rank this goal on how important it is to me or my caregivers, out of all of my goals in this service plan, this one would be: (the most important, the second most important, the third most important, the fourth most important)			
Interventions and supports, including incremental action steps	Person Responsible	Start date	End date

Goal #2

I want			
My expected objective (measurable/observable): I will			
Background / barrier(s) to meeting goal:			
If I had to rank this goal on how important it is to me or my caregivers, out of all of my goals in this service plan, this one would be: (the most important, the second most important, the third most important, the fourth most important)			
Interventions and supports, including incremental action steps	Person Responsible	Start date	End date

Goal #3

I want			
My expected objective (measurable/observable): I will			
Background / barrier(s) to meeting goal:			
If I had to rank this goal on how important it is to me or my caregivers, out of all of my goals in this service plan, this one would be: (the most important, the second most important, the third most important, the fourth most important)			
Interventions and supports, including incremental action steps	Person Responsible	Start date	End date

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Goal #4

I want			
My expected objective (measurable/observable): I will			
Background / barrier(s) to meeting goal:			
If I had to rank this goal on how important it is to me or my caregivers, out of all of my goals in this service plan, this one would be: (the most important, the second most important, the third most important, the fourth most important)			
Interventions and supports, including incremental action steps	Person Responsible	Start date	End date

Additional goals may be added.

Section 5: My Services and Supports

My Waiver or Habilitation Services (Medicaid Funded Services)

Provider Responsible/ NPI	Name of Service	Service Code & Modifier	Units	Frequency	Rate (CMH Waiver)	Start Date	End Date
NPI:							
NPI:							
NPI:							
NPI:							
NPI:							
NPI:							

Reductions or Terminations to My Services

Effective Date	Service Code & Modifier	Type	Original Units	New Units	Reason	My need is now being met by

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My Non Waiver/Habilitation Services, Supports, and Community Resources

Such as my guardian, Payee, legal representative, Veteran Benefits, IVRS, AEA, Schools – IEP/504, therapy, doctors, specialist, home health, pharmacy, transportation, housing, SNAP benefits, MHDS Region, etc.

Service Name / Description	Name/Agency Responsible	Phone Number	Funding Source	Frequency of Service	Start Date (month/yr)

My Natural Supports Are

Name	Relationship to me	How does this person provide support?	What training or resources are needed to provide support?	How will training or resources be provided (i.e. where, when)?
Comments:				

My Backup Plan for Services

These are my supports if my home and community based service staff are not available.

Name	Backup plan / Backup staff	Backup phone number

Services or Supports that are needed but declined, not available, or inaccessible

Services, supports and resources identified in this PCSP are adequate to meet my needs:

☐ Yes ☐ No, complete table below

Service / Support / Resource	Reason for not utilizing	How is the need being met?

My Discharge Plan for Services

I understand that waiver and habilitation services are voluntary and can be ended at any time. If I end my waiver or habilitation services, there may be an impact on my Medicaid, as well as, the service and supports for which I qualify. If I lose Medicaid eligibility, I will also lose my waiver and habilitation services. If my level of care changes or I reach all of my goals, I may not qualify for waiver or habilitation eligibility services anymore. If I do not meet with my Health Home Team, my waiver or habilitation eligibility could be impacted. In order to stay eligible for CMH waiver services, I must use at least one unit of CMH waiver service every three months.

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My discharge plan for each service I receive is as follows:

Service Name	Discharge Plan

Section 6: My Self-Management Plan

My crisis and safety plan

- In case of **severe weather or tornado**, I will
- In case of **fire**, I will
- In case of **flood**, I will
- If I am **sick or injured**, I will
- If my **caregiver is sick or injured**, I will
- If I **lose electricity**, I will
- If I **lose water**, I will
- If I need to **evacuate my home**, I will
- In the event I am unable to care for any children or pets, I will

My Medical and Behavioral Plan

When I experience the following **medical symptoms**, these are the steps I take to manage them

Medical Symptom	What I do to manage on my own	How others can support me

My **behavioral plan** is as follows

- My **baseline mood** is
- My **triggers** are
- My **early intervention plan** is
- The **indicators** that I need help are
- Things I can do to **help myself** are
- My **coping skills and natural supports** are

I have these supports available in the event I need to enact my crisis or safety plan:

Specialty	Provider Name	Address	Phone
Integrated Health Home			
Primary Doctor (PCP)			
Dentist			
Counselor			
Psychiatrist			
Pharmacy			
Urgent Care Office			

Hospital For Medical Care			
Hospital for Mental Health Care			
Other			

In the event of a major incident, my Care Coordinator should be contacted as soon as possible. An incident report should be completed and sent to the members assigned MCO (by the provider who first became aware of the incident) by midnight of the next business day.

To reach my Integrated Health Home **after hours**, I can reach them by .

If I suspect that I am being abused, neglected and/or or exploited, I can call the local DHS office or use the toll-free, hot line number, which is answered 24 hours a day, 7 days a week: 1-800-362-2178. I can also talk with IHH staff, my therapist, or other care providers who can support me in making a call. If I am in immediate danger, I can call 911.

Section 7: My Right Restrictions

I know that all of my right restrictions will be reviewed at least quarterly with my Care Coordinator. Any changes to my right restrictions will result in a revision to my plan. I/my guardian agree to these right restrictions. These right restrictions will not cause undue harm.

Restriction	Date Implemented	Reason for Restriction	Past Interventions Tried	Plan to Restore
Comment:				

Section 8: My Education and Employment

My Education Level
Comments:

I am currently employed ☐ Yes ☐ No
a. My current employer is . I started on and work these days and these hours .
b. I am not currently working, but I have the following plans (include any barriers or resources needed)

I am currently volunteering ☐ Yes ☐ No
a. I volunteer at . I started on and volunteer these days for hours.
b. If no, I have the following plans to volunteer (include any barriers or resources needed) .

I am currently working with Iowa Vocational Rehabilitation Services ☐ Yes ☐ No
a. My IVRS counselors name is and their contact information is . I began working with IVRS (month/year) .

b. I am receiving prevocational or supported employment service ☐ Yes ☐ No, skip to Section 9

I work in the following setting

I receive hours a week of prevocational services. I began receiving prevocational services in (month/year)

I earn a subminimum wage ☐ Yes ☐ No

a. I was provided with counseling, information, and referral regarding community employment on by with the following provided to me .

b. I was **not** provided with counseling, information, and referral regarding community employment because .

I am receiving small group employment ☐ Yes ☐ No

a. I work with (number) people in my group and hours each week.

I am receiving individual supported employment ☐ Yes ☐ No

a. I work hours a week and have staff on-site for support hours a week.

I receive long term job coaching ☐ Yes ☐ No

a. I work hours a week and have staff support hours per month.

Section 9: Where I Live

I live in an integrated setting of my choosing ☐ Yes ☐ No

If no, my integration plan is

I live (check all that are applicable)

- ☐ A With family or legal guardian
- ☐ B In my own home
- ☐ C In a living unit/apartment rented from a community landlord that is not owned or operated by a Home-and-Community-Based Service (HCBS) provider
- ☐ D In a setting that is located on the grounds of or directly next to a public or private institution
- ☐ E In a setting that is a licensed facility (e.g. residential care, assisted living, other)
- ☐ F In a setting where two or more people receiving Medicaid funded services live together to receive waiver/habilitation services
- ☐ G In a setting where multiple HCBC/habilitation living units are co-located in close proximity to each other within the community
- ☐ H In a setting that is owned or operated by the provider of service

I choose the setting in which I live now. ☐ Yes ☐ No

If no, please explain:

I selected the setting where I live among available alternatives. ☐ Yes ☐ No

If no, please explain:

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What alternative settings were discussed?

I had setting options to choose from. For example, I had the choice to live in a non-disability specific setting or to have a private unit in a residential setting. ☐ Yes ☐ No ☐ N/A
If no, please explain:

The setting where I live encourages my own resourcefulness, independence, and freedom in making life choices, including but not limited to daily activities, physical environment, and with whom I choose to interact.
☐ Yes ☐ No If no, please explain:

I had a choice regarding services and supports and who provides them.
☐ Yes ☐ No If no, please explain:

The setting where I live supports full access to the greater community including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
☐ Yes ☐ No If no, please explain:

The setting where I live ensures the right to privacy, dignity and respect, and freedom from coercion and restraint.
☐ Yes ☐ No If no, please explain:

I am receiving home-based habilitation services
☐ Yes ☐ No

- I have members with home-based habilitation or supported community living services also living in my home with me.
- I need hours of supervision per day.
- The living environment is

For settings that are E, F, G, and H, selected above, the following questions need to be answered:

The living unit entrance doors and my bedroom door are lockable by me.
☐ Yes ☐ No

Staff have access to keys to my living unit.
☐ Yes ☐ No

I have the freedom to furnish and decorate my sleeping or living unit.
☐ Yes ☐ No

If no, please explain:

I am able to have visitors of my choosing at any time?
☐ Yes ☐ No
If no, please explain:

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Section 10: Acknowledgments

Item	Confirmation	Member's / Guardian's Initial
1	I gave input into my assessment, right restrictions, goals and additional information included in this service plan.	
2	I gave consent to the right restrictions that have been identified in my service plan. If I wish to change them, I can request a meeting to review and change. My Care Coordinator will review these with me at least quarterly and document my understanding of them.	
3	I was given a choice of providers and selected the providers I want to deliver my services.	
4	I am in agreement with my service plan and I know who to work with on my goals.	
5	I understand the information in this service plan and have had a chance to ask questions and receive clarification.	
6	I understand that I can request to have changes to the service plan at any time and that I contact my Care Coordinator about making changes.	
7	My Care Coordinator has explained to me how to make a report if I suspect I am being abused, neglected, and/or or exploited.	
8	I understand that my Care Coordinator is responsible for monitoring my service plan.	
9	I understand that my Care Coordinator will meet with me face-to-face at least every 3 months or sooner, if needed. Every month there is not a face-to-face visit, my Care Coordinator will call me or my guardian if I choose.	
10	I understand that my Care Coordinator will contact my providers ongoing, to assess progress with goals, to evaluate changes in need and to make necessary adjustments to the service plan.	
11	I understand that I have the right to appeal and that there is a grievances process. I have the right to appeal any reduction, termination, or denial of services. In the event of a reduction, termination, or denial of services. I will receive a written letter with my appeal rights.	

My Care Coordinator's next contacts will be:

With me on or before (date) by (method).

With my provider (name) on or before (date) by (method).

With my provider (name) on or before (date) by (method).

With my provider (name) on or before (date) by (method).

Member Name:
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The people who have signed below understand and agree to participate in implementing my plan.

Signature	Print Name	Date	Role	Attended PCSP meeting? Yes / No	Date a copy of this service plan was sent/ given & Method (e.g. mail, email, etc.)
			Member		Date: Method:
			Care Coordinator		N/A
					Date: Method:
					Date: Method:
					Date: Method:
					Date: Method: