Person Centered Support Plan

Today's Date:

<My Name>

Optional Photo

What People Like and Admire About Me

What's Important to Me

How to Best Support Me

Person Centered Support Plan

My Information

Name		
Address		
Phone Number		
Last PCSP Revision Date		
Legal Guardian		Phone:
Other Auth Rep. (indicate type)		Phone:
Targeted Case Manager		Phone:
MCO		Phone:
Primary Care Physician		Phone:
Emergency Contact		Phone:
Informal Supports		
Name	Relationship	Phone Number
HCBS Providers		
Provider Name	Provider Phone Number	Service

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My Communication Preferences

My primary mode of communication is :	
Interpreter Services:	
☐ I need services	Type:
☐ I do not need services	
I have someone who helps me to communicate and/or speaks on my behalf.	
Name of Person:	

PERSON(S) PARTICIPATING IN THIS PERSON-CENTERED SUPPORT PLAN

I chose to participate in filling out this PCSP?	☐Yes ☐No
To what degree?	☐Actively ☐Somewhat ☐Not at All
If anything other than actively, please describe participation level.	
Person Providing the Information:	

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About Me

My Accomplishments & Skills

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What My Circle of Support Says About Me: include positive comments from friends, family, providers, etc.

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My Lifestyle Preferences Include: comment on both what I have now and what I want for: where I live, whom I live with, how I spend my day, my hobbies, my favorite people/things, my routine, my favorite activities, what is important to me, making choices and decisions, etc.)

What I Have Now	What I Want in the Future

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Opportunities Regularly Provided to Me for Choice and Control*:* include how choice and control are offered and for what regular activities, items, situations.

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My Vision for a Good Life: My Future Plans Hopes, and Dreams: other living/work options, other activities, learning to express more choice/control over certain decisions, etc.)

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Barriers to My Lifestyle Preferences and Future Plans:

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My Options/Goals for Overcoming These Barriers:

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My Goals

Goal	Outcome Measure	Anticipated Completion Date	Person/Provider Responsible

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My Supports

Support at Home: Comment on supports needed with activities in the home including, but not limited to cleaning, shopping, meal preparation, laundry, home maintenance, dressing, eating, bathing, toileting, other personal hygiene, calling others, evacuating the home, using transportation (including public), crossing the street, etc. Indicate my preferences and explain how I would like to be supported for each need.

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Support with Work, School & Daily Activity: Comment on supports needed at work, school, volunteer or in community/day services activities. This includes, but is not limited to social interactions, work or volunteer tasks, community safety, personal care, transportation, etc. Indicate my preferences and explain how I would like to be supported for each need.

☐I attend school and have an IEP.

A copy of my IEP has been given to my TCM and MCO Care Coordinator ☐Yes ☐No

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Community and Social Support: Comment on supports needed with cultural, religious or ethnic preferences, social relationships with family and friends, education regarding romantic relationships, dealing with grief and loss, accessing preferred community activities, handling conflict and change, etc. Indicate my preferences and explain how I would like to be supported for each need.

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Wellness Support: Comment on supports needed with sleep, stress, exercise, nutrition, substance use, taking needed medications, going to appointments, scheduling preventative care, following physician/therapist advice or orders, etc. Indicate my preferences and explain how I would like to be supported for each need.

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Medical Support: Comment on supports needed with medications, allergies, and a brief medical overview. Indicate my preferences and explain how I would like to be supported for each need.

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Risk Assessment & Intervention Plans:

Comment on any area of risk, and what the risk is, and supports needed. Include any related to health, safety, financial, undesirable behavior, mental health issues, or other risks that may or do require restrictive procedures.

☐I have a Positive Behavior Support Plan.

A copy of it has been given to my TCM and MCO Care Coordinator ☐Yes ☐No

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Restrictive Procedures, Limitations and Modifications: List all current restrictive procedures or limitations to preferred lifestyle, and include the assessed need. This cannot solely be the disability. Include all of the information below for each restriction, limitation or modification to the preferred lifestyle.

Description of Restriction/Limitation/Modification:

Assessed Need:

History of Decision-Making and Potential Consequences to Poor Choices (long and short term):

Potential Risk of the Restriction/Limitation/Modification (long and short term):

Less Restrictive Alternatives Tried:

Safeguards for Protecting My Rights and Safety:

Frequency of Review:

Person/Provider Responsible for Data Collection:

Person/Provider Responsible for the Reviews:

Date Informed Consent Obtained:

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Legal and/or Financial Support: Comment on supports needed with any legal issues and finances including managing personal funds, banking, purchasing items, planning a budget, paying bills, reporting personal income, filing tax returns, planning for the future (savings, trusts, etc.), finding an advocate or guardian, planning for the succession of a current guardian, etc. Indicate my preferences and explain how I would like to be supported for each need.

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Communication & Decision-Making Support: Comment on supports need with daily communication and decision making, expressing feelings, expressing health symptoms, important life decisions, self-directing care, voting, reporting potential ANE, etc. Indicate my preferences and explain how I would like to be supported for each need.

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My Rights

Information & Training Provided:

Please mark each box after the information has been reviewed

☐ I have been given information and training to know and exercise my rights, in a manner that I can understand.

☐ I have been given information and training to recognize and report Abuse, Neglect and Exploitation, and how to report it, in a manner that I can understand.

☐ If I need help to know or exercise my rights, or report ANE, I will contact my Targeted Case Manager, provider, MCO Care Coordinator or trusted friend or family member. I understand that my rights cannot be restricted without my consent, a risk assessment, and review and approval of the human rights/behavior management committee.

My signature/ legally recognized unique mark below means that I participated to the best of my ability and agree that the information here is what I want in my Person-Centered Support Plan.

My Signature	Date
My Guardian's Signature	Date
Targeted Case Manager	Date
Other (indicate title/relationship)	Date
Other (indicate title/relationship)	Date

Person Centered Support Plan

Person-Centered Support Planning Meeting

I would like to have my next Person-Centered Support Planning meeting at the following location, if possible:		
I would like to have the following persons or entities attend the meeting, or participate by phone:		
Person/Entity	Relationship	Contact Information