WEST VIRGINIA CHILDREN WITH SERIOUS EMOTIONAL DISOREDER (CSED) WAIVER MASTER PLAN OF CARE		
PLAN OF CARE SERVICE YEAR: *mm/dd/yr – mm/dd/yr*	**DATE OF MEETING:** Click here to enter a date.	**MONTH THIS PLAN WILL BE REVIEWED:** Click here to enter a date.

TYPE OF PLAN OF CARE MEETING:

☐ **ANNUAL** ☐ **3-MONTH** ☐ **6-MONTH** ☐ **9-MONTH** ☐ **SIGNIFICANT LIFE EVENT**

☐ **TRANSFER** ☐ **DISCHARGE** ☐ **7-DAY** ☐ **30-DAY**

DEMOGRAPHICS

Member Name: **Address:** **Phone Number:** **Date of Birth:**	**Additional Insurance (if applicable):** **Date of Financial Eligibility:** **Date of Medical Eligibility:** **Anchor Date:**	
Legal Representative: Yes ☐ No ☐ If "Yes" Full ☐ Limited ☐ Name: Address: Phone:	**Medical Power of Attorney:** Yes ☐ No ☐ Name: Address: Phone:	
MCO Care Manager Name: Telephone #, ext: E-mail:	Date of last CANS: Date of last CAFAS/PECFAS: Date of last BASC:	
Wraparound Facilitation: WF Name: WF Provider Agency: WF Telephone #, ext.: WF e-mail:	**Attachments:** ☐ Crisis Plan ☐ Therapy plan ☐ Other: _____	

Non-CSED Waiver State Plan (Medicaid) Services: (Describe all services the member is receiving not covered under the waiver)		

Coordination of Healthcare Needs:

Name of Primary Care Physician:

Date of Last Annual Physical Exam:

Are there any outstanding medical issue? Yes ☐ No ☐

Does the person who receives services need assistance in scheduling any medical appointments?
Yes ☐ No ☐

For any "yes" answers, describe in Health & Safety Issues area of Evaluation and Assessments Section, below

MEETING MINUTES
Who attended this meeting? Did any team members attend by phone, and why?
Summary of what was discussed during this meeting *(describe specific details including, but not limited to, person-centered items, current events, concerns, anticipated/upcoming changes, unmet needs, input/recommendations, etc.)*
Review of Services *(list each service authorized and include: total number of units authorized, how many units used to date, and how many units remain for the remainder of the service year)*
Incident Reports *(List any incidents which have occurred since the last Plan of Care - Child and Family Team (POC-CFT) meeting; include any trends identified and measures that are being taken to address trends. Ensure that corresponding incident reports are on file and that each incident has been entered into MCO's Incident Management System)*

Meeting Minutes Completed By	

CIRCLE OF SUPPORT
Intimacy: Who can I count on?
Friendship: Who is a good friend?
Participation: What people, organizations, or networks am I involved with?
Exchange: Who are the people paid to be in my life (i.e. staff)?
Who would I like to participate in developing my plan? (May include anyone I want: professionals, direct care providers, family members, friends, etc.; however, it must include my legal representative – if applicable and a representative of any agency that provides services for me.)
GOALS AND DREAMS ***Goals and dreams should be carried through the rest of this plan and incorporated into the Service Plans and goals/objectives including responsible persons and/or provider and timelines for making plans happen.***
What are my short-term and long-term goals and dreams? My dreams should be positive and possible. ***(Where do I want to live? Ideal job? Who do I want to live with? Dream vacation? What do I want to learn?)*** **Who is going to help me achieve these goals/dreams?**
Short-term goals: **Long-term goals:**
What do I expect to be different as a result of receiving services and supports? What outcomes do I expect to accomplish with the help of supports?
What are the things that I like and dislike? What things do I consider pleasant and important? What do I like to do during my leisure time? What community activities do I enjoy?
What are my strengths? What am I good at?

AGREED UPON EXPECTATIONS AND VALUES
Talking to the family about their expectations from service providers and other family members. Also discussing family's values. What are your expectations for this program? What do you want to gain/improve from your participation?

Evaluation	Date of Evaluation	Summary of Assessments/Evaluations Results and Recommendations (List all assessments used to develop the service and habilitation plan):
Person-Centered Assessment		SUMMARY OF CURRENT PERSON CENTERED PLANNING TOOL Based on my strengths, dreams and goals, my Child and Family Team has determined that the following services, supports and/or resources are needed:

Evaluation	Date of Evaluation	Summary of Assessments/Evaluations Results and Recommendations (List all assessments used to develop the service and habilitation plan):
CANS		SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS Based on these findings, my Child and Family Team recommends the following training goals/ programs and/or support activities to be implemented: • Based on these findings, my Child and Family Team recommends the following behavioral objectives to be implemented: (delete if n/a) • Based on my needs as stated above, my Child and Family Team has determined that the following services, supports and/or resources are needed:

Evaluation	Date of Evaluation	Summary of Assessments/Evaluations Results and Recommendations (List all assessments used to develop the service and habilitation plan):
Health & Safety Issues Identified Crisis Planning	Ongoing	SUMMARY OF MOST CURRENT HEALTH AND SAFETY ISSUES AS IDENTIFIED BY THE PCSPT. Based on my needs as stated above, my Child and Family Team has determined that the following services, supports and/or resources are needed:
Medical	Ongoing	LIST ALL PHYSICIANS, DATES OF LAST APPOINTMENTS, AND RECOMMENDATIONS. Based on my needs as stated above, my Child and Family Team has determined that the following services, supports and/or resources are needed:
Psychological/ Psychiatric (if applicable)		SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS Based on my needs as stated above, my Child and Family Team has determined that the following services, supports and/or resources are needed:
Therapy (PT, OT, ST, etc. – if applicable)		SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS Based on my needs as stated above, my Child and Family Team has determined that the following services, supports and/or resources are needed:
Diagnosis	N/A	

Evaluation	Date of Evaluation	Summary of Assessments/Evaluations Results and Recommendations (List all assessments used to develop the service and habilitation plan):
Wraparound Facilitation Assessment		SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS Based on my needs as stated above, my Child and Family Team has determined that the following services, supports and/or resources are needed:
Therapist Assessment (if applicable)		SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS Based on my needs as stated above, my Child and Family Team has determined that the following services, supports and/or resources are needed:
IEP (if applicable)		SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS Based on my needs as stated above, my Child and Family Team has determined that the following services, supports and/or resources are needed:

Living Arrangement Evaluation		
Family Demographics including name and relationship to Participant: Biological Family (if reunification is the goal) : Foster/Adoptive Family: :	**Family Strengths:**	**Family Needs:**

Medications that I take	Dosage	Frequency	Reason for taking this medication (applicable diagnosis)	Who will administer? (agency name and staff title or natural support)

IF PSYCHOTROPIC MEDICATIONS ARE ADMINISTERED, PLEASE INCLUDE A RATIONALE FOR CHANGES OR CONTINUATION OF EACH MEDICATION:

CSED Waiver Services Needed to Support Me Plan of Care			
Service Code	**Service Description**	**Provider (include *name* of staff person)**	**Is this service available/accessible?**
			☐ Yes ☐ No
Amount/Frequency: Service should average _____ units per month & should not exceed ____ units per year.			
Duration of Service: This service should begin on _____ and end on _____.			
Plan of Action/Scope of Work to be done to support me. **What, specifically, will the provider do to support my needs? What has changed since my last Child and Family Team meeting?**			

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Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs? What has changed since my last Child and Family Team meeting?			

Non-CSED Waiver State Plan (Medicaid) Services		
Support:	**Who provides this support (name)?**	**Is this service available/accessible:** ☐ **Yes** ☐ **No** *If no, indicate what steps will be taken for the service to become available/accessible in Plan of Action.*
Frequency of Support:		
Duration of Support: This support should begin on _____ and end on _____.		
Plan of Action/Scope of Work to be done to support me.		

Non-CSED Waiver Services and Natural Supports (Volunteer groups, clubs, churches, schools, etc.)		
Support:	**Who provides this support (name)?**	**Is this service available/accessible:** ☐ **Yes** ☐ **No** *If no, indicate what steps will be taken for the service to become available/accessible in Plan of Action.*
Frequency of Support:		
Duration of Support: This support should begin on _____ and end on _____.		
Plan of Action/Scope of Work to be done to support me.		

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Frequency of Support:		
Duration of Support: This support should begin on _____ and end on _____.		

Plan of Action/Scope of Work to be done to support me.

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Frequency of Support:		
Duration of Support: This support should begin on _____ and end on _____.		
Plan of Action/Scope of Work to be done to support me.		

Discharge Criteria
Include measurable goals and objectives along with expected time frames for completion: If applicable, describe transition plan:

PARTICIPANT NAME / RECORD ID # MM/DD/YYYY

Plan of Care – Child and Family Team Signature Sheet		
Participant Name:	**Date of Meeting:** Click here to enter a date.	**DATE UPLOADED TO MCO:** Click here to enter a date.

TYPE OF PLAN OF CARE MEETING:

☐ **ANNUAL** ☐ **3-MONTH** ☐ **6-MONTH** ☐ **9-MONTH** ☐ **CRITICAL JUNCTURE**

☐ **TRANSFER** ☐ **DISCHARGE** ☐ **7-DAY** ☐ **30-DAY**

Relationship	**Signature and Credentials**	**Time Spent in Meeting** **(start/stop times)*	**Agree**	***Disagree**	**Date this Plan of Care was sent out**
Waiver Participant					
Parent/Legal Representative					
Wraparound Facilitator					
Other Relationship:					
Other Relationship:					
Other Relationship:					

***Rationale for Disagreement with the Plan (if applicable)**

_____

_____

_____

_____

Signature: _____ Date: _____