# **Personal Plan\* for Developmental Services**

\*This Personal Plan serves as an attachment to an Individual Support Plan (ISP) or Individual Plan of Care (IPC) for Members seeking to access Section 21/29 Waiver Services. To minimize duplication, if a section below corresponds to a completed section on the ISP/ IPC, indicate “see corresponding section” and note the specific location on the ISP/IPC.

|  |  |
| --- | --- |
| Member Name:Click or tap here to enter text. | Date of Birth: Click or tap to enter a date. |
| MaineCare #:Click or tap here to enter text. | EIS # (if Known):Click or tap here to enter text. |
| Guardian (if applicable):Click or tap here to enter text. | Co-Guardian (if applicable): Click or tap here to enter text. |
| Date of Meeting: Click or tap to enter a date. | Plan Start Date: Click or tap to enter a date. |

**List names and affiliations/relationships of all team members who participated in planning:**

|  |
| --- |
| 1. Click or tap here to enter text. |
| 1. Click or tap here to enter text. |
| 1. Click or tap here to enter text. |
| 1. Click or tap here to enter text. |
| 1. Click or tap here to enter text. |
| 1. Click or tap here to enter text. |

Additional Space to add team Members (if Applicable): Click or tap here to enter text.

**Member’s Strengths and Preferences**

|  |
| --- |
| Click or tap here to enter text. |

**Needs of the Member**

Reflect Clinical and Support Needs as Identified Through and Assessment of Functional Need. Include any Risk Factors:

|  |
| --- |
| Click or tap here to enter text. |

**Goals and Desired Outcomes**

List all the Member’s Goals and Desired Outcomes (in plain language), including the Member’s goals for strengthening and cultivating personal, community, family, and professional relationships.

Example of Goals/Desired Outcomes: Home Supports (I would like to be able to wash my clothes by myself).

Community Supports (I would like to be able to go to a concert in the park).

Work Supports (I want to be able to have money to spend on trips).

|  |
| --- |
| 1. Click or tap here to enter text. |
| 1. Click or tap here to enter text. |
| 1. Click or tap here to enter text. |
| 1. Click or tap here to enter text. |
| 1. Click or tap here to enter text. |
| 1. Click or tap here to enter text. |

Additional Space for Goals and Desired Outcomes (if Applicable): Click or tap here to enter text.

**Home and Community Based Services and Supports**

**List** **Current** and **Proposed** Services to assist the Member in achieving the above identified goals. This includes all Maine Care Benefit services determined medically necessary by the team, and includes all other services (i.e. NET Transportation) and/or natural supports that may not be covered under Section 21 or Section 29 but the Member identifies and may access:

|  |  |  |
| --- | --- | --- |
| **Name of Provider** | **Type of Service** | **Duration and Frequency**  **(days per week/hours per day)** |
| Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |
| Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |
| Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |
| Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |
| Click or tap here to enter text. | Choose an item. | Click or tap here to enter text. |

Additional Space to Add Other Services and/or Natural Supports (if Applicable). Click or tap here to enter text.

**Describe** what services and supports identified above will do **To/With/For** the Member. For any Risk Factors identified, include measures to minimize them (i.e. Backup Plans):

|  |
| --- |
| Click or tap here to enter text. |

**Personal Plan Meeting Narrative**

Include in the Narrative:

1. Date and location of meeting at convenience to the Member.
2. Attendees (First, last & relationship or affiliation) the Member chose to be at his/her meeting.
3. Cultural considerations and/or accommodations needed to ensure planning is accessible to the Member.
4. Informed choice regarding the services and supports the Member receives and from whom.
5. Conflict of interest guidelines, including ensuring providers of waiver services do not provide Case Management services or develop the Personal Plan.
6. How services contribute to the Member’s health and well-being and the member’s ability to reside in a community setting;
7. Alternative home and community-based settings considered by the Member.
8. Unmet needs and interim plans to meet those needs (if applicable).
9. The individual and/or entity responsible for monitoring the plan.
10. Written notification to the Member and/or Guardian regarding the grievance process which can be located at <http://www.maine.gov/dhhs/oads/home-support/disability-with-autism/grievance-process.html>.

|  |
| --- |
| Click or tap here to enter text. |

I approve the plan dated Click or tap to enter a date.. **I understand that I may request to update my plan or revoke my approval at any or all parts of this plan at any time.**

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Individual | Date |
|  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Guardian | Date |
|  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Guardian | Date |
| By signing, I agree this plan accurately reflects the planning process and the person’s needs and desires. The recommended MaineCare services are medically necessary and in compliance with MaineCare rules. | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Case Manager | Date |