New Choices Waiver
Person-Centered Care Plan

My Name: Click here to enter client name.	**My Medicaid ID:** Click here to enter ID#.
Introduction to Person-Centered Care Plans (PCCP)	
The person-centered care planning process is a process that will help me develop a care plan that addresses my health and long term needs in a manner that maximizes and reflects my individual strengths, preferences and goals. The care planning process is intended to assist me with identifying appropriate natural supports as well as available paid supports to meet these identified needs so that I can reach my personal goals. It also serves to identify risks, support freedom of choice related to my services and providers, and lists any special provisions that I am assessed to need. To help me with the care planning process, I have asked for the following people to participate with me: Click here to enter the names of the people the client wants to participate.	
My Strengths	
Click here to enter the client's strengths.	
Natural Supports and What They Do for Me	
Click here to enter the client's natural support systems and the unpaid services/supports they provide.	
Relationships That are Especially Important to Me	
Click here to enter the names and relationships that are important to the client.	
My Health and Wellness Concerns and Preferences	
Click here to enter the client's health concerns and preferences (not assessed needs).	
My Education, Employment and/or Volunteer Work Preferences	
Click here to enter the client's education, employment, and volunteer preferences.	
My Preferences for My Personal Finances	
Click here to enter the client's financial preferences.	
My Lifestyle Preferences (Cultural, Spiritual and Community Activities)	
Click here to enter the client's cultural, spiritual, and community activity preferences.	
My Community Integration Preferences	
I understand that it is important to receive the opportunity to access the community to the degree that I choose. **Activities that are important to me:** Click here to enter the client's desired activities (either to maintain or explore new). **What supports I need to access my community:** Click here to enter client's support needs to successfully access their community. **How often I desire to go out into the community:** Click here to enter how often the client desires to access their community. **Other considerations regarding my access to the community:** Click here to enter the team discussion including how services will meet the client's community integration needs and desires.	
My Personal Goals and Preferred Outcomes	
Goal/Outcome #1: I want to Click here to enter client's goal.	

Goal/Outcome #2: I want to Click here to enter client's goal.

Goal/Outcome #3: I want to Click here to enter client's goal.

My Choices About Where I Live

While I'm enrolled in the New Choices Waiver program, I have the right to choose where I live from among the available home and community based setting options as long as my needs can be safely met there and as long as I can afford to pay the costs of room and board in the chosen setting. I choose to live in:

☐ A private home/apartment
☐ A certified independent living facility
☐ An assisted living facility
☐ A licensed community residential facility

I have chosen to live:

☐ Alone
☐ With a roommate

Before making the above choice about where I live, I also discussed and considered all of the other community-based living options available to me and listed above: ☐ Yes ☐ No

Mini PCCP Date (for ALF/Type N applicants). To be completed upon the initial assessment to discuss living setting options): Click here to enter date or enter "n/a" if a full PCCP meeting was held at the time of the assessment.

My Case Management

My case management agency will help me to develop my care plan and will be responsible for monitoring my care plan and the services that I receive while I am participating in the New Choices Waiver program.

My chosen case management agency is: Click here to enter CMA name.
Their phone number is: Click here to enter CMA phone number.

My case management agency met with me face to face on Click here to enter a date **to perform a comprehensive needs assessment (MDS-HC assessment). During this process, I helped my case management agency to identify all of my needs. By initialing below I agree that the assessment does reflect all of my current needs.**

Client's or representative's initials: ___________

My Services

My case management agency has counseled me about the need to maximize use of my natural supports, third party insurance benefits, Medicare benefits and my traditional Medicaid benefits prior to accessing services through the New Choices Waiver program. My case management agency has also provided me with a complete list of available New Choices Waiver services and has advised me of the specific New Choices Waiver services that I can select based on my assessed needs in order to help me to achieve my

personal goals and remain safe in the community. My service selections will be listed on my comprehensive care plan and I will review it with my case managers before signing it.

I have chosen to decline the following service(s):
Click here to enter service(s) that the client is assessed to need but that he/she declines to accept.
If no services have been declined, enter "none."
Client's or representative's initials: ___________

Medication Set-Up and Administration:
I will be responsible for both setting-up and administering all of my own medications. ☐ Yes ☐ No
If "No," I have identified the following person or entity or the following combination of people or entities to set-up and/or administer them for me:
Click here to enter person or entity or combination of people or entities who will set-up and/or administer client's medications. For example, adult residential services provider, home health or other agency nurse who performs diabetic medication set-up and administration, provider who reminds client to take scheduled medications, and devices that aide in self-administration.

Freedom of Choice of Providers Statement:
For the New Choices Waiver services listed on my comprehensive care plan, my choice of agency based service providers is documented on the Freedom of Choice of Providers form. If I have chosen to receive self-administered services this choice is documented in the self-administered service packet.

Risk Factors (If Applicable)

I acknowledge that my care planning team has identified the following risk factors with some of the choices I'm making: ☐ N/A
Click here to enter assessed risk factors.
I also acknowledge that I am free to assume a reasonable amount of risk and have chosen the following plan to minimize these risks:
Click here to enter client's plan to minimize risks.
If my plan for minimizing these risks fails or places me at unreasonable risk, I agree to the following plan:
Click here to enter back-up plan to minimize risks.

Modifications

If I accept a safety intervention or support that modifies a condition that is my right as a New Choices Waiver participant, that support is listed below: ☐ N/A

Intervention and support: Click here to enter the intervention.
Specific assessed need, condition directly proportionate to the need, and justification for the intervention: Click here to enter clinical justification for the intervention.
Positive interventions and supports attempted prior to any modification: Click here to enter less restrictive interventions that have previously been attempted.
Does the PCCP team believe this support will cause any harm? ☐Yes ☐ No

The ongoing effectiveness of this intervention will be reviewed by regular collection and review of the following data: Click here to enter data to be reviewed. For example, provider summaries and reports, MDS-HC data, case manager/RN log notes, etc.
My ongoing need for this intervention will be reviewed on the following schedule: Click here to enter review schedule.

Intervention and support: Click here to enter the intervention.
Specific assessed need, condition directly proportionate to the need, and justification for the intervention: Click here to enter clinical justification for the intervention.
Positive interventions and supports attempted prior to any modification: Click here to enter less restrictive interventions that have previously been attempted.
Does the PCCP team believe this support will cause any harm? ☐Yes ☐ No
The ongoing effectiveness of this intervention will be reviewed by regular collection and review of the following data: Click here to enter data to be reviewed. For example, provider summaries and reports, MDS-HC data, case manager/RN log notes, etc.
My ongoing need for this intervention will be reviewed on the following schedule: Click here to enter review schedule.

Self-Administered Services (SAS)

Self-Administered Services (SAS) is an alternative to the traditional agency-based service delivery method. Through SAS, the participant and/or their designee serve as the employer and hire employee(s) to provide specific New Choices Waiver services. SAS is only available to participants who live in a private residence. Services are limited and must be based on the assessed need(s) of the participant.

My case manager has explained self-administered services and reviewed the risks, rights and responsibilities with me and I have chosen to utilize SAS. ☐ Yes ☐ No ☐ N/A

I have chosen to have a designee assist with the administration of SAS and serve as the employer. I understand that the designee may not also serve as an employee. ☐ Yes ☐ No
Name of Designee: Enter text. Relationship to Participant: Enter text.
Phone Number: Enter text. Email: Enter text.

Based on the comprehensive needs assessment (MDS-HC assessment) conducted on Enter date the following services have been identified and will be provided via SAS:
☐Attendant Care
Description of Need: *Enter text.*
☐Chore Services
Description of Need: *Enter text.*
☐Homemaker Services
Description of Need: *Enter text.*
☐Respite Services

Description of Need: *Enter text.*

Employee(s)

Name: Enter text. Phone Number: Enter text. Email: Enter text.
Address: Enter text. Relationship:Enter text.
Service(s) Provided: ☐Attendant Care ☐Chore Services ☐Homemaker Services ☐Respite Services

Name: Enter text. Phone Number: Enter text. Email: Enter text.
Address: Enter text. Relationship:Enter text.
Service(s) Provided: ☐Attendant Care ☐Chore Services ☐Homemaker Services ☐Respite Services

Name: Enter text. Phone Number: Enter text. Email: Enter text.
Address: Enter text. Relationship:Enter text.
Service(s) Provided: ☐Attendant Care ☐Chore Services ☐Homemaker Services ☐Respite Services

Name: Enter text. Phone Number: Enter text. Email: Enter text.
Address: Enter text. Relationship:Enter text.
Service(s) Provided: ☐Attendant Care ☐Chore Services ☐Homemaker Services ☐Respite Services

SAS Backup Plan

This section serves as the formal SAS Backup Plan for service delivery and program performance measure compliance.

Which self-administered services are currently authorized?

☐Attendant Care
☐Chore Services
☐Homemaker Services
☐Respite Services

Please list three individuals who are trained to substitute for your usual caregiver(s) in an emergency:

Name: Enter text. Phone Number: Enter text. Email: Enter text. Address: Enter text. Relationship to Participant:Enter text. Current SAS Employee: Yes☐ No☐
Name: Enter text. Phone Number: Enter text. Email: Enter text. Address: Enter text. Relationship to Participant:Enter text. Current SAS Employee: Yes☐ No☐
Name: Enter text. Phone Number: Enter text. Email: Enter text. Address: Enter text.

Relationship to Participant:Enter text.	Current SAS Employee: Yes☐ No☐
Please describe what steps will be taken to ensure the continued provision of services in the event that none of the named individuals are able to substitute for your usual caregiver(s) .	

Acknowledgements and Signatures

I understand the contents of my care plan and I agree that it serves to help me to achieve my personal goals and that it maximizes my strengths and natural supports. If I need help understanding any part of the care plan or if I feel that a change is needed in the future, I will contact my case management agency to request the change. If my case management agency and I have a disagreement and cannot seem to reach a resolution, I can contact the New Choices Waiver program office for assistance: (800) 662-9651, option 6.

I understand that I have the right to appeal in a Medicaid fair hearing if I am denied my choice of available waiver service providers, if any of my waiver services are terminated, reduced or suspended, if I am involuntarily disenrolled from the waiver or if I am denied waiver services that I believe I am eligible to receive. To obtain a hearing request form, I can contact my case management agency or the Utah Department of Health Hearing Office at (801) 538-6576. The Hearing Request form is located at the Utah Medicaid website at https://medicaid.utah.gov/utah-medicaid-forms.

Client's Signature:		Date:
Representative's Signature (if applicable):		Date:
SSW Case Manager Name: Enter name.	SSW Case Manager Signature:	Date:
RN Case Manager Name: Enter name.	RN Case Manager Signature:	Date:

PCCP Updates

Updates to PCCP occurring prior to the annual assessment should be documented by completing this section. Please indicate which section(s) have been updated, the effective date and events/factors leading to the change.

Section	Effective Date	Description of Change and Events/Factors Leading to the Change

<table>
<tr><td colspan="2">Client’s Signature:</td><td>Date:</td></tr>
<tr><td colspan="2">Representative’s Signature (if applicable):</td><td>Date:</td></tr>
<tr><td>SSW Case Manager Name:
Enter name.</td><td>SSW Case Manager Signature:</td><td>Date:</td></tr>
<tr><td>RN Case Manager Name:
Enter name.</td><td>RN Case Manager Signature:</td><td>Date:</td></tr>
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