S PERSON-CENTERED PROFILE

Name:	DOB: / /	Medicaid ID:	Record #:
(Non - CAP-MR/DD Plans ONLY) PCP Completed on: / /	(CAP-MR/DD Plans ONLY) Plan Meeting Date: / / Effective Date: / /		

WHAT PEOPLE LIKE AND ADMIRE ABOUT….
WHAT'S IMPORTANT TO….
HOW BEST TO SUPPORT….
ADD WHAT'S WORKING / WHAT'S NOT WORKING
What is Working: ***What isn't working:***

NAME: **DOB:** **MEDICAID:** **RECORD#:**

ACTION PLAN

Long Range Outcome: (Ensure that this is an outcome desired by the individual, and not a goal belonging to others).

Where am I now in the process of achieving this outcome? (Include progress on goals over the past years, as applicable).

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL:		
WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
HOW (Support/Intervention)		

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Code**	**Progress toward goal and justification for continuation or discontinuation of goal.**
/ /	/ /		
/ /	/ /		
/ /	/ /		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

NAME: **DOB:** **MEDICAID:** **RECORD#:**

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL:

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**

HOW (Support/Intervention)

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Codes**	**Progress toward goal and justification for continuation or discontinuation of goal.**
/ /	/ /		
/ /	/ /		
/ /	/ /		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

NAME: DOB: MEDICAID: RECORD#:

CRISIS PREVENTION AND INTERVENTION PLAN

Date of Initial Crisis Plan (mm/dd/yyyy):	Date of Last Revision (mm/dd/yyyy):	Medicaid ID #:	Record #:
Name:		Date of Birth (mm/dd/yyyy):	
Address:		Telephone Number:	
Clinical Home/First Responder:	Emergency Phone #:	Alternate Phone #:	
LME-MCO:	LME-MCO Phone #:	County:	

Living Situation

Living Situation (Stable, Unstable):	If "Unstable" Describe:

In a crisis, assistance will be needed in the following areas (if not applicable, leave blank)

Children (if yes, indicate ages):	Pets (Yes/Blank):	Transportation (Yes/Blank):	Other (Describe the type of assistance needed):

Explain what help will be needed:

Employment (In a crisis, assistance will be needed to contact my employer)

Assistance will be needed (Yes/No):	Contact Name:	Contact Phone #:

Please inform them:

Communication	Preferred Language	
Method (Verbal, Nonverbal, Picture System, Gestures, Sound/Gestures, Other Device):	Preferred Language ☐English, ☐Spanish, ☐Sign Language, Other):	If "Other", specify:

Legally Responsible Person

Guardian Appointed (Yes/No):	Legally Responsible Person Name:	Contact Phone #:

Insurance

Type of Insurance:	Name of Company or Payer (If Type is Private or Other):	Policy Number/Member ID:

Diagnoses

DSM Code:	Diagnosis:	Diagnosis Date (mm/dd/yyyy):

NAME: DOB: MEDICAID: RECORD#:

Current Medications (Update/revise anytime there is a change)

Medication Name:	Dose:	Frequency:	Reason for Change:	Date:	Prescribing MD:	Pharmacy:

Allergies (Medication(s) and reaction - Update/revise anytime there is a change)

Poorly Tolerated Medications (Medication(s) and reaction - Update/revise anytime there is a change)

Medical/Dental Concerns

Supports For The Individual

Notification

List the individuals that should be called in the event of a crisis, indicate the calling order, provide contact information, and indicate if a consent to release information to that person exists.

Calling Order	Who	Agency	Name	Address	Phone #	Is there a valid consent to release (Yes/No)?
	Guardian/ Legally Responsible Person					
	Family Contact 1					
	Family Contact 2					
	Family Contact 3					
	Service Provider					
	Residential Program					
	Care Coordinator					
	Primary Therapist					
	Primary Care Physician					
	Psychiatrist					
	Other Physician					

	Peer Support Specialist					
	Other Support					

Crisis Follow Up Planning
(Include contact number(s) if not provided above)

	Name	Contact #	Contact #
Who is the primary contact to coordinate care if the individual requires inpatient or other specialized care?			
Who will visit the individual while hospitalized? (This information should come from the individual and reflect the individual's preference)			

	Name	Timeframe
Who will lead a review/debriefing following a crisis? Within what timeframe?		

Additional Planning Documents
(Indicate if the individual has any of the following documents. If "Yes", attach the document to the Crisis Plan)

	Yes/No	Notes
Individual Behavior Plan		
Suicide Prevention and Intervention Plan		
WRAP Plan		
Futures Plan (youth in transition/young adult)		
Psychiatric Advance Directive (PAD). A PAD is a legal document allowing a consumer to direct his or her psychiatric treatment in the event that he or she becomes unable to make or communicate decisions about that treatment. To find out more information about PADs in North Carolina, go to http://www.nrc-pad.org/states/north-carolina-resources.		
Other Advance Directive or Living Will		

NAME: **DOB:** **MEDICAID:** **RECORD#:**

General Characteristics/Preferences - as described in the individual's own words

What am I like when I am feeling well? Describe what a good day looks like for this person. Provide examples of how s/he interacts, behaves, appears and feels when s/he has an overall sense of wellness and wellbeing.

What are some events or situations that have caused me trouble in the past? Outline significant events that may create or increase stress and trigger the onset of a crisis. (Examples include: anniversaries, holidays, noise, change in routine, inability to express medical problems or to get needs met, out of medication, being isolated, etc.)

What are the early warning signs that I am not doing well? What will others notice about my behavior, speech, and actions when I am not doing well? Describe what others observe when s/he is entering a crisis episode. Include lessons learned from previous crisis events. (Examples include: not keeping appointments, isolating himself, loud or hyper-verbal speech, not sleeping well, eating too much, etc.)

Observations from the past:

How can others help me and what can I do to help myself to address a crisis early on? Who is best able to assist me? Describe prevention and intervention strategies that have been effective in reducing stress, problem solving, and keeping the person from needing higher levels of care such as a trip to an emergency department or crisis center or inpatient hospitalization. (Examples include: breathing exercises, journaling, taking a walk, listening to music, calling a friend or family member or provider, etc.)

If I am in crisis, what are ways that others can help me and how can I help myself? What strategies do not work well for me? List everything that has worked well for the person in the past. Focus first on the least restrictive steps including natural and community supports. Describe how crisis staff should interact with the person in crisis. Describe preferred and non-preferred medications, treatment facilities, and options for respite. Include the person's preferred process for obtaining back-up in case of emergency. (Examples include: I like music, I like to go for a walk, I like to be talked to, call my sponsor, remind me of my PRN meds, I don't like to be talked to, I don't like to be touched, I prefer ABC hospital over XYZ hospital, etc.)

NAME: DOB: MEDICAID: RECORD#:

PLAN SIGNATURES

I. PERSON RECEIVING SERVICES:

- ☐ I confirm and agree with my involvement in the development of this PCP. My signature means that I agree with the services/supports to be provided.
- ☐ I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this PCP.
- ☐ For CAP-MR/DD services only, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with mental retardation instead of participating in the Community Alternatives Program for individuals with Mental Retardation/Developmental Disabilities (CAP-MR/DD).

Legally Responsible Person: Self: Yes ☐ No ☐

Person Receiving Services: (Required when person is his/her own legally responsible person)

Signature: _____ _____ Date: / /

(Print Name)

Legally Responsible Person (Required if other than person receiving Services)

Signature: _____ _____ Date: / /

(Print Name)

Relationship to the Individual: _____

II. PERSON RESPONSIBLE FOR THE PCP: The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided.

Signature: _____ _____ Date: / /

(Person responsible for the PCP) (Name of Case Management Agency)

Child Mental Health Services Only:

For individuals who are less than 21 years of age (less than 18 for State funded services) and who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the person responsible for the PCP must attest that he or she has completed the following requirements as specified below:

- ☐ Met with the Child and Family Team - Date: / /
- ☐ **OR** Child and Family Team meeting scheduled for - Date: / /
- ☐ **OR** Assigned a TASC Care Manager - Date: / /
- ☐ **AND** conferred with the clinical staff of the applicable LME to conduct care coordination.

If the statements above do not apply, please check the box below and then sign as the Person Responsible for the PCP:

- ☐ This child is not actively involved with the Department of Juvenile Justice and Prevention or the adult criminal court system.

Signature: _____ _____ Date: / /

(Person responsible for the PCP) (Print Name)

III. SERVICE ORDERS: *REQUIRED for all Medicaid funded services; RECOMMENDED for State funded services.*

(SECTION A): For services ordered by one of the Medicaid approved licensed signatories (see Instruction Manual).

My signature below confirms the following: (Check all appropriate boxes.)

- Medical necessity for services requested is present, and constitutes the Service Order(s).
- The licensed professional who signs this service order has had direct contact with the individual. ☐ Yes ☐ No
- The licensed professional who signs this service order has reviewed the individual's assessment. ☐ Yes ☐ No

Signature: _____ _____ License #: _____ Date: / /

(Name/Title Required) (Print Name)

(SECTION B): For Qualified Professionals (QP) / Licensed Professionals (LP) ordering:

- CAP-MR/DD or
- Medicaid Targeted Case Management (TCM) services (if not ordered in Section A)
- **OR recommended** for any state-funded services not ordered in Section A.

My signature below confirms the following: (Check all appropriate boxes.) Signatory in this section must be a Qualified or Licensed Professional.

- ☐ Medical necessity for the CAP-MR/DD services requested is present, and constitutes the Service Order.
- ☐ Medical necessity for the Medicaid TCM service requested is present, and constitutes the Service Order.
- ☐ Medical necessity for the State-funded service(s) requested is present, and constitutes the Service Order

Signature: _____ _____ License #: _____ Date: / /

(Name/Title Required) (Print Name) (If Applicable)

IV. SIGNATURES OF OTHER TEAM MEMBERS PARTICIPATING IN DEVELOPMENT OF THE PLAN:

Other Team Member (Name/Relationship): _____ Date: / /

Other Team Member (Name/Relationship): _____ Date: / /