

State of Montana
 Department of Public Health and Human Services
 Developmental Disabilities Program

Personal Support Plan

Name:	Effective Date of Plan:
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Section IX. Signatures

Annual PSP
 PSP Amendment
 Exit PSP

My plan has been explained to me. I have been told what my rights are under my plan and I know that I may request another meeting, at any time, to make changes to my plan.

It has also been explained to me that the Department of Public Health and Human Services checks my progress in the plan. I have been assured that this information will only be used by persons who need to see it. Each member of my planning team will receive a copy of this plan.

Signature	Date

Individual did not attend the meeting after attempting to hold it with him/her on two separate occasions. Please discuss the reasons why and how the Case Manager and team members made accommodation to get the individual to attend.

As a member of this team, my signature below reflects my understanding of the confidential nature of the information contained and discussed in this plan. Signing the form also indicates that I attended the meeting and that I accept my responsibilities under the plan.

Name (Please Print)	Relationship	Signature

This plan is approved. It is person-centered and the individual was involved in its development. The plan was developed based on assessments of the persons needs, vision, preferences and health and safety risk factors. In addition, all services listed on the person's cost plan are identified in actions in this plan of care.

Case Manager Signature _____ Date _____