



Community First Choice Services (CFCS)/Personal Care Services (PCS) Person-Centered Planning (PCP) Form

Member Name:	Plan Date:
Medicaid ID:	DOB:
CFCS Provider Agency:	Plan Facilitator:

Strengths/Interests (What are my talents? What activities do I enjoy?):	What should my PCA know about my personal needs and preferences?
Goals (Things I would like to work on or achieve this year. My dreams and plans.):	
Services Needed (What kind of help would make me successful in reaching my goals?):	Backup plan:

Personal Emergency Response Systems (PERS): <table><tr><td>Is PERS authorized on the MP profile?</td><td>Yes</td><td>No</td></tr><tr><td>Has the member received PERS unit?</td><td>Yes</td><td>No</td></tr><tr><td>Is the PERS system working?</td><td>Yes</td><td>No</td></tr><tr><td>Does the member use PERS?</td><td>Yes</td><td>No</td></tr><tr><td>Is the member appropriate for PERS?</td><td>Yes</td><td>No</td></tr></table> Comments:	Is PERS authorized on the MP profile?	Yes	No	Has the member received PERS unit?	Yes	No	Is the PERS system working?	Yes	No	Does the member use PERS?	Yes	No	Is the member appropriate for PERS?	Yes	No	Please initial to acknowledge (only on intake): I have received information about and understand my rights and responsibilities and those of my Plan Facilitator. I have received the conflict resolution and grievance procedures information. I have received an advocacy resource. I have received my CFCS/PCS Handbook.
Is PERS authorized on the MP profile?	Yes	No														
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Is the PERS system working?	Yes	No														
Does the member use PERS?	Yes	No														
Is the member appropriate for PERS?	Yes	No														

Member/Personal Representative Settings Attestation: I have been given a choice of available options regarding where to live and receive services.	Date:	Yes	No
Plan Facilitator:	Date:		
Provider Agency:	Date:		

Distribution: Copy to Plan Facilitator, Provider, and Member