

**KANSAS DEPARTEMENT OF SOCIAL AND REHABILITATION SERVICES
HOME AND COMMUNITY BASED SERVICES
CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (HCBS/SED)
PLAN OF CARE**

SECTION I. IDENTIFICATION INFORMATION

Client Name: _____ **Medicaid I.D.#** _____ **SSN:** _____

Birth Date __/__/__ **Gender:** _____ **Date of KanBe Healthy Screen** __/__/__ **Clinical Eligibility Date:** __/__/__

Address: _____ **Phone#:** () _____

Guardian: _____ **Address:** _____ **Phone#:** () _____

Approved Mental Health Provider: _____ **Phone#:** () _____

CMHC Contact Person (=Case Manager on electronic POC) _____ **Phone#:** () _____

Wraparound Facilitator: _____ **Phone#:** () _____

Diagnosis: Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____ **GAF:** _____

Prognosis _____

SECTION II. PARTICIPATANTS (List participants in the development of the plan)

<u>Involvement</u>	<u>Name</u>	<u>Relationship to Child or Family</u>	<u>Telephone</u>
C <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/>			
C <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/>			
C <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/>			
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C <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/>			
C <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> R <input type="checkbox"/>			

Codes: C – contacted prior to plan development, A – completed assessment prior to plan development, P – Present at the planning meeting, and R – Reviewed the completed plan

SECTION III. DOMAINS/NEEDS STRENGTHS (describe the client's and / or family's caretaker's problems, issues and needs. Include strengths/assets which are relevant to meeting the needs).

➤ All services will be provided directly to the eligible client for the benefit of the Medicaid eligible client

DOMAINS	STRENGTHS	NEEDS
<u>Home</u>		
<u>Community</u>		
<u>Financial/Economic</u>		
<u>Health</u>		
<u>Legal</u>		
<u>Leisure/Recreation</u>		
<u>Vocational/Educational</u>		
<u>Socialization</u>		
<u>Other</u>		

SECTION IV. TERMINATION PLAN;

PRESENTING PROBLEM: (This should describe the child's problems/needs prior to the plan of care)

STATEMENT OF GOALS/OUTCOMES REQUIRED FOR TERMINATION OF THE PLAN OF CARE:

(This should describe how the child will function when all the objectives are met. (This statement of goals/outcomes is to be written at the time the Plan Of Care is being developed).

Example: (Child's name) will have no evidence of suicidal thoughts or gestures and will attend a full day of school without running away.

I.D. LETTER	GOAL/OUTCOME

Date Plan of Care Terminated: _____

Was the cost of the POC contained? Yes ___ No ___

SECTION V. OBJECTIVES: List objectives and action steps needed to reach goals. Include a target date to reach objective

Goal ID Letter _____ Objective: Projected date for meeting objective:				
Measurement Strategy (what, who, and when)				
Action Step	Responsible Person	Target Date	Date Done	Progress Notes (date)
1. 2. 3. 4. 5.				
Services and Supports needed for Objective(s)	Type of Support	Duration and Frequency	Total Units	

SECTION VI. CRISIS PLAN:

Potential Crisis	Action Steps		Person(s) Responsible
Services and Supports needed for Objective(s)	Type of Support		Duration and Frequency

SECTION VII. INDIVIDUALIZED CARE PLAN THREE MONTH BUDGET

Waiver and Non-Waiver /Services Supports	Provider	Provider I.D.	Procedure Code	Effective Date	Unit of Service	Frequency & Duration Totals	Rate	Waiver Cost or Other Source of Pymt.

Total Waiver Cost \$ _____

Plan of Care Start Date: _____

Total Non-Waiver Cost \$ _____

Plan of Care End Date: _____

Total Plan of Care Cost \$ _____

Monthly Cost:

\$ _____
MM/YY

\$ _____
MM/YY

\$ _____
MM/YY

\$ _____
Crisis

SECTION VIII. SIGNATURES

Client: _____

Date: _____

Parent/Guardian: _____

Date: _____

Wraparound Facilitator: _____

Date: _____

Mental Health Center QMHP: _____

Date: _____

Mental Health Center Physician: _____

Date: _____

SECTION IX. APPROVAL- MHDD

() Yes. This plan of care is approved as written

() No. This plan of care requires revision(s) in the following areas.

Specify _____

Signature, Title

Date of Decision _____

