8.00
APPENDIX 9
PERSON CENTERED CARE PLAN FORM

The Person Centered Care Plan (PCCP) Form shall be utilized by the Division of Senior and Disability Services (DSDS), Home and Community Based Services (HCBS) providers when requesting care plan changes for active HCBS participants.

The PCCP Request Form is not to be utilized to report abuse, neglect, or exploitation. Mandated Reporters are required to report these concerns to the Adult Abuse & Neglect Hotline via the Online Reporting Application. Specific hotline information should not be disclosed on the PCCP Request Form as that information cannot be uploaded into CyberAccess Web Tool.

The form shall be completed in its entirety to best serve the needs of the participant. For increased legibility please type the form.

INSTRUCTIONS

PARTICIPANT NAME: Enter the participant's last name and first name.

DCN: Enter the participant's Departmental Client Number (DCN).

DOB: Enter the participant's full date of birth.

PHONE NUMBER: Enter the participant's current phone number with the area code.

ALTERNATIVE PHONE NUMBER: Enter the participant's alternative phone number with the area code, if applicable.

PARTICIPANT EMAIL: Enter the participant's e-mail address, if applicable.

PHYSICAL ADDRESS: Enter the participant's full address where they currently reside.

MAILING ADDRESS: Enter the participant's complete mailing address, if different from the physical address.

CARE PLAN CHANGE REQUEST

Utilize the drop down boxes to select the task or waivered service requested in each programmatic area. Utilize the row of boxes to the right of the task to indicate if the request is to add, increase, decrease, or remove the task or waiver. If there are more than two being requested, please add that information in the "Details of Requests/Additional Information" section.

CLOSING REQUESTED

This section should only be used when the participant's entire HCBS authorization and case needs to be closed. In this circumstance, select "Yes".

Utilize the drop down box to select the reason that the participant's authorization for HCBS be closed. All participant's that voluntarily request all HCBS authorizations be closed, must contact DSDS to confirm.

If a case closing is request for any other reason, besides the reason listed in the drop down box, utilize the "Other Reason" field to provide explanation.

Enter the anticipated closing date.

21-DAY NOTICE
This section should only be used by Agency Model (IHS) providers when a participant has been given a formal 21 Day Notice.

In this circumstance, select "YES".

Upload a copy of the 21 Day Notice provided to the participant in the attachment section of HCBS Web Tool, following instructions outlined on the form.

Enter the participant's last day of service, as noted on the 21 Day Notice.

PROVIDER CHANGE
This section should be used to communicate instances where a participant needs or requests a new HCBS provider.

In this circumstance, select "YES".

Indicate if the request will be switching from one program to another.

Select the reason for the provider change request based on guidance below:

- Participant Choice: Select when the participant requests a new provider
- Provider Choice: Select when the provider is unable/unwilling to continue providing services
- Unable To Self-Direct: Select when there are concerns that the participant is unable to direct their own care
- Moved Out of Service Area: Select when the participant moved out of provider's coverage area

Enter the proposed new provider's name, if applicable.

Enter the proposed new provider's phone number, if applicable.

Indicate if the new provider is willing and able to accept the participant as a client.
Provide the tentative start date for the proposed new provider. All provider changes require DSDS approval. Services with the proposed provider may not start until authorized by DSDS.

Indicate if the participant needs a Provider Listing to select a new provider. DSDS will utilize the participant's e-mail address to send the Provider Listing, if applicable. If the participant does not have an e-mail address, DSDS will mail the participant a Provider Listing.

DETAILS OF REQUEST/ADDITIONAL INFORMATION

Add any additional information pertinent to the request being submitted.

REQUESTOR INFORMATION
Enter the Name, Affiliation, Phone Number, and E-mail of the person submitting the request.

OTHER RESPONSIBLE PARTY/LEGAL GUARDIAN CONTACT INFORMATION
Enter the Name, Phone Number, Alternate Phone Number, Mailing Address, and E-mail of the guardian or other responsible party of the participant.