DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF SENIOR AND DISABILITY SERVICES

PERSON CENTERED CARE PLAN (PCCP) FORM

DATE

ALL FIELDS REQUIRED - RETURN FORM TO PCCP@HEALTH.MO.GOV

Upon receipt of completed request, DSDS will contact all necessary parties to continue process. HCBS Providers can check Cyber Access Web Tool for status updates.

PARTICIPANT NAME: LAST, FIRST	DCN	DATE OF BIRTH

PHONE NUMBER	ALTERNATE PHONE NUMBER	PARTICIPANT EMAIL

PHYSICAL ADDRESS	CITY	ZIP CODE	COUNTY

MAILING ADDRESS	CITY	ZIP CODE	COUNTY

CARE PLAN CHANGE REQUEST	ADD	INCREASE	DECREASE	REMOVE
AGENCY MODEL TASK				
	☐	☐	☐	☐
	☐	☐	☐	☐
ADVANCED PERSONAL CARE				
	☐	☐	☐	☐
	☐	☐	☐	☐
AUTHORIZED NURSE VISIT				
	☐	☐	☐	☐
	☐	☐	☐	☐
CDS TASK				
	☐	☐	☐	☐
	☐	☐	☐	☐
WAIVER SERVICE				
	☐	☐	☐	☐

DETAILS OF REQUEST/ADDITIONAL INFORMATION:

CLOSING REQUESTED ☐ YES

*Participants choosing to close services are required to contact DSDS

REASON	OTHER REASON	ANTICIPATED CLOSING DATE

21-DAY NOTICE ☐ YES

Please ensure a copy of the 21-Day Notice is uploaded to the participant's case records in Web Tool. The letter can be uploaded as an attachment using the "PCCP REQUEST" category from the dropdown box in the Web Tool. Please refer to HCBSWebToolInformation page. ***21-Day Notice only for IHS.**

ANTICIPATED CLOSING DATE

PROVIDER CHANGE ☐ **YES** ☐ TO CDS ☐ TO IHS ☐ TO RCF/ALF

REASON

☐ PARTICIPANT CHOICE ☐ PROVIDER CHOICE ☐ OTHER ____________________

☐ UNABLE TO SELF-DIRECT ☐ MOVED OUT OF SERVICE AREA ____________________

NEW PROVIDER'S NAME	NEW PROVIDER'S PHONE NUMBER	HAS THE NEW PROVIDER ACCEPTED PARTICIPANT? ☐ YES ☐ NO
TENTATIVE START DATE PENDING DSDS APPROVAL		DOES PARTICIPANT NEED A COPY OF PROVIDER LIST? ☐ YES ☐ NO

NOTICE: Due to the increased volume of requests, all communication from DSDS will be directed to the email address provided above, unless a call is warranted. Please ensure you are checking your email for the latest information related to your request.

* REQUESTOR INFORMATION

NAME	AFFILIATION/RELATIONSHIP
PHONE NUMBER	EMAIL

OTHER RESPONSIBLE PARTY/LEGAL GUARDIAN CONTACT INFORMATION

NAME	PHONE NUMBER	ALTERNATE PHONE NUMBER
MAILING ADDRESS	EMAIL	

I, the requestor, am submitting this form on behalf of the participant identified in this request. I attest that I, or the entity I am affiliated with, has communicated with the participant or legal guardian to inform them of the requested changes outlined on this form. I understand that any requested changes to a participant's care plan requires the Division of Senior and Disability Services to coordinate with the participant or legal guardian before modifying the participant's person centered care plan.