



The Person Centered Care Plan (PCCP) form shall be utilized by Home and Community Based Services (HCBS) providers when requesting care plan changes for HCBS participants. It is not to be utilized to report abuse, neglect, or exploitation or disclose hotline information. Mandated Reporters are required to report these concerns to the Adult Abuse & Neglect Hotline via the [Online Reporting System](#).

The form shall be completed in its entirety to best serve the needs of the participant. Information can be entered into the fillable areas.

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 dropdown for the following:

- Select the task or waived service that is being requested in each area

Utilize the columns to the right of the task to select the following actions:

- Request to add, increase, decrease, or remove the task or waiver
 - If more than two actions are requested, add the information in the "Details of Requests/Additional Information" section.

CLOSING REQUESTED

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

Utilize the dropdown to select the following:

- Reason the participant’s authorization for HCBS needs to be closed
 - All participants who voluntarily request all HCBS authorizations be closed must contact DSDS to confirm.
- Enter the anticipated closing date

NOTE: If a case closing is a request for any other reason besides the reason listed in the dropdowns, utilize the “Other Reason” field to provide an explanation.

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 to the Documents tab in the participant’s electronic case record
- 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 is to switch 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 the 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 list to select a new provider.

- DSDS will utilize the participant’s e-mail address to send the provider list, if applicable.
- If the participant does not have an e-mail address, DSDS will mail the participant a provider list.

DETAILS OF REQUEST/ADDITIONAL INFORMATION

Add any additional information pertinent to the request being submitted.

REQUESTOR INFORMATION

The following shall be entered:

- Name
- Affiliation
- Phone Number
- E-mail of the person submitting the request

OTHER RESPONSIBLE PARTY/LEGAL GUARDIAN CONTACT INFORMATION

The following shall be entered:

- Name, Phone
- Number
- Alternate Phone Number
- Mailing Address
- E-mail of the guardian or other responsible party of the participant