



DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 DIVISION OF SENIOR AND DISABILITY SERVICES  
**PERSON CENTERED CARE PLAN (PCCP) FORM**

DATE
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**ALL FIELDS REQUIRED - RETURN FORM TO [PCCP@HEALTH.MO.GOV](mailto:PCCP@HEALTH.MO.GOV)**

Upon receipt of completed request, DSDS will contact all necessary parties to continue process. HCBS Providers can check the electronic case record 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
<b>AGENCY MODEL TASK</b>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ADVANCED PERSONAL CARE</b>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>AUTHORIZED NURSE VISIT</b>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CDS TASK</b>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>WAIVER SERVICE</b>				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**DETAILS OF REQUEST/ADDITIONAL INFORMATION:**

**CLOSING REQUESTED**  **YES** \*Participants choosing to close services are required to contact DSDS

REASON	OTHER REASON	ANTICIPATED CLOSING DATE
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**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? <input type="checkbox"/> YES <input type="checkbox"/> NO
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TENTATIVE START DATE PENDING DSDS APPROVAL	DOES PARTICIPANT NEED A COPY OF PROVIDER LIST? <input type="checkbox"/> YES <input type="checkbox"/> NO
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**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
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PHONE NUMBER	EMAIL
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**OTHER RESPONSIBLE PARTY/LEGAL GUARDIAN CONTACT INFORMATION**

NAME	PHONE NUMBER	ALTERNATE PHONE NUMBER
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MAILING ADDRESS	EMAIL
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**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.**