SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

COMMUNITY FIRST CHOICE Policy Manual	Section: CFC/PAS Person Centered Planning
	Subject: Person-Centered Planning Requirements Overview

Reference: 37.40.1005, 37.40.1114

PURPOSE

Person Centered Planning (PCP) is a service delivery process that focuses on learning what is important to a member and how they want to live. It utilizes a member's strengths and abilities to determine how services should be implemented. The ultimate goals of PCP are increased member choice, participation and independence; while also assuring health and safety.

DEFINITIONS:

PLAN FACILIITATOR

The Plan Facilitator is the person responsible for facilitating the development of the Community First Choice/Personal Assistance Service (CFC/PAS) PCP process and ensuring that services are reflective of program philosophy.

CASE MANAGER PLAN FACILIITATOR

If the member has a Developmental Disability case manager or Waiver case manager the Plan Facilitator is the member's case manager. The Case Manager Plan Facilitator is responsible for incorporating CFC/PAS services into the case manger's pre-existing PCP process and facilitating the development of the CFC/PAS PCP process within the general case management framework for PCP.

If the Plan Facilitator is a case manager, the Plan Facilitator will receive appropriate PCP training through the case management program.

PROVIDER AGENCY PLAN FACILITATOR

If the member does not have a case manager the Plan Facilitator is a person employed by the CFC/PAS provider agency. That person must be certified in the person-centered planning philosophy. The provider

agency Plan Facilitator is responsible for facilitating the development of the CFC/PAS PCP process.

If the Plan Facilitator is CFC/PAS provider agency, the Plan Facilitator must receive training certification in the PCP philosophy (CSB 1103).

PROVIDER AGENCY

The Provider Agency is an approved CFC/PAS agency that enrolls with Xerox and the Department to deliver state plan CFC/PAS services.

REQUIREMENTS

1. The member and Plan Facilitator shall complete a PCP form (SLTC-200) that identifies, in writing, member-specific goals and objectives for the delivery of CFC/PAS.

2. The PCP Form must be completed initially and renewed at least annually or whenever significant changes occur.

3. The CFC/PAS provider agency nurse supervisor (agency-based) or program oversight staff (self-directed) must also participate in the initial person centered planning process and must participate in-person in the annual person-centered planning visit.

4. The PCP form will be based on the member's functional assessment and service profile; which will be developed by Mountain Pacific Quality Health nurses.

5. The key components of the CFC/PAS PCP process include the PCP form and the CFC/PAS Handbook.

6. The PCP form must be signed by the Plan Facilitator and the CFC/PAS provider upon intake and annually.