Iowa | Medicaid and Children's Health Insurance Program

Integrated Health Home Non-ICM Person-Centered Care Plan

Section 1: PCCP Information

Type of PCCP: Choose an item.
Program Type: Choose an item.
Date PCCP Held: Click or tap to enter a date.
PCCP Date Span:
Previous PCCP Date Range:
Integrated Health Home:
Health Home Staff:
Health Home Phone Number:
Health Home Staff Email:
Managed Care Organization: Choose an item.

I choose the following people to attend my meeting:

Comprehensive Assessment Date: Click or tap to enter a date.

Section 2: My Information

Address (Street, City, State & Zip):
Phone Number:
Email Address:

- If child, do they reside with their parents:
- Parent(s) Name:
- Parent(s) Contact Information (if different than members):

I am currently approved and accessing the following Waiver:

- Identify Community Based Case Manager in My Care Team & Natural Supports section. CBCM should be involved in the PCCP planning.

I have applied for the following Long Term Services and Supports Waivers and I am on a waitlist for:

My strengths are

My preferences are

My physical health diagnoses include

My mental health diagnoses include

Section 3: My Risk Factors & Needs

The following risks have been identified from my comprehensive assessment, social history, and other records.

Identified Risk Factors & Needs Areas	Identified risk factors, needs, background information	Measures in place to minimize, including back-up plans and strategies when needed
Allergies		
Behavioral/Mental Health		
Communication and Language		
Developmental Milestones (children only)		
Domestic Violence, Physical, Emotional, Sexual Abuse, Trauma		
Education		
Employment/Volunteering		
Financial		
Gambling/Dependence		
Housing		
Hospitalization/Emergency Room		
Legal		
Leisure Activities		
Marital/Dating/Relationships		
Medical/Physical Health		
Medical Support Team		
Preventative Visits		
Self-Care/ADLs/IDLs		
Social, Cultural & Spiritual		
Substance Use or Abuse		
Transportation		
Other		

Section 4: My Goals

I have agreed to the following goals that I developed with my Health Home team.

Goal #1

I want			
My expected objective (measurable/observable: I will			
Background/barriers to meeting goal:			
If I had to rank this goal on how important it is to me or my caregivers, out of all of my goals in this service plan, this one would be: (the most important, the second most important, the third most important, the fourth most important)			
Interventions and supports, including incremental action steps	Person Responsible	Start date	End date

Goal #2

I want

My expected objective (measurable/observable: I will

Background/barriers to meeting goal:

If I had to rank this goal on how important it is to me or my caregivers, out of all of my goals in this service plan, this one would be: (the most important, the second most important, the third most important, the fourth most important)

Interventions and supports, including incremental action steps	Person Responsible	Start date	End date

Section 5: My Medical & Behavioral Health Plan

When I experience the following **medical symptoms**, these are the steps I take to manage them

Medical Symptom	What I do to manage on my own	How others can support me

My **behavioral plan** is as follows

- My **baseline mood** is
- My **triggers** are
- My **early intervention plan** is
- The **indicators** that I need help are
- Things I can do to **help myself** are
- My **coping skills and natural supports** are

Section 6: My Care Team & Natural Supports

The following are members of my care team and natural supports that I can utilize for my health and safety plan (include natural supports, guardian, POA, medical professionals, etc.)

Provider Name	Specialty	Address	Phone
	Integrated Health Home		
	Primary Doctor		
	Hospital For Medical Care		

	Hospital for Mental Health Care
	Urgent Care Office
	Dentist
	Pharmacy
	Psychiatrist
	Counselor
	Guardian
	Power of Attorney (POA)

*To reach my Integrated Health Home **after hours**, I can reach them by .*

If I suspect that I am being abused, neglected and/or or exploited, I can call the local DHS office or use the toll-free, hot line number, which is answered 24 hours a day, 7 days a week: 1-800-362-2178. I can also talk with IHH staff, my therapist, or other care providers who can support me in making a call. If I am in immediate danger, I can call 911.

Section 7: My Discharge Plan

I understand that my Health Home Services are voluntary and that I can end them at any time. If I lose Medicaid eligibility, I will not be eligible for Health Home services. If I do not meet with my Health Home Team, my Health Home eligibility could be impacted.

My discharge plan for Integrated Health Home Services is:

Section 8: Acknowledgments

Item	Confirmation	Member's / Guardian's Initial
1	I gave input into my assessment, goals and additional information included in this care plan.	
2	I am in agreement with my care plan and I know who to work with on my goals.	
3	I understand the information in this care plan and have had a chance to ask questions and receive clarification.	
4	I understand that I can request to have changes to the care plan at any time and that I contact my Health Home Team about making changes.	
5	I understand that my Health Home Team is responsible for monitoring my goals and overall plan.	
6	I understand that my Health Home Team will review my plan with me at least every 365 days, or sooner at my request.	
7	I was given a choice of providers and choose the providers I want to work with.	

Section 8: Signature Page

The people who have signed below understand and agree to participate in implementing my plan.

Signature	Print Name	Date	Role	Date a copy of the plan was sent/ given	Method plan was provided (e.g. mail, email, etc.)
			Member		
			IHH RN	N/A	