[INSERT NAME]

Date of Birth: xx/xx/xxxx

Life Plan / ISP

Member Address:

Phone:

Medicaid #:

Medicare #:

Enrollment Date:

Plan Effective Dates:

Willowbrook Member:

CCO

Address:

Phone:
Fax:

Provider ID:

Meeting History

Plan Review Date	Reason For Meeting	Member Attendance

SECTION I

ASSESSMENT NARRATIVE SUMMARY

This section includes relevant personal history and appropriate contextual information, as well as skills, abilities, aspirations, needs, interests, reasonable accommodations, cultural considerations, meaningful activities, challenges, etc., learned during the person-centered planning process, record review and any assessments reviewed and/or completed.

My Home:	
My Work:	
My Health and My Medications:	
My Relationships:	

SECTION II

OUTCOMES AND SUPPORT STRATEGIES

This section includes measurable/observable personal outcomes that are developed by the person and his/her IDT using person-centered planning. It describes provider goals and corresponding staff activities identified to meet the CCO goal/valued outcome. It captures the following information: goal description, valued outcomes, action steps, responsible party, service type, timeframe for action steps and Personal Outcome Measures. Evidence of achievement must be reflected in monthly notes from assigned providers.

CQL POMS Goal/ Valued Outcome	CCO Goal/Valued Outcome	Provider Assigned Goal	Provider / Location	Service Type	Frequency	Quantity	Time Frame	Special Considerations

Action Step Labels: (G) = Goal, (S) = Support, (T) = Task

Section III

Individual Safeguards/Individual Plan of Protection (IPOP)

Compilation of all supports and services needed for a person to remain safe, healthy and comfortable across all settings (including Part 686 requirements for IPOP). This section details the provider goals and corresponding staff activities required to maintain desired personal safety.

Goal/Valued Outcome	Provider Assigned Goal	Provider / Location	Service Type	Frequency	Quantity	Time Frame	Special Considerations

Section IV

HCBS Waiver and Medicaid State Plan Authorized Services

This section of the Life Plan includes a listing of all HCBS Waiver and State Plan services that have been authorized for the individual.

Authorized Service	Provider/Facility	Effective Dates	Unit	Comments

Section V			
All Supports and Services; Funded and Natural/Community Resources *This section identifies the services and support givers in a person's life along with the needed contact information. Additionally, all Natural Supports and Community Resources that help the person be a valued individual of his or her community and live successfully on a day- to-day basis at home, at work, at school, or in other community locations should be listed with contact information as appropriate.*			
Name	**Role**	**Address**	**Phone**

Signatures:

Care Manager: _____ Date: _____

Person: _____ Date: _____

Advocate: _____ Date: _____

**Signatures are required for the finalization of an individual's Life Plan; however, the signature page of the Life Plan may be formatted differently within the CCO/HH's information technology system. The above list is not a comprehensive list of potential signatories.