Plan of Care

What is the Plan of Care and Person-Centered Planning?

Shortly after an individual is enrolled in their Medicaid managed care organization, a "plan of care" is developed. This is a written document that includes important information such as:

- the clinical and support needs identified through the assessment process;
- the person-centered goals and objectives, the services and supports (paid and unpaid) that will assist the enrollee in achieving identified goals;
- and the service providers.

It is important to know that there are detailed requirements about how this process must involve the individual through what is called "***person-centered***" planning. This means that the process should actually be directed by the individual to the "maximum extent possible."

Enrollees are encouraged to make decisions about service options and identify personal goals. They must also be allowed to invite anyone of his/ her choosing to participate in the process and provide aid as needed or desired.

Significantly, the plan must be discussed with and agreed to by the enrollee, and the enrollee has the right to appeal if services are denied or reduced. In addition, all individuals and providers responsible for its implementation have to sign the care plan.

In sum, the Plan of Care (or "Care Plan") is the critical written document that specifies the services and supports that are to be furnished. A list of what must be included is below:

What Is Included In the Person-Centered Plan of Care?

The Medicaid Agency (AHCA) website provides the following information on what the person-centered plan of care must include:

- Enrollee's name and FloridaMedicaid identification number
- Plan of care effective date
- Plan of care review date (at least every 90 days)
- Plan of care review date (at least every 90 days)

- The enrollee's personal goals
- The enrollee's strengths and preferences
- Routine medical services needed, including how much, how often, and who is providing the service(s)
- Availability of natural supports to assist in the enrollee's care
- Long-term care waiver services, including how much, how often, and who is providing the service(s)
- Each service authorization start and end date (if applicable)
- A complete list of services and supports to be provided, no matter who is paying Medication oversight strategies
- Current living arrangement and choice of living arrangement
- If the enrollee's, current living arrangement and choice of living arrangement differ, a goal toward achieving the chosen living arrangement and barriers to be overcome in achieving the goal
- Records of enrollees' advance directives, health care powers of attorney, do not resuscitate orders, or a legally appointed guardian
- If the enrollee resides in an assisted living facility (ALF), services provided by the ALF, including how much and how often the ALF provides those services
- Identification of any existing plans of care and service providers and assessment of the adequacy of existing services
- Identification of who is responsible for monitoring the plan of care
- Case manager's signature
- The word-for-word written statement before the enrollee signature field as follows:

  > *"I have received and read the plan of care. I understand that I have the right to file an appeal or fair hearing if my* services *have been denied, reduced, terminated, or suspended"*, and

- Enrollee or enrollee's authorized representative's signature and date.