SELF-DIRECTED SERVICES

COMMUNITY HABILITATION STAFF ACTION PLAN

Name (print): _____

Medicaid Number (CIN#): _____ Staff Action Plan Review Date: ____ / ____ /____

Name of Care Coordination Organization: _____

Individual Habilitative Goals/Valued Outcomes (My Goal – Section II of Life Plan)

1) CQL POMs Goal:
   My Goal:
   (G)

Provider Assigned Habilitative Goals (Section II of Life Plan)

Provider Assigned (Habilitative) Goal: (G)
Staff Action:
Frequency: Staff will work on the above goal as needed on an ongoing basis.

Individual Safeguards/Individual Plan of Protection (IPOP) (Section III of Life Plan)

Goal/ Valued Outcome:
Provider Assigned (Safeguard) Goal:
Staff Action:
Frequency: Staff will work on the above goal as needed on an ongoing basis.

Other Safeguards for Staff

Guardianship:

Consent Status:

Incident Reporting:

Budgeting:

Transportation:

Backup Plan for Daily Needs:

Medication: SDS STAFF WILL NOT ADMINISTER MEDICATION.

Medical/ Health Concerns:

Nutrition:

Supervision:

Fire Safety/ Personal Safety/ Emergency Preparedness:

Communication Connections:

Other:

COMMUNITY HABILITATION
STAFF ACTION PLAN

Distribution:

Copies of the signed Staff Action Plan have been distributed on this date ___ / ___ / _____ by the Broker to:

- the person
- his/her advocate
- Care Coordination Manager
- Fiscal Intermediary
- Other _____

Signatures:

Staff Action Plan Author's (Print) : _____Title: Agency Support Broker

Staff Action Plan Author's Signature : _____ Date: ___ / ___ / _____

Individual (optional) : _____ Date: ___ / ___ / _____

Advocate (optional) : _____ Date: ___ / ___ / _____

Supervisor/Reviewer (optional) : _____ Date: ___ / ___ / _____