COORDINATED SYSTEM OF CARE

Magellan HEALTHCARE

Provisional Plan of Care & Freedom of Choice

Section I: Identifying Information		
Recipient/Child's Name:	Date of Birth:	
Physical Address:		
City:	State:	Zip:
Phone Number:	Medicaid Number:	
Recipient Currently Resides in (check one): ☐ Family Home ☐ Group Home ☐ Nursing Home ☐ Psychiatric Hospital ☐ Development Center / ICF ☐ Psychiatric Residential Treatment Facility		
Name of Facility (if applicable):		

Section II: Freedom of Choice
I understand that I have a choice in accepting CSoC Services or placement in an institution. CSoC and institutional services have been explained to me. I would like to receive (check one): ☐ CSoC Waiver Services ☐ Institutional Services *Initials of Recipient / Legal Guardian or Custodian:* *Date:*
My Wraparound Facilitator gave me a copy of the Louisiana CSoC Member Handbook, which includes important information such as my rights and responsibilities, how to find providers, and how to file an appeal and grievance. *Initials of Recipient / Legal Guardian or Custodian:* *Date:*
My Wraparound Facilitator helped me know how to report suspected abuse, neglect, extortion, exploitation, and death of adults and children and my right to be free from restraints, seclusion, and harm, and provided material for my review. *Initials of Recipient / Legal Guardian or Custodian:* *Date:*

Section III: Release of Information

I permit the release of any and all information pertaining to my application for services, which may be in the possession of the Wraparound Agency (WAA), to Magellan Health Services of Louisiana. The release of information includes, but is not limited to, my individualized Plan of Care, progress notes, doctor's reports/evaluations, psychological reports/evaluations, medical/social/educational assessments, including those provided by schools, other agencies, and or organizations, including all third party information which may be in LDH's possession. In the event that this form is signed by the Department of Children and Family Services (DCFS), the information released is confidential pursuant to state and federal law including but not limited to Louisiana Revised Statute 46:56. The use of this information shall be limited to the purpose of providing behavioral health services to the above named child.

Signature of Recipient / Legal Guardian or Custodian:	
Relationship to Recipient:	*Date:*

Section IV: Services

I understand that I have a choice of providers and between which services I may be eligible to receive. These services have been explained to me, and a listing of service providers in my area has been made available to me. I have chosen the following provider(s) and service(s).

My Wraparound Facilitator helped me know what waiver services are available to me and provided material for my review.

Initials of Recipient / Legal Guardian or Custodian: *Date:*

CSoC Waiver and Home and Community Based Services

Service	Provider	MIS#	Contact Person	Contact #	Frequency

Community Resources		
Educational	**Involved**	**Referral Requested**
504 Accommodations		
IEP		
Families Helping Families		
SBLC Meeting		
Education Evaluation		
Developmental	**Involved**	**Referral Requested**
Chisholm		
OCDD Evaluation		
OCDD Referral		
OCDD Waiver		
OCDD Waiver Wait List		
Personal Care Attendant		
Medical	**Involved**	**Referral Requested**
Occupational Therapy		
Physical Therapy		
Speech Therapy		
Juvenile Justice	**Involved**	**Referral Requested**
FINS		
OJJ		
Probation		
Other	**Involved**	**Referral Requested**
ABA Therapy		
Indep. Transitional Living		
Respite–non waiver		
Residential Sub. Use Facility		
Other:		

Section V: Crisis Plan

Identify immediate crisis concerns and create clear and specific action steps for the team to follow in order to reach stability and maintain youth in the home and community.

Name:	Date:

Immediate Safety Issues:

HOME — Action Step	Person Responsible	Contact Number

SCHOOL — Action Step	Person Responsible	Contact Number

Section V: Crisis Plan		
OTHER:		
Action Step	Person Responsible	Contact Number
I participated in making the crisis plan and agree to the steps developed.		
Signature of Recipient / Legal Guardian or Custodian:	Date:	
Signature of Youth:	Date:	
Signature of Facilitator:	Date:	

Waiver/HCBS Services

Links go to descriptions of evidence based practices on the Louisiana Evidence to Practice website.

- Assertive Community Treatment
- Child Parent Psychotherapy
- Counseling–Group
- Counseling–Individual
- Counseling–Family
- CPST (Community Psychiatric Support and Treatment)
- Crisis Intervention Crisis Stabilization
- Dialectic Behavior Therapy
- EMDR (Eye Movement Desensitization and Reprocessing)
- Functional Family Therapy
- Functional Family Therapy CW
- Homebuilders
- ILSB (Independent Living Skills Building)
- Medication Management
- Parent Child Interaction Therapy
- Parent Support
- Play Therapy
- Preschool PTSD Treatment (Preschool Post Traumatic Stress Disorder Treatment)
- Psychological Testing
- Psychosocial Rehabilitation
- Trauma Focused CBT (Trauma Focused Cognitive Behavioral Therapy)
- Short-term Respite
- Substance Use IOP (Substance Use Intensive Outpatient)
- Triple P
- Trust-Based Relational Intervention
- Youth PTSD Treatment (Youth Post Traumatic Stress Disorder Treatment)
- Youth Support