

# Caring for Students (C4S) Medical Plan of Care (POC)



<b>Student Demographics</b>				
Last:		First:		Middle:
SFX:	Grade:	Birth Date:	District:	
ID:		School:		UIC:
<b>Parent/Guardian Contact</b>				
The parent(s)/guardian(s) were contacted by the school to ensure that they would have an opportunity to attend this meeting and to explain the purpose of the meeting and the role of the participants. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>				
<b>Meeting Details</b>				
Date:	Last POC Date:	Purpose:		
<b>Meeting Participants</b>				
Name:			Title:	
<b>Eligibility</b>				
The student is eligible for behavioral/medical service support at school. <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>				
<b>Reason for Treatment</b>				
The student's reason for treatment is such that they require assistance with daily personal care services. <input type="checkbox"/> Yes <input type="checkbox"/> No *This serves as the authorization for medically necessary personal care services.*				
<b>Medically Necessary Personal Care Services</b>				
<input type="checkbox"/> Assistance with self-administered medications		<input type="checkbox"/> Redirection and Intervention for Behavior		
<input type="checkbox"/> Other (i.e., monitoring for seizures/glucose levels)		<input type="checkbox"/> Health-related functions through hands-on assistance, cueing, or monitoring		

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<b>Current Level of Performance</b>				
<b>Annual Goals and Short-Term Objectives</b>				
Goal:				
Objective:		Objective:		
Goal:				
Objective:		Objective:		
<b>Planned Intervention/Support Details</b>				
Service Type (medical providers)	Service Delivery (Direct/Consult)	Time (low to high)	Frequency (week, month)	Duration (begin to end date)
<input type="checkbox"/> Behavior Analyst				
<input type="checkbox"/> Counselor				
<input type="checkbox"/> Marriage and Family Therapist				
<input type="checkbox"/> Psychologist				
<input type="checkbox"/> Social Worker				
<b>Medical Accommodations/Supports</b>				
Accommodation/Support	Frequency (week, month)	Location		
<b>Coordination of Services</b>				

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<b>Anticipated Needs</b>	
<b>Other Comments</b>	
<b>Plan Begin Date</b>	<b>Anticipated Plan End Date</b>
<b>Qualified Provider</b>	
<input type="checkbox"/> I confirm that the student <b>does not</b> have a reason for treatment that requires a <i>Medical Plan of Care</i> .	
<input type="checkbox"/> I confirm that I agree with the <i>Medical Plan of Care</i> .	
<input type="checkbox"/> When necessary, I will keep providers informed of the student's response to treatment.	
Name:	Title:
Signature:	Date:
<b>Parent/Guardian Consent</b>	
<input type="checkbox"/> I confirm that my child <b>does not</b> have a reason for treatment that requires a <i>Medical Plan of Care</i> .	
<input type="checkbox"/> I confirm that I have received a copy of the <i>Medicaid Annual Notification</i> .	
<input type="checkbox"/> I confirm that I have received a copy of my student's <i>Medical Plan of Care</i> .	
<input type="checkbox"/> I consent to the <i>Medical Plan of Care</i> .	<input type="checkbox"/> I do not consent to the <i>Medical Plan of Care</i> .
Name:	Relationship:
Signature:	Date: