Caring for Students (C4S) - Medical Plan of Care (POC) Documentation Tool

SERVICE LEADERSHIP COLLABORATION EXCELLENCE

Student Demographics			
Last:	First:		Middle:
SFX:	Grade:	Birth Date:	District:
ID:	School:		UIC:
☐ **Attached**		☐ **MiStar**	

Parent/Guardian Contact	
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. ☐ **Yes** ☐ **No**	
☐ **Attached**	☐ **MiStar**

Meeting Details		
Date:	Last POC Date:	Purpose:
☐ **Attached**		☐ **MiStar**

Meeting Participants	
Name:	Title:
☐ **Attached**	☐ **MiStar**

Eligibility	
☐ Medial Orders	☐ Medical Management Plan
☐ Safety Plan	☐ Individualized Healthcare Plan
☐ Attention Deficit Hyperactivity Disorder Plan	☐ School Refusal Behavior Plan
☐ Other:	☐ Other:

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☐ **Attached**	☐ **MiStar**
Reason for Treatment	
☐ **Attached**	☐ **MiStar**
The student's reason for treatment is such, that they require daily personal care services. ☐ **Yes** ☐ **No** ***This serves as the authorization for medically necessary personal care services.**	
Medically Necessary Personal Care Services	
☐ Assistance with self-administered medications	☐ Redirection and Intervention for Behavior
☐ Other (i.e. monitoring for seizures/glucose levels)	☐ Health-related functions through hands-on assistance, cueing, or monitoring
☐ **Attached**	☐ **MiStar**
Current Level of Performance	
☐ **Attached**	☐ **MiStar**
Annual Goals and Short-Term Objectives	
Goal:	
Objective:	Objective:
Goal:	
Objective:	Objective:

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☐ Attached	☐ MiStar

Planned Intervention/Support Details

Service Type (medical providers)	Service Delivery (Direct/Consult)	Time (low to high)	Frequency (week, month)	Duration (begin to end date)
☐ Behavior Analyst				
☐ Counselor				
☐ Marriage and Family Therapist				
☐ Psychologist				
☐ Social Worker				

☐ Attached	☐ MiStar

Medical Accommodations/Supports

Accommodation/Support	Frequency (week, month)	Location

☐ Attached	☐ MiStar

Coordination of Services

☐ Attached	☐ MiStar

Anticipated Needs

☐ Attached	☐ MiStar

Other Comments

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☐ **Attached**	☐ **MiStar**
Plan Begin Date	**Anticipated Plan End Date**
☐ **Attached**	☐ **MiStar**
Qualified Provider	
☐ I confirm that I agree with the *Medical Plan of Care*. ☐ When necessary, I will keep providers informed of the student's response to treatment.	
Name:	Title:
Signature:	Date:
☐ **Attached**	☐ **MiStar**
Parent/Guardian Consent	
☐ I confirm that I have received a copy of the *Medicaid Annual Notification.* ☐ I confirm that I have received a copy of my student's *Medical Plan of Care*.	
☐ I consent to the *Medical Plan of Care*.	☐ I do not consent to the *Medical Plan of Care*.
Name:	Relationship:
Signature:	Date: