

##

#  Serving Nine Local School Districts

 \* Ann Arbor Public Schools \* Lincoln Consolidated Schools \* Saline Public Schools

 \* Chelsea Public Schools \* Manchester Public Schools \* Whitmore Lake Public Schools

 \*Dexter Public Schools \* Milan Public Schools \* Ypsilanti Community Schools

**Plan of Care**

**\*To be Completed After 30 days of First Initial Contact for Ongoing Services (Medicaid Requirement) \***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Student Name:**  |  |  | **DOB:**  |  |
| **District:**  | **Building:**  |   | **Grade:**  |
| **School Year:**   |   | **Teacher:**  |  |

**Participants:**

|  |  |
| --- | --- |
|  **Parent/Guardian:**  | **Parent/Guardian:**  |
| **Mental Health Provider:**   | **Mental Health Provider:**  |
| **Administrator:**  | **Other:**  |
|  |  |

**Student Profile:**

|  |
| --- |
|  ***Qualifying Diagnosis and Medical Condition: What is the student’s diagnosis (if already diagnosed or suspected diagnosis and/or medical condition)*** |
| *Guidance: High risk behaviors being displayed? Frequency?*      |
| **District and Parent Comments/Concerns:**  |
|  |

 **Progress Monitoring/Plan for Reaching Goals:**

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| **Long Term Goal:** |
| *Guidance: This serves as an indicator that the service is no longer necessary.*   |
|  **Anticipated *Frequency* and *Duration* to meet time-related goals:** |
| **Short-Term Measurable Objective:**  |
|  |
| **Anticipated *Frequency* and *Duration* to meet time-related goals:**  |
|  **Short-Term Measurable Objective:**  |
|      |
| **Anticipated *Frequency* and *Duration* to meet time-related goals:** |

 **Service Plan:**

|  |  |
| --- | --- |
| **Start Date:**  | **End Date:**  |
| **Primary Care Provider (PCP):**  |
| **How will progress be monitored?**  |
|   |
| **Statement detailing coordination of services with applicable providers:**  |
|  *Guidance: Include all outside agencies.*  |
| **Anticipated Needs and Other Comments:**  |
|  *Guidance: Optional field to capture any comments, concerns, and future needs to be considered.* |

**PARENT CONSENT TO TREAT:**

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| **I understand and agree that the ISD and its local school districts may provide treatment as needed for medically necessary services.** |
| **Parent or Guardian Signature** |  |
| **Date Signed** |  |

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| **MENTAL HEALTH PROVIDER SIGNATURE PAGE**(POC must be signed, titled and dated by qualified staff)*I agree with this plan of care, which has been developed in the best interest of the student/child and included one or more of the following activities: assessments, observations, formal testing, parent/family input, physician input.* |
| **Print Name** |  |  |
| **Signature** |  |  |
| **Profession/Title** |  |  |
| **Date Signed** |  |  |