

## 

# 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:**

|  |
| --- |
| **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:**

|  |  |
| --- | --- |
| **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** |  |

|  |  |  |
| --- | --- | --- |
| **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** |  |  |