PARTICIPANT CARE PLAN

If applicable: Medicaid # _____

DMAS Provider ID#_____

Participant' Name:_____ Name of ADCC _____

See reverse side for signatures and additional information.

Description of needs is based upon the participant assessment.

Description of Participant' s Needs	Expected Outcomes/Goals	Activities and Services to be Provided	Persons Who will Provide Activities and Services	Time by which Goals Should be Achieved

Participant's Name: _____

Description of Participant' s Needs	Expected Outcomes/Goals	Activities and Services to be Provided	Persons Who will Provide Activities and Services	Time by which Goals Should be Achieved

SIGNATURES:

_____	_____	_____	_____
Staff Person Who Completed Plan	**Date Plan Completed**	**Participant**	**Date**

PLAN REVIEW/MODIFICATIONS

Staff Person Designated to Review, Monitor, Ensure Implementation, and Make Appropriate Modifications to Plan: _____

Dates Implementation Monitored and Initials: _____ _____ _____ _____ _____

SIGNATURES:

_____	_____	_____	_____
Staff Person Who Completed Plan Review	**Date**	**Staff Person Who Completed Plan Review**	**Date**