MSSP Care Plan

Participant Name:		MSSP #:		Care Plan Conference Date:		Duration of Care Plan	

Date	Participant Need #	Participant Need Statement	Participant Goal/ Outcome	Service Provider & Type (I, R, P, C)	Plan/Intervention	Date Resolved/ Comments

MSSP Staff Signatures:

PCM: _____ Date: _____ SCM: _____ Date: _____

I acknowledge receipt and acceptance of this care plan, and receipt of the notice regarding my rights to a fair hearing if I am dissatisfied with the action(s) affecting MSSP-funded services.

Participant's Signature: _____ Date: _____