

**UPCAP SERVICES INC.
PLAN OF CARE AGREEMENT**

PARTICIPANT: _____ **WAIVER DATE:** _____

I, _____ have had input into my Plan of Care (POC) and have received a copy of my Plan of Care and it reflects the services I wish to receive at this time. I know the plan may change over time based on my needs, wishes, or approval of the suggestions made by my Care Manager. I know that I can refuse, end, or suspend my services by calling my Care Manager and requesting a change. If I choose to do this, the Care Manager will make the changes according to my wishes. I will contact my Care Manager if and when I wish to change my plan. I APPROVE THIS PLAN.

I further acknowledge that I understand my Plan of Care will be monitored by my Care Managers through phone contacts and home visits: and that my Informal Supports are aware of the services they have agreed to provide to me **and will be uncompensated.**

**I agree to allow the following agencies, my primary care physician, and informal supports to receive a copy of my POC.
List names:**

I do not wish anyone but myself to have a copy of my POC. Participant initial _____

Initial Assessment:

Participant/Representative	Date	RN Care Manager	Date
Informal Support	Date	SW Care Manager	Date

Reassessments/Care Plan Reviews:

Participant/Representative	Date	Care Manager	Date
Participant/Representative	Date	Care Manager	Date

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Reassessments/Care Plan reviews:

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