**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 Supports Coordinator. I know that I can refuse, end, or suspend my services by calling my Supports Coordinator and requesting a change. If I choose to do this, the Supports Coordinator will make the changes according to my wishes. I will contact my Supports Coordinator 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 Supports Coordinator 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 Supports Coordinator** | **Date** |
| **Informal Support** | **Date** | **SW Supports Coordinator** | **Date** |

**Reassessments/Care Plan Reviews:**

| | | | |
|---|---|---|---|
| **Participant/Representative** | **Date** | **Supports Coordinator** | **Date** |
| **Participant/Representative** | **Date** | **Supports Coordinator** | **Date** |

**UPCAP SERVICES INC.**

**PLAN OF CARE AGREEMENT**

**PARTICIPANT:**_____ **WAIVER DATE:**_____

## Reassessments/Care Plan reviews:

| | | | |
|---|---|---|---|
| **Participant/Representative** | **Date** | **Supports Coordinator** | **Date** |
| **Participant/Representative** | **Date** | **Supports Coordinator** | **Date** |
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