MSSP Care Plan

Participant Name:_____ MSSP ID:_____ 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:** _____