Alex Moore **'S PERSON-CENTERED PLAN**

Name: Benjamin Alexander Moore "Alex"	**DOB:** 06/21/2007	**Medicaid ID:**	**Record #:**
(Non - I/DD Plans ONLY) **PCP Completed on:** 10/30/2025	**(I/DD Plans ONLY)** **Plan Meeting Date:** / /	**Effective Date:** / /	

Life Domains Assessed during Development of Person-Centered Plan:

Daily Life and Employment	**Community Living**
Current Situation: Alex is a 17-year-old high school senior who excels in computer science and enjoys problem-solving and coding. He currently participates in an after-school robotics club and part-time job shadowing with the school IT department. **Vision:** Alex wants to attend a four-year university to study software engineering and eventually work in technology security. **Strengths:** Analytical thinker, strong memory, reliable, self-motivated, punctual, respectful of rules and routines. **Obstacles:** Difficulty managing unstructured time, social anxiety in group work settings, and occasional rigidity when plans change.	**Current Situation:** Lives at home with his parents and younger brother in a suburban area with access to public transportation. **Vision:** Plans to live in a college dorm with a quiet roommate and gradually develop independent living skills (meal prep, budgeting, self-advocacy). **Supports:** Parents provide coaching on daily routines; will connect with the university's disability resource office for housing accommodations.
Safety and Security	**Healthy Living**
Current Situation: Manages personal safety well; tends to be overly trusting online and sometimes overshares personal information in group chats. **Vision:** Learn digital safety, budgeting, and decision-making skills to maintain independence and safety as a college student. **Supports:**	**Current Situation:** Good physical health, tends to skip meals when focused on projects, experiences occasional sensory overload (e.g., noise in cafeteria). **Vision:** Maintain balance in eating, exercise, and downtime to reduce anxiety and sensory fatigue. **Supports:**

Family, school counselor, and community safety workshops.	School nurse and counselor collaborate on a sensory regulation plan (e.g., quiet lunch space, scheduled breaks).
Social and Spirituality **Current Situation:** Has a small friend group in robotics and enjoys online gaming. Sometimes struggles to initiate or sustain conversation with unfamiliar peers. **Vision:** Wants to build more friendships and feel comfortable collaborating in group classes and work settings. **Supports:** Social skills coaching, peer mentoring through Best Buddies, and continued participation in robotics and computer clubs.	**Citizenship and Advocacy** **Current Situation:** Understands his autism diagnosis and has begun to self-advocate with teachers. **Vision:** Wants to speak up about his needs (quiet study space, extra processing time) and learn to request accommodations independently in college. **Supports:** Transition coordinator and speech therapist help him practice disclosure and self-advocacy scripts; participation in Youth Leadership Forum.

What do you want to work on? What would you like to accomplish?

I want to be ready for college, know how to handle things on my own, and make new friends.

What strengths do you currently have?

- Analytical, systems-oriented thinker with strong memory and attention to detail
- Reliable and punctual; follows routines and completes tasks as assigned
- Demonstrates growing self-advocacy and openness to feedback
- Highly proficient with technology, coding, and problem-solving
- Uses supports effectively (planner, visual schedule, noise-reduction tools)
- Supported by a strong family and educational team; highly motivated for college success

What are the obstacles to meeting your goals?

- Difficulty managing unstructured time and maintaining planner use without prompts
- Experiences sensory overload in noisy or crowded spaces, which can affect focus
- Finds it challenging to initiate or sustain social interactions with unfamiliar peers
- Becomes anxious or rigid when routines or plans change unexpectedly
- Occasionally overshares personal information online and needs ongoing support with digital safety
- Tends to skip meals or neglect self-care when deeply focused on academic or tech projects

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ACTION PLAN

The Action Plan section of the PCP includes the individual's long-term goal, short-term goals, interventions, and timeframes.

Long-Term Goal:

Alex wants to feel prepared for college across multiple domains (i.e., executive functioning/planning for assignments and courses, social skills, and independent living skills)

Short-Term SMART Goal

Goal: Within 4 months, Alex will use a planner or digital calendar to record all assignments and due dates for at least four consecutive weeks, turning in 90% of assignments on time as verified by teacher reports.

Interventions – Provider (s):

- School transition coordinator will provide 1:1 instruction on time management and organization once a week for 8 weeks.
- School counselor will review academic progress monthly and provide check-ins.

Interventions – Individual and/or Natural Support Actions:

- Alex will update his planner daily and review it with his parents every Sunday.
- Parents will support by helping him create a visual weekly routine posted in his study area.

Short-Term SMART Goal

Goal: Within 6 months, Alex will initiate or respond appropriately in group discussions at least once per robotics club meeting for three consecutive months, as recorded by the club advisor.

Interventions – Provider (s):

- Speech therapist will use role-play and video modeling 1x/week for 8 weeks to practice conversational turns and self-advocacy statements.
- Club advisor will prompt and positively reinforce participation during meetings.

Interventions – Individual and/or Natural Support Actions:

- Alex will use conversation starters prepared ahead of time.
- Parents will encourage him to invite a peer to study or meet outside of school once a month.

Short-Term SMART Goal

Goal: Within 6 months, Alex will independently complete three targeted independent living skills—doing laundry, preparing one simple meal, and creating a weekly budget—each with 100% accuracy across two consecutive trials, as verified by his parents.

Interventions – Provider (s):

- Transition coordinator will link Alex to a community-based “College Readiness” workshop.
- Parents will work with Alex on these skills at home.

Interventions – Individual and/or Natural Support Actions:

- Parents will supervise weekly practice at home and gradually fade support.
- Alex will track progress using a checklist.

**** Copy and use as many Action Plan pages as needed.****

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PLAN SIGNATURES

I. PERSON RECEIVING SERVICES:

- ☐ I confirm and agree with my involvement in the development of this PCP. My signature means that I agree with the services/supports to be provided.
- ☐ I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this PCP.
- ☐ For I/DD services only, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with Intellectual/Developmental Disabilities (I/DD) (instead of participating in the Community Alternatives Program for individuals with Intellectual/Developmental Disabilities (I/DD).

Legally Responsible Person: Self: Yes ☐ No ☐

Person Receiving Services: (Required when person is his/her own legally responsible person)

Signature: _____ _____ Date: __/__/____

(Print Name)

Legally Responsible Person (Required if other than person receiving Services)

Signature: _____ _____ Date: __/__/____

(Print Name)

Relationship to the Individual: _____

II. PERSON RESPONSIBLE FOR THE PCP: The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided.

Signature: _____ _____ Date: __/__/____

(Person responsible for the PCP) (Name of Case Management Agency)

Child Mental Health Services Only:

For individuals who are less than 21 years of age (less than 18 for State funded services) and who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the person responsible for the PCP must attest that he or she has completed the following requirements as specified below:

- ☐ Met with the Child and Family Team - Date: __/__/____
- ☐ **OR** Child and Family Team meeting scheduled for - Date: __/__/____
- ☐ **OR** Assigned a TASC Care Manager - Date: __/__/____
- ☐ **AND** conferred with the clinical staff of the applicable LME to conduct care coordination.

If the statements above do not apply, please check the box below and then sign as the Person Responsible for the PCP:

- ☐ This child is not actively involved with the Department of Juvenile Justice and Prevention or the adult criminal court system.

Signature: _____ _____ Date: __/__/____

(Person responsible for the PCP) (Print Name)

III. SERVICE ORDERS: *REQUIRED for all Medicaid funded services; RECOMMENDED for State funded services.*

(SECTION A): For services ordered by one of the Medicaid approved licensed signatories (see Instruction Manual).

My signature below confirms the following: (Check all appropriate boxes.)

- Medical necessity for services requested is present and constitutes the Service Order(s).
- The licensed professional who signs this service order has had direct contact with the individual. ☐ Yes ☐ No
- The licensed professional who signs this service order has reviewed the individual's assessment. ☐ Yes ☐ No

Signature: _____ _____ License #: _____ Date: __/__/____

(Name/Title Required) (Print Name)

(SECTION B): For Qualified Professionals (QP) / Licensed Professionals (LP) ordering:

- I/DD or
- Any state-funded services not ordered in Section A or

My signature below confirms the following: (Check all appropriate boxes.) Signatory in this section must be a Qualified or Licensed Professional.

- ☐ Medical necessity for the I/DD services requested is present and constitutes the Service Order.
- ☐ Medical necessity for the State-funded service(s) requested is present, and constitutes the Service Order

Signature: _____ _____ License #: _____ Date: __/__/____

(Name/Title Required) (Print Name) (If Applicable)

IV. SIGNATURES OF OTHER TEAM MEMBERS PARTICIPATING IN DEVELOPMENT OF THE PLAN:

Other Team Member (Name/Relationship): _____ Date: __/__/____

Other Team Member (Name/Relationship): _____ Date: __/__/____