Caring for Students (C4S)
Medical Plan of Care (POC)

Student Demographics					
Last:			First:		Middle:
SFX:	Grade:	Birth Date:	District:		
ID:		School:			UIC:

Parent/Guardian Contact
The parent(s)/guardian(s) were contacted by the school to ensure that they would have an opportunity to attend this meeting and to explain the purpose of the meeting and the role of the participants. ☐ **Yes** ☐ **No**

Meeting Details		
Date:	Last POC Date:	Purpose:

Meeting Participants	
Name:	Title:

Eligibility
The student is eligible for behavioral/medical service support at school. ☐ **Yes** ☐ **No**

Reason for Treatment
The student's reason for treatment is such that they require assistance with daily personal care services. ☐ **Yes** ☐ **No** ***This serves as the authorization for medically necessary personal care services.***

Medically Necessary Personal Care Services	
☐ Assistance with self-administered medications	☐ Redirection and Intervention for Behavior
☐ Other (i.e., monitoring for seizures/glucose levels)	☐ Health-related functions through hands-on assistance, cueing, or monitoring

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Current Level of Performance

Annual Goals and Short-Term Objectives	
Goal:	
Objective:	Objective:
Goal:	
Objective:	Objective:

Planned Intervention/Support Details

Service Type (medical providers)	Service Delivery (Direct/Consult)	Time (low to high)	Frequency (week, month)	Duration (begin to end date)
☐ Behavior Analyst				
☐ Counselor				
☐ Marriage and Family Therapist				
☐ Psychologist				
☐ Social Worker				

Medical Accommodations/Supports

Accommodation/Support	Frequency (week, month)	Location

Coordination of Services

THE WAYNE COUNTY REGIONAL EDUCATIONAL SERVICE AGENCY

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Anticipated Needs			
Other Comments			
Plan Begin Date	**Anticipated Plan End Date**		
Qualified Provider			
☐ I confirm that the student **does not** have a reason for treatment that requires a *Medical Plan of Care*.			
☐ I confirm that I agree with the *Medical Plan of Care*. ☐ When necessary, I will keep providers informed of the student's response to treatment.			
Name:		Title:	
Signature:			Date:
Parent/Guardian Consent			
☐ I confirm that my child **does not** have a reason for treatment that requires a *Medical Plan of Care*.			
☐ I confirm that I have received a copy of the *Medicaid Annual Notification.* ☐ I confirm that I have received a copy of my student's *Medical Plan of Care*.			
☐ I consent to the *Medical Plan of Care.*		☐ I do not consent to the *Medical Plan of Care.*	
Name:		Relationship:	
Signature:		Date:	

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