## Permanency Planning Review

### Client Information
- **Last Name/Suffix:**
- **First Name:**
- **Middle Name:**
- **Client ID:**
- **Local Case Number:**
- **Component:**

### Action
- **Add:**
- **Change:**
- **Delete:**

### Review Date
- **MM DD YYYY**
- **Permanency Plan Goal**
- **Does the family/LAR support goal?**  
  (Y=Yes, N=No)

### Contact Information
- **Contact Name:**
- **Contact Phone:**

### Family and Community Supports to Achieve Goal
- **Architectural Modifications**
- **Behavioral Intervention**
- **Child Care**
- **Crisis Intervention**
- **Durable Medical Equipment**
- **Transportation**
- **Family Based Alternative**
- **In Home Health Services**
- **MH Services, Counseling**
- **Night Time Supervision**
- **Ongoing Medical Services**
- **Personal Assistance-ADL**
- **Respite-In Home**
- **Respite-Out of Home**
- **Special Equipment**
- **Specialized Therapies**
- **Specialized Transport.**
- **Training**
- **Volunteer Advocate**

### Traumatic Brain Injury
- **(Y=Yes, N=No)**

### Family and Community Supports
- **LAR and/OR Family participated/POC/IPC**
  - **Y=Yes, N=No, N/A= Not applicable**
- **Located Family**
  - **Y=Yes, N=No**
- **Family Responded**
  - **Y=Yes, N=No**

### Family Responded
- *(Y=Yes, N=No)*

### Individual Access
- **Individual is enrolled, enrolling, or has access to a Medicaid Waiver**  
  (Y=Yes, N=No)

### Completion Details
- **Completed by:**
- **Date:**
Permanency Planning Review (CARE-PPR)

**Identifying Information**: Complete the identifying information at the top of the form. The local case number is a maximum of 10 characters. The component code is the 3-digit code for your component.

**Action**: Check the Add box to submit permanency planning review data for the first time. If you want to add to or change permanency planning review data that was previously submitted, check the Change box. Check the Delete box to delete a previously submitted form.

**Permanency Planning Information** *(These fields are required.)*

- **Review Date**: Enter the date of the person’s permanency planning review.
- **Permanency Plan Goal**: Enter the code indicating the permanency plan goal: 1=Return to family or own home, 2=Move to family-based alternative (e.g., foster, extended family care, open adoption) Does the family/LAR support goal and work to achieve it: Enter Y (Yes) if the family/LAR agrees with the goal if and when the needed supports can be accessed and supports activities to achieve it. Enter N (No) if the family/LAR chooses for the individual to remain in the current residence even if needed supports can be accessed or prefers an alternate non-family living arrangement.
- **Contact Frequency**: Enter the code indicating the frequency of parent/guardian contact with the individual during the last six months: 1=New Admission, 2=Daily, 3=Weekly, 4=Monthly, 5=1-3 times, 6=None.
- **# Visits by Family**: Enter the number of visits to the facility by the parent/guardian.
- **# Visits to Family**: Enter the number of the resident’s visits to the home.
- **Traumatic Brain Injury**: *(This field is not required.)* Enter Y (Yes) or N (No) to indicate if the person has a history of traumatic brain injury.
- **LAR and/OR Family participated/POC**: Within the last 6 months, did the family/LAR participate in the initial or annual meeting to discuss the Individual Plan of Care (IPC) or Individual Program Plan (IPP)? Enter Y (Yes) if the family/LAR did participate, N (No) if the family/LAR did not participate, and N/A (Not applicable) if the annual meeting did not occur within the last six months. Participation may include attending a meeting or participating by telephone or other means of communication.
- **LAR and/OR Family participated/PP**: Did the family/LAR participate in this initial or review of the permanency plan (whichever is applicable)? Answer based on the family’s/LAR’s participation in this permanency plan. Enter Y (Yes) if the family/LAR did participate, or N (No) if the family/LAR did not participate. Participation may include attending a meeting or participating by telephone or other means of communication.
- **Located Family**: Within the last six months, could the family be located in order to invite their participation in a permanency planning meeting, an annual meeting to discuss the plan of care, or when medical consents were required? Enter Y (Yes) if the family could be located when needed in all circumstances described, if applicable, and N (No) when the family could not be located when needed in any circumstance described, if applicable. If the family could be located for some but not all circumstances described (for instance, could be located to invite their participation in an annual POC meeting but could not be located for the permanency planning meeting, enter N (No). Could not be located means that you no longer have a valid address, phone number, or other contact information that would enable you to make contact with the family/LAR in order to invite their participation.
- **Family Responded**: Within the last six months, did the family/LAR respond to requests to participate in applicable permanency planning meetings, annual meeting to discuss the plan of care, or when medical consents were needed? Enter Y (Yes) if the family did respond, or N (No) if the family did not respond. “Did respond” means the family could be located and either by phone or in writing indicated their preference to participate or not participate.

**Family and Community Supports to Achieve Goal**:

*Note*: List the supports that will be needed by the individual in order to achieve the permanency planning goal.

Enter Y (Yes), N (No), or leave blank for each support. The system defaults to “No”.

- **Architectural Modifications**: Includes widening of doorways, lowering of counters, ramps, bathroom modifications, kitchen modifications, etc. that allow access to a person’s home. Does not include modifications to public facilities.
- **Behavioral Intervention for Child or Training for Family**: Includes the services of a behavioral specialist or therapist in developing a plan of intervention and training of the family in behavioral intervention as related to that child’s needs for behavioral intervention.
- **Child Care or After School Care**: Child care needs above and beyond normal child care needs.
- **Crisis Intervention**: Supports for child and family to prevent institutionalization caused by impending out of home placement within a 72-hour time period with no supports.
- **Durable Medical Equipment**: Adaptive aids and other disability equipment needs that increase independence in daily life. Also includes medical supplies that are needed on a regular basis. Wheelchairs, communication devices, medical supplies, adaptive eating equipment, etc. (reference to Medicaid definition of DME).
- **Transportation**: Transportation that is available to the general public or contracted with a private individual; i.e., bus, taxi, per mile or trip contract, etc.
- **Family Based Alternative**: Provide assistance in the referral and support for placement in alternate community program in a family, e.g., foster care, shared parenting, open adoption.
- **In Home Health Care Services**: Identified nursing needs to be provided within the home setting.
Mental Health Services, including Counseling: Evaluation and identified mental health support needs including evaluation, testing, counseling, medication supports, behavioral interventions.

Night Time Supervision: Staff available for supervisory needs for health and safety identified needs, assistance in going to bathroom, positioning, prevent running away, etc.

Ongoing Medical Services: Medical services that have been identified to be regular monitoring services due to the medical needs of the child, blood levels, regular follow-up visits to monitor condition or medical need, access to medical specialists.

Personal Assistance Support for Activities of Daily Living: Assistance with daily living needs including bathing, grooming, eating, mobility, etc.

Respite for Family In Home: Periodic relief of caregiving that is provided in the home of the individual. (hourly or daily)

Respite for Family Out of Home: Periodic relief of caregiving that is provided in another setting other than the person/family home. (hourly or daily)

Special Equipment: Equipment that has been identified by the appropriate licensed professional for the person to be independent in daily living. Wheelchairs, communication devices, specialized eating utensils, etc.

Specialized Therapies (e.g., Occupational Therapy, Physical Therapy, Speech Therapy): Evaluations and therapy services that are provided by the appropriate licensed therapist.

Specialized Transportation: Accessible transportation for those with disabilities.

Training to Assist Person in Independent Living or Assist Family in Providing Proper Care for Unique Needs: Identified training to improve or increase the independence of the individual to live at home. Includes dressing, bathing, eating, completing chores, making bed, cooking, etc. Training of the family in how to take care of the daily needs of the child including bathing, medical care, feeding, etc.

Volunteer Advocate: A person selected by the parent or guardian, an adult relative, or a representative of a child advocacy group not employed by or under contract with the institution in which the individual resides Contact Name: Enter the name of the person responsible for conducting permanency planning activities.

Contact Phone: Enter the telephone number of the person responsible for conducting permanency planning activities.

Individual is enrolled, is enrolling, or has access to a Medicaid Waiver: Identify if the individual is enrolled or enrolling in a Medicaid waiver program, or has immediate access to a Medicaid waiver through a target group. Enter Y (Yes) if any of the three choices apply and No (No) if none of the three choices apply. If an individual is living in an HCS group home or has been offered HCS services and is in the process of enrolling in HCS, then enter Y (Yes). If the individual is living in an ICF/IID and is on the HCS interest list but has not yet been offered HCS services, enter N (No). If the individual has been offered HCS services but has declined the offer and the offer is no longer valid, enter N (No).

Completed By: Indicate who completed the permanency planning instrument by entering the correct name and completion date.