INSTRUCTIONS FOR COMPLETING SERVICE COORDINATION PLAN FORMS - FORM MA 399
(PLEASE USE BLACK INK OR TYPE)

Client's Control Number: - Enter the recipient control number from the targeted Case Management Approval Notice.

Recipient Number: - Enter the 10 digit recipient number as it appears on the client's Pennsylvania ACCESS card.

Case Manager's Name: - Enter the full name of the case manager chosen by the client.

Provider ID Number: - Enter the 13 digit ID number assigned to the case manager by the Office of Medical Assistance Programs.

Physician's Name - Enter the full name of the client's primary care physician.

Provider ID Number License Number: - Enter the 13 digit ID number assigned to the physician by the Office of Medical Assistance Programs. If not a medical assistance enrolled provider, enter the physician's professional license number.

Phone Number: - Enter the physician's three digit area code and seven digit telephone number.

Date Physician's Plan Reviewed: - Enter date (mm,dd,yy) that the physician's plan of care is reviewed and updated. (Required every six months.)

Dates Care Plan (SCP) Reviewed: - Enter date (mm,dd,yy) the service plan is reviewed. Required monthly, or more often, if needed.

Long Term Goals: - Based on physician's plan of care, and needs of client, state goals to be achieved with service plan.

Need/Problem: - State all need(s)/problem(s) to be resolved, identified through the client's assessment. Items identified should include medical, socioeconomic, psychological/emotional needs.

Action Required (1): - Describe action(s)/step(s) required to alleviate or assist client with problem. **State potential or actual provider or community resource to be used for accomplishment of action.**

Goal: - State goal to be accomplished by action.

Target Date: - Enter date on which completion of goal is anticipated.

Result: - Describe the result of action(s) taken. State whether the need/problem was resolved or whether an alternative action is needed. To be done either at time of monthly review or on target date noted (whichever comes first).

Date Revised/ Completed (2) - Enter date action (service) is revised or completed. If action is changed to accomplish a more effective outcome to client, list change as a new need/problem and identify the number of the new need/problem in this block.

Approved by Client: Initials/Date: - Client's initials and date initialed by client. If client is unable to initial, parent or legal representative may do so.

Approved by Case Manager: Signature/Date: - Case manager's signature and date signed by case manager.

SERVICE COORDINATION PLAN

CLIENT'S CONTROL NUMBER		**RECIPIENT NUMBER**	
CASE MANAGER'S NAME		**PROVIDER ID NUMBER**	
PHYSICIAN'S NAME	**LICENSE NO. OR PROVIDER ID NO.**		TELEPHONE NUMBER ( )

DATE PHYSICIAN'S PLAN REVIEWED	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY
DATE CARE PLAN REVIEWED	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM	DD	YY

LONG TERM GOAL(S)

NEED/PROBLEM	ACTION(S) REQUIRED (1)	GOAL	TARGET DATE	RESULT	DATE REVISED COMPLETED (2)

(1) INCLUDE SERVICE PROVIDER/COMMUNITY RESOURCES USED (2) DESCRIBE ANY REVISIONS AS A NEW ACTION

APPROVED BY CLIENT		APPROVED BY CASE MANAGER	
CLIENT/PARENT/REPRESENTATIVE'S INITIALS	DATE	CASE MANAGER'S SIGNATURE	DATE