Department of Human Services
Med-QUEST Division

Medical Respite Person Centered Service Plan

This plan is your opportunity to learn about the Community Integration Services (CIS+) program, share what is important to you, and explore how the program can best support your goals. You are welcome to involve anyone from your support network in creating this plan. If at any point you want to make changes, your plan can be updated at your request.

A. Contact Information

1. Name (as shown on Medicaid or QI Health Plan Card):	
2. Medicaid or Health Plan ID # (If known):	3. DOB (MM/DD/YYYY):
4. If applicable, name of Guardian or Legal Authorized Representative:	
5. Contact Phone Number (indicate cell or house):	6. Contact Email:

7. What are your medical respite goals and needs? (select all that apply)
   - ☐ Recover in a safe, supportive environment.
   - ☐ Improve how I manage my ongoing health conditions.
   - ☐ Get support to take my medications as prescribed.
   - ☐ Work toward stable, long-term housing.
   - ☐ Keep my follow-up appointments and get connected to regular medical or behavioral health care.
   - ☐ Be part of a community with people who may have similar experiences.
   - ☐ Other: _____

8. *[Optional]* What are some barriers to reaching your medical respite goals? (select all that apply)
   - ☐ My health conditions are complicated, and it's hard for me to keep track of everything.
   - ☐ I sometimes have trouble understanding medical information or instructions.
   - ☐ I want support, but I don't always feel ready to make big changes.
   - ☐ Other: _____
   - ☐ None

9. What medical respite benefit are you receiving or are going to receive?
   - ☐ Short-term pre-procedure housing
   - ☐ Short-term post-hospitalization housing
   - ☐ Short-term recuperative care

10. Are you interested in receiving Housing Navigation Supports while in medical respite? This service offers support to help you work toward permanent housing.

☐ Yes, I am interested in Housing Navigation Supports
☐ Maybe, I would like to learn more at another time
☐ No

Sign below if you agree to this person-centered service plan.

Member Signature: _____ Date: _____

If not signing for self, guardian, or legal authorized representative name:

_____

For Health Plan or Delegate Use Only
Was the plan authorized verbally? ☐ Yes ☐ No Health Plan or Delegate Organization Name:_____ Staff Name (print): _____ Staff Signature: _____ Date: _____