

Case Management Action Plan

The purpose of the Case Management Action Plan is that a person receiving services has an individualized, personalized plan for their supports, formal and informal. The plan is created with the assistance of a person's Case Manager. The plan identifies the supports the person has chosen to use, the person's intention or desired outcomes of their supports, who is responsible for the supports, and, how and when those supports will be reviewed for effectiveness. The plan acts as a bridge from the Independent Living Assessment (ILA) to the actual delivery of support services.

- A Case Management Action Plan must be completed for people receiving services that have complex case management needs that extend beyond advocacy or counseling for benefit programs.
- A plan must be completed for all people receiving Choices for Care Highest/High needs at home or in an Enhanced Residential Care (ERC) setting.
- If a person receives services through CFC Moderate Needs or the Older American's Act, and, do not have complex case management needs, the case manager is not required to complete a plan, although their case management services must comply with current DDAS Case Management Standards. Case managers shall use their professional judgment and document, in the person's case notes, their decision to not use a Case Management Action Plan.
- The person, their legal representative, caregiver or family member, develops the plan with the case manager.
- The plan provides a written summary of Issues and Goals, the Plan/Strategy of each support, the Responsible Person(s) for providing that support, and the Target Dates for completion.
- The plan is not simply a to-do list for the case manager.
- Documentation of the plan can be in any format which meets the intent and all the requirements of a Case Management Action Plan, including that it be a format that is easily shared and understood by the person receiving supports.

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Scott C. Dulebohn



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