CPOC CHECKLIST FOR EPSDT SUPPORT COORDINATION APPROVAL PROCESS - INITIAL AND SPECIAL NEEDS SUPPORT COORDINATION

BENEFICIARY NAME:	DATE:
SUPPORT COORDINATOR AND AGENCY NAME:	

This checklist identifies the forms that are to be sent to BHSF/SRI for review and approval. The documents are to be sent immediately after submission of the plan of care in LSCIS for all Initial plans of care and all plans of care identified as "Special Needs." Documents can be e-mailed to ksalling@statres.com or faxed to 225-767-0502 attention: Kim Willems.

	FORM
	SOA and/or Participant Recap Sheet (if an Initial CPOC)
	CPOC Signature Page • With planning participant's signatures (**everyone present signs in the box**), participant/guardian's CPOC approval signature, SC signature & SC Supervisor signature.
	Typical Weekly Schedule
	EPSDT Rights & Responsibilities (just the signature sheet)
	Legal Guardianship Document, Supported Decision-Making Agreement, Power of Attorney, Non-Legal Custodian Affidavit, or an Authorized Representative Form • Required if the beneficiary is interdicted, if the beneficiary has given power of attorney to another person, or if the legal guardian is not the parent. An authorized representative form or supportive decision-making agreement needs to be on file if the beneficiary is a competent major and he or she does not sign the CPOC documents or if he or she is not the contact for monthly phone calls.
	Current Formal Information Documents • A current formal document is less than a year old at the time of CPOC meeting. • An initial CPOC requires all assessments/evaluations and supporting documents from the regional OCDD office in addition to current formal documents. • A CPOC flagged as "Special Needs" requires all of the current formal information documents.
	Is the beneficiary receiving **Special Education** services? Yes or No • If yes, must have current **Individualized Education Plan**.
	Is the beneficiary receiving **Extended Home Health** services? Yes or No • If yes, must have current **Extended Home Health Plan of Care**.
	Is the beneficiary receiving **Pediatric Day Healthcare** services? Yes or No • If yes, must have current **Pediatric Day Healthcare Plan of Care**.

Your signature below indicates that the packet has been reviewed by your agency for completeness and that all required information is being submitted for review by LDH-BHSF.

Signature:_____ Date:_____
SUPPORT COORDINATION AGENCY REPRESENTATIVE