# My Plan

|  |  |  |
| --- | --- | --- |
| Person’s name | icare reference number | Date of birth or age |
|  |  |  |
| Plan number | Plan Period | Plan length (weeks) |
|  | From: Enter a date. To: Enter a date. |  |
| Person’s address |
|  |
| Date of injury | Interim (with end date) or Lifetime |
|  |  |
| Injury type and CANS level or ASIA score (if applicable) |
|  |
| Name of family member or nominated person & contact details | Relationship to person |
|  |  |
| Name of icare contact & contact details |
|  |
| Name of case manager / planning facilitator & contact details |
|  |

## 1. Reflection summary

Capture below, a summary of reflections from your review of the previous plan period. (Summarise the insights gained from your Plan Preparation).

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| --- |
| Consider what has worked well and what has stopped you achieving what you wanted to do. What have you learned about yourself/your abilities and/or your limitations?Notes on reflections: |
|  |

## 2. Aspirations

Think about your hopes for the future and the things you are looking forward to doing or achieving in the future. Thinking about these aspirations can help you decide what you’d like to focus on in your next plan.

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| --- |
| Consider: your injury recovery, work, leisure, family, education, volunteering, interactions with friends, travelling, sport, driving, looking after yourself, looking after your home, involvement with your community. Notes on aspirations: |
|  |
| Would you like support to help you find suitable work or to start getting ready for work or volunteering? If yes, what support do you think you need? If not at the moment, why?  |
|  |
| Are there any important changes coming up in the future that you need to think about as part of your plan?  |
|  |
| Planning facilitator: is there any other relevant information which may have impacted the person’s over-all progress or current situation or that may influence directions in the next plan period, that have not already been noted? (e.g. housing, family relationships, pre-existing conditions) |
|  |

## 3. Review of your previous plan

(This section is not relevant if this is the first plan. Go to section 4)

Note any medical, therapy or progress reports which inform this plan:

|  |  |
| --- | --- |
| Report | Date |
|  |  |

### Goal Ratings:

W: Withdrawn 1. Not Achieved 2. Partially Achieved 3. Achieved

### Strategy Ratings:

W: Withdrawn 1. Not Effective 2. Somewhat Effective 3. Effective

\*include any strategies, supports or new goals that were added since the previous plan

\*\*before starting, copy and paste the following table to match the number of goals you will be reporting on

|  |  |
| --- | --- |
| Goal | Goal rating |
|  |  |
| **Your Strategy Outcomes** – How did you go doing the things you hoped you would do to achieve your goal? | **Agreed strategy rating** |
|  |  |
|  |  |
| **Other Strategy Outcomes –** How did the other strategies and supports go in helping you achieve your goal? | **Agreed strategy rating** |
|  |  |
|  |  |
| **If needed:** person and planning facilitator further comments on over-all progress towards the goal, including barriers/facilitators and implications for the next plan |
|  |

## 4. Priorities for the next plan period

Think about what the main things are you’d like to work on in the next [12] months that will help you achieve your aspirations.

Is there anything that you are not doing that you would like to do? Consider what is stopping you doing these things and how we can plan to over-come these barriers.

### 4.1 Goals & actions

|  |  |
| --- | --- |
| Goal no 1 | Goal: |
| What you’ll do to work towards this goal |
|  |
|  |
|  |
| **What support you’d like to help you achieve this goal** Consider: What will your family do?  What paid supports do you need?  What other non-funded supports will you access? |
| Support type/person | Description of what they will do/how they can help/what program/s you will participate in |
| e.g. Physiotherapy | e.g. To help me get stronger and use my arms better |
|  |  |
|  |  |
| Optional: Further reasoning for supports identified |
|  |

|  |  |
| --- | --- |
| Goal no 2 | Goal: |
| What you’ll do to work towards this goal |
|  |
|  |
|  |
| **What support you’d like to help you achieve this goal** Consider: What will your family do?  What paid supports do you need?  What other non-funded supports will you access? |
| Support type/person | Description of what they will do/how they can help/what program/s you will participate in |
| e.g. Physiotherapy | e.g. To help me get stronger and use my arms better |
|  |  |
|  |  |
| Optional: Further reasoning for supports identified |
|  |

(copy and paste table for as many goals as needed)

## 5. Services summary

### 5.1 Services to achieve goals

NB for each service type, consider related enablers such as report writing and travel

|  |  |  |  |
| --- | --- | --- | --- |
| Service type | Goals this service relates to | Description of hours, frequency and duration, OR flat rate/quote(do not include codes & costs – these are recorded in the Request Sheet) | Total hours for this plan, or quoted flat fee |
| delete this example before completing:physiotherapy  | 2,3 & 5 | 1 x 2hour assessmentfortnightly sessions in clinic for 4months, then monthly 6months (1hr/session)HEP review – 2 x HV @ 90mins/visit1 x 1hr case conferencetravel – 2 x HV @ 1hr/visit2 x progress reports | 2hrs assess18hrs physio2hrs travel2hrs reports |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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## 6. Plan implementation

(To be completed by the planning facilitator/case manager)

Is case management required to help implement this plan?

[ ]  Yes [ ]  No

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| --- |
| If yes, outline case management role and reasons (please focus on role not already included in the Goals tables) |
|  |
| How is the person’s independence, health literacy and self-efficacy being developed, such that they may be able to move towards disengagement from case management? |
|  |

Summary of case manager hours

|  |  |  |  |
| --- | --- | --- | --- |
|  | Hours attached to the goals | Hours attached to plan implementation | Total CM hours for plan |
| **Case Management** |  |  |  |
| **Travel** |  |  |  |
| **Report writing** |  |  |  |
| **Other** |  |  |  |

## 7. Routine/Other services

List any routine assessments, reviews or services which do not directly fit with the goals or implementation (e.g. GP consultations, podiatry, medical specialist reviews, equipment maintenance, person’s travel for appointments).

|  |  |  |
| --- | --- | --- |
| Service | Frequency/date | Provider details |
| Delete this example before completingRehabilitation Specialist Review | 1 per year | Dr X Belamy |
|  |  |  |
|  |  |  |
|  |  |  |
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## 8. Use of My Plan document (Workers Care only)

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| --- | --- |
| I have advised the worker that this document will be provided to their insurer who manages all other aspects of their claim. [ ]  Yes [ ]  No[ ]  The worker has been provided with a copy of/link to *Working together – understanding responsibilities Information Sheet W15*The worker is required to have an Injury Management Plan (IMP) which is provided to the employer (if still involved) and the person’s treating doctor. This Plan is an acceptable IMP. Which of the following is the worker agreeable to?[ ]  The entire document to be provided as their IMP[ ]  From *Section 4: Priorities for the next plan period* of this document] as their IMP[ ]  From *Section 4: Priorities for the next plan period* of this document with the following changes (document in box below) as their IMP

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| --- |
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## 9. Declaration

[ ]  The person has been involved as much as possible in the development of this plan in collaboration with their family member or nominated person and the case manager

[ ]  The person (and their family member or nominated person) agrees with the goals and actions in this plan.

[ ]  The person has been provided with a copy of this plan, or

[ ]  The person has been provided with a copy of their goals and what they are going to do to work towards their goals

**Case Manager/Planning Facilitator**

|  |  |
| --- | --- |
| Name | Date |
|  | Enter a date. |
| Signature |
|  |

NB: Ensure all of the icare funding requests (including routine services) have been entered into the correct “Request for Funding Approval” form

|  |  |  |  |
| --- | --- | --- | --- |
|  | Lifetime CareGPO Box 4052, Sydney, NSW 2001**General Phone Enquiries: 1300 738 586**Email: care-requests@icare.nsw.gov.auwww.icare.nsw.gov.au |  | Workers CareGPO Box 4052, Sydney, NSW 2001**General Phone Enquiries: 1300 738 586**Email: care-requests@icare.nsw.gov.auwww.icare.nsw.gov.au |