1. **Meeting Information**
2. **Member Profile**
3. **Preferences and Strengths**
   1. Medical Supports and Information
   2. Medications
   3. Preventative Screening Services
4. **Individual Setting**
5. **IndividualIZED Goals and Outcomes**
6. **Activities of Daily Living**
7. **Services Authorized**
   1. Paid Services/Supports
   2. Non-Paid Services/Supports
8. **Identification of Risks**
9. **Risk Assessment**
10. **Modifications to the Plan Through Restriction of Member’s Rights**
11. **Action Plan for follow-up**
12. **Informed Consent**
13. **Next Meeting Information**

**Supplemental Documents (discuss/complete as applicable):**

Advance Directives

Advance Directives for Pets

Assisted Living Facility Residency Agreement

Behavioral Health Quarterly Reviews

Behavioral Health Treatment Plan

Community Intervener Member Assessment Tool

Direct Care Service Acknowledgment Form

Emergency Disaster Plan

End of Life Treatment Plan

Home and Community Based Services (HCBS) Needs Tool (HNT)

Managed Risk Agreement

Member Contingency/Back-Up Plan

Self-Directed Attendant Care Forms

Spousal Acknowledgment Form

Uniform Assessment Tool (UAT)

1. **Meeting Information**

Plan Revision Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **I consent to the following individuals to be invited to the planning meeting/be involved in the development of my plan:** | | |
| **Name** | **Attended Meeting** | **Provided Input**  ***(e.g. by phone, email)*** |
|  | Yes  No |  |
|  | Yes  No |  |
|  | Yes  No |  |

Communication Preferences:

Contact Preference (phone, mail, email, other): Best Time to Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spoken Language: Written Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interpreter Needed? \_\_\_\_\_\_\_\_\_\_

Meeting location: \_\_\_\_\_\_

Was the member/Health Care Decision Maker (HCDM) asked to decide when and where the meeting took place?  Yes  No  N/A

Did the member/HCDM consider meeting locations outside of the home?  Yes  No  N/A

If no or N/A, explain why? ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where did the previous meeting take place? \_\_\_\_\_\_

List any changes to the member’s contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Member/Responsible Person Contact Information (if applicable or if information has changed):**

Health Care Decision Maker (HCDM) (If applicable): \_\_\_\_\_\_

Designated Representative (DR) (if applicable):

Power of Attorney (If applicable): \_\_\_\_\_\_\_

Public Fiduciary (If applicable):

Name of Social Security Payee (If applicable):

Serious Mental Illness (SMI) Special Assistance Advocate (if applicable):

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Meeting Notes or Special Considerations:**

1. **Member Profile**

Document brief background of the member’s lived and life experiences (e.g., place of birth, developmental history, education, and employment history, justice system involvement, previous living situations):

**Summary of Discussion:**

Have you served in the military? ☐ Yes ☐ No

How are things going (since we last spoke/last review)? What does a typical day/week look like? What is the best part of your day? What is the hardest part of your day? What can make your day/week go really well? What can make your day/week really challenging?

What can you tell me about your past medical history (medical diagnosis, surgeries, significant

treatments/illnesses, including dates, if possible)?

Have there been any major changes in your life recently (since we last spoke/last review)?

What do you understand about your physical and/or behavioral health from your doctor or service providers?

Is there an area regarding your physical or behavioral health or services and supports related to your health that you want to work towards improving?

Yes  No (if yes note in goal section as appropriate)

**Summary of Discussion:**

1. **Preferences and Strengths**

Documentation shall include key aspects of daily routines and rituals focus on the member’s strengths and interests, outline the member’s reaction to various communication styles, and identify the member’s favorite things to do and experience during the day, as well as experiences that contribute to a bad day.

* *What are you good at? What would others say you are good at? What do others like and admire about you?*
* *Who do you like providing your support? What about them makes them a good supporter/service provider? What is something important about you for us to know?*
* *Are there activities you used to enjoy doing that you can no longer do, but would like to?*
* *What makes you happy currently?*
* *Anything that has happened recently that makes you feel good or proud?*
* *What traditions and practices (e.g., family, cultural, religious.) are important to you?*
* *Do you have any beliefs or preferences that affect the care you receive (e.g., religious or other feelings and beliefs, such as a preference for natural healers)?*
* *Do you have the support available to ensure that your preferences are met?*
* *Do you prefer to do activities alone or interact with people? Do you prefer 1 on 1, small group or large group activities?*
* *What is important for us to know, and your providers to know, about how you communicate?*
* *How do you express yourself? What can we do to make sure that you understand what others are saying to you?*
* *Are you registered to vote? If no, are you interested in registering?*

**For individuals who are unable to express their preferences, the questions about the following may be asked of family members, friends, or others that know the member to help inform personal goal development and/or meaningful day activities.**

* *Marital and Familial history*
* *Employment/Professional/Educational history*
* *Hobbies/Community Involvement/Clubs*
* *Favorite Music Style/Movies/Books/Sports*

**SUMMARY OF DISCUSSION:**

|  |
| --- |
| **Medical Supports and Information** |

The following information may be filled out prior to the meeting, over the phone, or at the meeting, based on member or family preferences. At the planning meeting, you will be asked questions about what supports, and services could assist you (or your family member). For this document, medical support includes health insurance, providers, medications, vision/hearing/speech, medical/adaptive equipment and/or supplies.

**Review Medical Supports and Information for changes:**

Has your Medicare or other health insurance information changed since the last meeting?

Yes  No

**Medicare Or Other Health Insurance:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Medicare**  **or Other Health Insurance** | **Medicare Number or Policy Number** | **MediCare Part A** | **MediCare Part**  **B** | **Medicare PART C** | **MediCare**  **Part D – Plan Name** | **Name of Insured**  *(if member is not primary holder of insurance)* | **Phone Number** |
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Has your medical, dental, or behavioral health provider information changed since the last meeting?

Yes  No

**Medical/Dental/Behavioral Provider Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Provider Name/Address** | **Phone Number** | **Provider Specialty** | **Last Visit** | **Next Visit** | **Transportation or companion care needed?** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Provider Name/Address** | **Phone Number** | **Provider Specialty** | **Last Visit** | **Next Visit** | **Transportation or companion care needed?** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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Do you use alternative, traditional, or holistic healing?  Yes  No

**SUMMARY OF DISCUSSION** (Include effective dates of any changes to insurance coverage or providers):

**ADDITIONAL PROVIDER AND SUPPORT INFORMATION:**

**Review Provider and Support Information for changes:**

Has your provider and support information changed since the last meeting?  Yes  No

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Has provider?** | **Provider Type** | **Provider Agency** | **Provider Name** | **Contact Information** |
| Yes  N/A | Assisted Living Facility |  |  |  |
| Yes  N/A | Behavioral Health Services |  |  |  |
| Yes  N/A | Community Health Representative |  |  |  |
| Yes  N/A | Day Program/Adult Day Health Care |  |  |  |
| Yes  N/A | Direct Care Services\* |  |  |  |
| Yes  N/A | Emergency Alert Service |  |  |  |
| Yes  N/A | Habilitation |  |  |  |
| Yes  N/A | Habilitation Residential (Group Home -GH, Adult Developmental Home -ADH, Child Developmental Home -CDH) |  |  |  |
| Yes  N/A | Hemodialysis |  |  |  |
| Yes  N/A | Home-Delivered Meals |  |  |  |
| Yes  N/A | Hospice/Palliative Care |  |  |  |
| Yes  N/A | Nursing |  |  |  |
| Yes  N/A | Nutrition |  |  |  |
| **Has provider?** | **Provider Type** | **Provider Agency** | **Provider Name** | **Contact Information** |
| Yes  N/A | Occupational Therapy |  |  |  |
| Yes  N/A | Physical Therapy |  |  |  |
| Yes  N/A | Public Health Nurse |  |  |  |
| Yes  N/A | Respite |  |  |  |
| Yes  N/A | Senior Programs |  |  |  |
| Yes  N/A | Skilled Nursing Facility/Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) |  |  |  |
| Yes  N/A | Speech Therapy |  |  |  |
| Yes  N/A | Vocational Rehabilitation |  |  |  |
| Yes  N/A | Work Program |  |  |  |
| Yes  N/A | Other: |  |  |  |

\**Attendant care, Personal care, Homemaker*

|  |
| --- |
| **MEDICATIONS** |

**Review medications for changes:**

Has your medication information changed since the last meeting?  Yes  No

Do you have any allergies *(medication, food, seasonal)?*  Yes  No If yes, describe:

List all current prescribed medications (physical/behavioral health/over the counter /vitamins/supplements). Use additional pages as needed:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of Medication** | **DOSAGE/**  **FREQUENCY** | **Why are you taking this medication?**  **(or BH medication include Drug use type)** | **IS THE MEDICATION EFFECTIVE (Y/N)**  **IF NO, EXPLAIN** | **SIDE EFFECTS (Y/N)**  **IF YES, EXPLAIN** | **PRESCRIBING**  **PHYSICIAN** |
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Where are your prescriptions filled?

Are you taking your medications as prescribed? If not, why? What support/assistance would help you to do so?

|  |
| --- |
| **Vision/Hearing/Speech:** |

How would you describe your vision?

*Check all that apply:*

No problem with vision

Can see adequately with glasses

Mild to moderate vision loss

Vision severely impaired or member is unresponsive to visual cues

Blindness

Needs eye exam

How would you describe your hearing?

*Check all that apply:*

No problem with hearing

Can hear adequately with hearing device

Mild to moderate hearing loss

Hearing severely impaired or member is unresponsive to verbal cues

Deaf

Needs hearing evaluated

Has your medical or adaptive equipment changed since the last meeting?  Yes  No

Do you use an assistive device to accommodate a vision, hearing, or speech impairment?  Yes No

|  |  |  |  |
| --- | --- | --- | --- |
| **Medical or Adaptive Equipment** | **What is the equipment used for?** | **How often is it used?** | **Who is providing equipment?** |
|  |  |  |  |
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Has there been a change to your medical supplies since the last meeting?  Yes  No

List all covered medical supplies:

|  |  |  |
| --- | --- | --- |
| **Medical Supplies** | **What are the supplies used for?** | **How often are they used?** |
|  |  |  |
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Height (inches):  Estimated Date recorded:  Not Available

Weight:  Estimated Date recorded:  Not Available

BMI (pediatric members): Document BMI education for Pediatric members (if applicable):

**Preventative Screening Services**

Have you had any of the following preventive services in the last year?

|  |  |
| --- | --- |
| Annual Eye Exam/Diabetic Retinal Exam (DRE)  Blood Pressure Screening  Cancer Screening  Cervical Screening  Colon Cancer Screening  Dental Exam  Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) (refer to periodicity schedule)  Family Planning Screening  General Health Exam | Hemoglobin A1C (HbA1c)  Hearing Test  Lipid Profile/Cholesterol Screening  Mammogram Screening  Osteoporosis Screening  Prostate Screening  Sexually Transmitted Disease (STD) Education/Awareness/Protection  Other:  Other: |

**SUMMARY OF DISCUSSION**:

Flu Vaccination:  No  Yes Date:

Pneumonia Vaccination:  No  Yes Date:

Have you stayed overnight as a patient in a hospital?  Yes  No

Have you gone to the emergency room for care and were not admitted to the hospital (including 23 hours observation)?  Yes  No If yes, describe frequency and circumstances:

Do you have any surgeries/procedures scheduled for the next six months?  Yes  No

If yes, describe:

If a child, when was the child’s last well visit (EPSDT visit)?

Have you (member) been assessed for the need to receive an SMI Eligibility Determination?

Yes  No  N/A (for members already determined SMI or for whom the member/HCDM has declined the option for SMI designation)

**SUMMARY OF DISCUSSION:**

If determined SMI, has the member been assessed/referred for Special Assistance from the Office of Human Rights (OHR)?

Yes  No If no, explain why:

1. **INDIVIDUAL SETTING**

The setting in which the member resides or receives services is the most integrated and least restrictive setting and affords the member full access to the benefits of community living. Documentation shall reflect the setting is of the individual’s choosing, provides support to the member to integrate into their community of choice as defined by their interests, preferences, abilities and health and safety risks.

**Home Life**

Considerations: Questions should be modified appropriately to ensure age appropriateness and applicability to institutional setting types. For example, questions related to going out and leaving the home may not be applicable to members living in a skilled nursing facility, but other questions regarding visitors, picking staff to provide assistance and activities do apply to these settings.

* *Did you pick where you live?*
* *Did you get to pick the people you live with?*
* *Do you pick who helps you at home?*
* *Are you allowed to eat when and what you want?*
* *Do you have a key to your home?*
* *Can you close and lock your bedroom and bathroom door?*
* *Do you get out of the house and do things? Do you pick what you do when you go out? Are you allowed to leave your home at any time?*
* *Are you able to handle your own finances? Can you get money when you need or want it?*
* *Do you get to visit or meet people who do not live in your home?*
* *Do you decide everyday what you want to do?*
* *Are you able to use the phone without assistance? Do you get to use a phone or computer to talk privately with people that you want to when you want to?*
* *Can you safely and freely move around your home? Are there any concerns with your home life/neighborhood?*
* *Do you want to learn about or visit other potential places to live?*
* Are you currently experiencing any concerns related to food, money, personal safety, housing, or transportation?

|  |
| --- |
| **DIRECTIONS FOR CASE MANAGER**:  If answers to any of the above questions are ‘negative’ as a result of a health and safety risk, with the exception of questions that are not age appropriate or appropriate to the setting (i.e. institutional setting), a risk modification plan must be completed see section entitled ‘Modification to Plan through Restriction of Member’s Rights. If answers to any of the above questions are ‘negative’ and there is no health or safety risks preventing the member from exercising the right, talk with the member about goal setting. |

**SUMMARY OF DISCUSSION:**

**Living Arrangement:**

☐ Lives Alone

☐ Lives with Family/Others

☐ Nursing Facility (NF)

☐ Alternative HCBS Setting

☐ Behavioral Health Facility or Unit

☐ Uncertified Setting

☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe current living/environment conditions:**

Document alternative Home and Community-Based Settings (HCBS) considered by/offered to the member, including information that helped inform the choices selected and decisions made by the member (e.g., preferences, needs, visits to other settings, etc.):

**If member expresses dissatisfaction with current living situation or wants to explore other options:**

Do you have suggestions of what we could work on that could make your living arrangement better?

Yes No (if yes, note in goal section as appropriate)

**DAILY LIFE (PROGRAMS/EMPLOYMENT/EDUCATION)**

**Considerations:** Questions should be modified appropriately to ensure age appropriateness and applicability to institutional setting types. For example, questions related to a program may not be applicable to members living in a skilled nursing facility, but other questions regarding a meaningful day including deciding what to do every day, learning new skills and activities do apply to these settings.

* *What do you do during the day? Do you decide everyday what you want to do?*
* *Are you in school? If not, are you interested in continuing your education?*
* *If you are in school, do you get to decide what you do after school?*
* *What do you want to do for work? Do you want a paying job or a volunteer job? Is anyone currently helping you find a job? If you have a job, are you receiving a paycheck?*
* *Are you interested in improving or learning any new skills related to work, education, hobbies, etc.?*

**For Members in a Day, Adult Day Health Program or Employment Program**

* *Are you in a program during the day? Did you get to pick the program you go to? Do you pick who helps you at the program?*
* *Do you decide everyday what you want to do? Do you get out to do things? Do you get to pick what you do when you go out?*
* *Can you get money when you need or want it for outings or food?*
* *Do you get to visit or meet people who do not participate in your program?*
* *Can you safely and freely move about your program? Do you have any concerns about your program?*
* *Do you want to learn about or visit other potential programs?*
* *Do you have any concerns with how you spend your day? If yes, how would you like to spend your day?*

**Directions for Case Manager:**

If answers to any of the above questions are “negative” because of a health and safety risk, with the exception of questions that are not age appropriate or appropriate to the setting (i.e., institutional setting), a risk modification plan must be completed (see section entitled “Modifications to Plan through Restriction of Member’s Rights). If answers to any of the above questions are “negative” and there are no health or safety risks preventing the member from exercising the right, talk with the member about goal setting.

**Document alternative programs settings considered by/offered to the member including information that helped inform the choices selected and decisions made by the member (e.g., preferences, needs, visits to other settings, etc.):**

**If member expresses dissatisfaction with program or wants to explore other options:**

Do you have suggestions of what we could work on that could make your program (e.g., day/employment/educational program) better?  Yes (*if yes, note in goal section as appropriate*)  No

Does member require assistance with community-based housing, employment and/or education (e.g., Housing Choice Voucher [formerly called HUD Section 8]; Utility Assistance; Vocational Rehabilitation; SSA; AHCCCS Freedom to Work)?  Yes  No

**SUMMARY OF DISCUSSION:**

1. **Individualized Goals and Outcomes**

**Considerations:** *What do you want to start learning/doing now? What is something that interests you that we can help you do? Are you able to be as independent in your personal care and or healthcare as you would like to be? What might help you reach your goals?*

**what area of your life would you like the team to support you in**?(*Goals are listed in order of priority. Use additional pages as needed and number each goal accordingly*).

Health  Home Life  Daily Life

|  |  |
| --- | --- |
| **Goal #1:** | |
| **Outcome:** | |
| Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)? | |
| What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.)? The case manager should document members’ active participation in goal progress or achievement. | |
| A. | |
| B. | |
| C. | |
| **Who will do:** | **When?** |
| A. |  |
| B. |  |
| C. |  |
| **Progress on Goal**  ***(Include progress updates from all planning team members and action items)*** | |
|  | |

**Is there another area of your life that you would like to work on?**

Health  Home Life  Daily Life

|  |  |
| --- | --- |
| **Goal #2:** | |
| **Outcome:** | |
| Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)? | |
| What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? The case manager shall document members active participation in goal progress or achievement. | |
| A. | |
| B. | |
| C. | |
| **Who will do:** | **When?** |
| A. |  |
| B. |  |
| C. |  |

|  |
| --- |
| **Progress on Goal**  ***(Include progress updates from all planning team members and action items)*** |
|  |

1. **Activities of Daily Living**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Mobility** | Independent | | Minimal | Moderate | | Maximum |
| **Transferring** | Independent | | Minimal | Moderate | | Maximum |
| **Bathing** | Independent | | Minimal | Moderate | | Maximum |
| **Dressing** | Independent | | Minimal | Moderate | | Maximum |
| **Grooming** | Independent | | Minimal | Moderate | | Maximum |
| **Eating** | Independent | | Minimal | Moderate | | Maximum |
| **Toileting** | Independent | | Minimal | Moderate | | Maximum |
| **Continent of Bladder** | No | | Partial | | Yes | |
| **Continent of Bowel** | No | | Partial | | Yes | |
| **Behaviors** | No | Yes | **Type/Frequency (including interventions):** | | | |

1. **Services Authorized**

|  |
| --- |
| **Paid services/Supports** |

Documentation shall contain confirmation that all services are being received as scheduled and address any gaps in services if they exist. If gaps are identified the team should develop a plan to assure that authorized services are being received. Document member’s satisfaction with long-term care services and providers.

Are you satisfied with the current long-term care services and supports? Do your current services meet your support needs? Are you satisfied with the providers? Have there been any gaps in services? What support do you need from your provider (s) to help accomplish your personal goals?

**For individuals living in their own home, ensure all service models have been discussed using ALTCS Member Service Options Decision Tree.**

**For members who have chosen the Agency with Choice or Self-Directed Attendant Care option, ask the following questions to help assess whether or not they are fulfilling their respective roles and responsibilities and/or if they need additional support including member-training services that may be authorized.**

*Do you understand your roles and responsibilities? Are you satisfied with the support you receive from the provider agency (or Fiscal Employer Agent) to help you direct and manage your care? Do you need some additional training to assist you in directing/managing your own care?*

**SUMMARY OF DISCUSSION:**

|  |
| --- |
| **Service Model Selected** |

☐ Traditional ☐ Agency with Choice ☐ Independent Provider (DDD)

☐ Self-Directed Attendant Care ☐ Spousal Attendant Care  N/A

|  |
| --- |
| **Non-Paid Services/SupportS** |

Documentation shall reflect the unpaid supports that will assist the member to achieve goals, and the provider of those services and supports including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of ALTCS HCBS paid services. *Informal/natural supports must be indicated on the HNT, as applicable.*

Are people assisting you who are not paid to do so? Are you satisfied with how they are helping you? Do you feel these supports help you to be able to do more? Go out places? Are you currently utilizing community resources? What support do you need from a natural support to help accomplish your personal goals?

**List out non-paid “natural supports” involved in member’s life:**

**Document community resources discussed:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **ALTCS Services** | | | | | |
| **Service & Provider** | **Service Frequency in place prior to this assessment** | **Service Frequency currently assessed** | **Service Change** | **Start/End Date** | **Member/HCDM** |
|  |  |  | ☐ None ☐ New ☐ Increase  ☐ Reduce ☐ Terminate  ☐ Suspend ☐ Retroactive |  | Agree  Disagree |
|  |  |  | ☐ None ☐ New ☐ Increase  ☐ Reduce ☐ Terminate  ☐ Suspend ☐ Retroactive |  | Agree  Disagree |
|  |  |  | ☐ None ☐ New ☐ Increase  ☐ Reduce ☐ Terminate  ☐ Suspend ☐ Retroactive |  | Agree  Disagree |
|  |  |  | ☐ None ☐ New ☐ Increase  ☐ Reduce ☐ Terminate  ☐ Suspend ☐ Retroactive |  | Agree  Disagree |
|  |  |  | ☐ None ☐ New ☐ Increase  ☐ Reduce ☐ Terminate  ☐ Suspend ☐ Retroactive |  | Agree  Disagree |

|  |  |  |
| --- | --- | --- |
| **List all non-ALTCS Funded Services Provided by Payer Source *(i.e. Medicare)*** | | |
| **Non-ALTCS Funded Service** | **Responsible Party/Payer Source** | **Approximate Service Frequency**  ***(example: daily, weekly, monthly)*** |
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1. **Identification of Risks**

The following shall be used to identify risks that compromise the individual’s general health condition and quality of life.

**Every individual must be assessed for Risk.**

* Indicate the following, as applicable, next to each risk identified below: **EM** (Effectively Managed); **FA** (Further Assessment); **RR** (Rights Restricted); **MRA** (Managed Risk Agreement)
* Consider normal and unusual risks for the individual in various areas of the person’s life.
* When risks are identified, the team will look for the factors that lead to the risk.
* The team then develops countermeasures and interventions to minimize or prevent the risk.

|  |  |  |
| --- | --- | --- |
| **Health And Medical Risks**  Allergies \_\_\_\_\_\_\_  Aspiration and\or pneumonia infection \_\_\_\_\_\_\_\_  Choking \_\_\_\_\_\_\_\_  Constipation \_\_\_\_\_\_\_\_  Dehydration \_\_\_\_\_\_\_\_  Diabetes \_\_\_\_\_\_\_\_  Dietary \_\_\_\_\_\_\_\_  End Stage Renal Disease (ESRD) or on dialysis \_\_\_\_\_\_\_\_  Feeding Tube \_\_\_\_\_\_\_\_  Heart problems; high or low blood  pressure \_\_\_\_\_\_\_\_  Hepatitis C \_\_\_\_\_\_\_\_  Medical Restrictions \_\_\_\_\_\_\_\_  Oxygen use \_\_\_\_\_\_\_\_  Pregnancy \_\_\_\_\_\_\_\_  Refusing medical care \_\_\_\_\_\_\_  Seizures \_\_\_\_\_\_\_\_  Serious or chronic health condition(s)  \_\_\_\_\_\_\_\_  Skin breakdown \_\_\_\_\_\_\_\_  Unreported/reported illness \_\_\_\_\_\_\_\_  Unreported/reported pain \_\_\_\_\_\_\_\_  Unsafe medication management  \_\_\_\_\_\_\_  Ventilator/Trach dependent \_\_\_\_\_\_  Other Health or Medical Risks:  \_\_\_\_\_  **Safety And Self-Help Risks**  Access to bodies of water \_\_\_\_\_\_\_  Access to medication \_\_\_\_\_\_\_\_  Court involvement\* \_\_\_\_\_\_\_\_ | Does not or cannot evacuate a home  or vehicle in an emergency \_\_\_\_\_\_\_\_  Exploitation \_\_\_\_\_\_\_\_  Falls \_\_\_\_\_\_\_\_  Household chemical safety \_\_\_\_\_\_  Lack of fire safety skills \_\_\_\_\_\_\_\_  Lack of judgment or difficulty  understanding consequences  \_\_\_\_\_\_\_\_  Lack of supervision \_\_\_\_\_\_\_\_  Memory loss \_\_\_\_\_\_\_\_  Mobility or ambulation \_\_\_\_\_\_\_\_  Safety and cleanliness of residence  \_\_\_\_\_\_\_\_  Vehicle safety \_\_\_\_\_\_\_\_  Water temperature \_\_\_\_\_\_\_\_  Other safety or self-help risks:  \_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Mental Health, Behavioral And Lifestyle Risks**  Attempted Suicide \_\_\_\_\_\_\_\_  Court involvement\* \_\_\_\_\_\_\_\_  Expressed Suicidal Thoughts  \_\_\_\_\_\_\_\_  Extreme food or liquid seeking  behavior \_\_\_\_\_\_\_\_  Harm to animals \_\_\_\_\_\_\_\_  High risk or illegal sexual behavior  \_\_\_\_\_\_\_\_  Illegal behavior \_\_\_\_\_\_\_\_  Inappropriate sexual behavior \_\_\_\_\_\_\_\_  Invades personal space \_\_\_\_\_\_\_\_  Isolation/isolating behavior \_\_\_\_\_ | Military Service/Veteran related illness or injury  \_\_\_\_\_\_\_\_  Other Mental Health, Behavioral or Lifestyle Risks: (loss of loved one, feeling sad, angry, or otherwise “not yourself”?):  \_\_\_\_\_\_\_\_  Past or potential police/justice involvement  \_\_\_\_\_\_\_\_  Physical aggression \_\_\_\_\_\_\_\_  Placing in mouth, or ingesting non-edible objects or PICA \_\_\_\_\_\_\_\_  Property destruction \_\_\_\_\_\_\_\_  Self-abusive behaviors \_\_\_\_\_\_\_\_  Smoking/vaping \_\_\_\_\_\_\_\_  Substance use: drug, alcohol or other\_\_\_\_\_\_\_\_  Traumatic illness/injury  Unsafe use of flammable materials \_\_\_\_\_\_  Use of objects as weapons  \_\_\_\_\_\_\_\_  Wandering or Exit seeking behavior \_\_\_\_\_\_\_\_  **Financial Risks**  Financial exploitation or abuse\_\_\_\_\_\_\_\_  Lack of individual  resources\_\_\_\_\_\_\_\_  Other Financial Risk:      *\* Can include court ordered protections, restrictions, and treatment* |

1. **Risk Assessment**

This section is applicable if the member's Rights are Restricted (RR) or if Effectively Managed (EM) but needs to be maintained to continue to minimize or eliminate the risk. If a risk is identified as EM, documentation shall include a description of how the risk is being effectively managed. The Risk Assessment will include information to identify what will be done differently to minimize or eliminate the risk. The Risk Assessment document should be easy to understand, simple, straightforward, visible, and readily available to the staff working directly with the individual. It is designed to assist direct support staff in safeguarding the member from identified risks.

|  |  |
| --- | --- |
| **What is the Risk?** | **Date Identified:** |

|  |
| --- |
| **Describe the Risk. What Does it Look Like for the Member?**  **Frequency? Location? Duration?** |

|  |
| --- |
| **List the Factors Contributing to Risk** |

|  |
| --- |
| **What is currently Working to Prevent the Risk/How is risk being effectively managed?**  **(Interventions that are Working and Not Working)?** |

|  |  |
| --- | --- |
| **What is the Risk?** | **Date Identified:** |

|  |
| --- |
| **DESCRIBE THE RISK. What Does it Look Like for the Member? Frequency? Location? Duration?** |

|  |
| --- |
| **List the Factors Contributing to Risk** |

|  |
| --- |
| **What is currently Working to Prevent the Risk/HOW IS RISK BEING EFFECTIVELY MANAGED?**  ***(Interventions that are Working and Not Working)?*** |

1. **Modifications to Plan Through Restriction of Member’s Rights**

This section is only applicable if a member’s rights are being restricted. Decisions regarding necessary modification of conditions related to home and community-based settings must be made with the member/HCDM prior to being implemented. Modification made to this plan by the planning team cannot be made without the member/HCDM’s involvement.

**Describe the modification to the plan that is restricting the member’s rights:**

**Identify the specific and individualized need that has been identified through the assessments of functionalized need (UAT, HCBS NEEDS TOOL, RISK ASSESSMENT TOOL):**

**Document the positive interventions and supports used prior to any modifications to the person-Centered Service Plan (PCSP):**

**Document less intrusive methods of meeting the need that have been tried but did not work:**

**Include a clear description of the condition that is directly proportionate to the specific assessed need:**

**Include a timeline for the regular collection and review of data to measure the ongoing effectiveness of the modification:**

**Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated:**

**Describe the assurance that the interventions and supports will cause no harm to the individual:**

1. **Action Plan for Follow-Up**

Documentation must reflect the individuals responsible for monitoring the PCSP. Action plan items should focus on measurable steps that will need to be taken to reach desired outcomes in the member’s life. These items may be related to a member’s goals or other areas that need to be addressed and followed up on.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **No.** | **Action to Be Taken** | **Person Responsible** | **Due Date *(Target)*** | **Follow Up Date** | **Date Complete** | **Comments** |
| **1** |  |  |  |  |  |  |
| **2** |  |  |  |  |  |  |
| **3** |  |  |  |  |  |  |
| **4** |  |  |  |  |  |  |
| **5** |  |  |  |  |  |  |
| **6** |  |  |  |  |  |  |
| **7** |  |  |  |  |  |  |
| **8** |  |  |  |  |  |  |
| **9** |  |  |  |  |  |  |
| **10** |  |  |  |  |  |  |
| **11** |  |  |  |  |  |  |
| **12** |  |  |  |  |  |  |

1. **Informed Consent**

Documentation must show that the PCSP is finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. An electronic signature in lieu of a wet signature is an acceptable method for obtaining consent and/or acknowledgement. My providers must receive a copy of the portions of the PCSP that explain how I want my services delivered and any restrictions agreed to by the PCSP team.

My case manager has provided me with information about fraud, waste, and abuse, including how to report abuse, neglect, exploitation, and other critical incidents.

My PCSP has been reviewed with me by my case manager. I know what services I will be getting and how often. All changes in the services I was getting have been explained to me. I have marked my agreement and/or disagreement with each service authorized in this plan. I know that any reductions, terminations, or suspensions (stopping for a set time frame) of my current services will begin no earlier than 10 days from the date of this plan. I know that I can ask for this to be sooner.

If I do not agree with some or all the services that have been authorized in this plan, I have noted that in this plan. I know that my case manager will send me a letter that tells me why the service(s) I asked for was denied, reduced, suspended, or terminated. The letter will tell me how to appeal the decision that has been made about my services. The letter will also tell me how I can receive continued services.

My case manager has told me how the appeal process works. I know how I can appeal service changes I do not agree with. I know that I can change my mind later about the services I agree with today. I know that if I change my mind before the changes go into effect, I will get a letter that tells me the reason my services changed. The letter will also tell me about my appeal rights, including how to receive continued services.

I know that I can ask for another PCSP meeting to go over my needs and any changes to this plan that are needed. I can contact my ALTCS Case Manager at . I also know that I can contact my Case Manager at any time to discuss questions, issues, and/or concerns that I may have regarding my services and/or related to fraud, waste, and abuse.

My Case Manager will contact me within 3 working days. Once I have talked with my Case Manager, he/she will give me a decision about that request within 14 days. If the Case Manager is not able to make a decision about my request within 14 days, s/he will send me a letter to let me know more time is needed to make a decision.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| *Member/Health Care Decision Maker Signature* |  | *Date* |
|  |  |  |
| *Individual Representation Signature (Agency with Choice Only)* |  | *Date* |
|  |  |  |
| *Case Manager/Support Coordinator Signature* |  | *Date* |

**Other Attendees Responsible for Plan Implementation:**

|  |  |  |  |
| --- | --- | --- | --- |
| *NAME* | *SIGNATURE* | *NAME OF AGENCY/RELATIONSHIP* | *Date* |
| *NAME* | *SIGNATURE* | *NAME OF AGENCY/RELATIONSHIP* | *Date* |
| *NAME* | *SIGNATURE* | *NAME OF AGENCY/RELATIONSHIP* | *Date* |

|  |
| --- |
| **With Whom And What Parts Of Your PCSP Would You Like Shared In Order To Promote Coordination Of Care? (E.G. Service Providers, Primary Care Physician)** |

**Case Manager/ Support Coordinators:** *A copy of the PCSP shall be provided to the member/HCDM and providers, as well as all parties involved in development of the PCSP (as consented to by the member/HCDM below). The PCSP shall be signed by the member/HCDM, as well as all other attendees responsible for the implementation of this plan. Document when the PCSP was sent to the Member, and/or the HCDM, and other people involved in the plan.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| I, |  | | hereby consent to the release of the following information from my | | |
| My PCSP or section(s) of my plan with the following individuals: | | | | | |
| **Name** | | **Relationship to Member** | | **Only The Following Information Can Be Release Under This Consent:** | **Date Sent** |
|  | |  | | Entire Plan  Member Profile  Individual Setting  Strengths/Preferences  Individual Goals/Outcomes  Services Authorized ☐Risks  Modifications to Plan  Action Plan |  |
|  | |  | | Entire Plan  Member Profile  Individual Setting  Strengths/Preferences  Individual Goals/Outcomes  Services Authorized  Risks  Modifications to Plan  Action Plan |  |
|  | |  | | Entire Plan  Member Profile  Individual Setting  Strengths/Preferences  Individual Goals/Outcomes  Services Authorized  Risks  Modifications to Plan  Action Plan |  |
|  | |  | | Entire Plan  Member Profile  Individual Setting  Strengths/Preferences  Individual Goals/Outcomes  Services Authorized  Risks  Modifications to Plan  Action Plan |  |
|  | |  | | Entire Plan  Member Profile  Individual Setting  Strengths/Preferences  Individual Goals/Outcomes  Services Authorized ☐Risks  Modifications to Plan  Action Plan |  |

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| --- |
| **Acknowledgment of Member Rights and Responsibilities** |

I (or my HCDM), , have received a copy of the Long-Term Care Member Handbook. I (or my HCDM have reviewed the “Member Rights and Responsibilities” with my case manager. My case manager has addressed any questions and concerns that I (or my designee) had.  Yes  No

|  |  |  |
| --- | --- | --- |
|  |  |  |
| *Member / Health Care Decision Maker’s Signature* |  | *Date* |

1. **Next Meeting Information**

**Next Review Date (*check one*):**

Not to exceed 90 days (HCBS)

Not to exceed 180 days (Nursing Facility, ICF-ID, or DDD Group Home)

Annual (Acute Care Only)

Date of Next Meeting:

Time:

Meeting Location/Address:

|  |
| --- |
| **For Case Manager Use Only** |

**Placement:** ☐ D ☐ H ☐ Q ☐ Z

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Major Diagnosis**  **(*must have at least one but allow up to three*)** | | | | | |
| **Chronic Disease** | |  | **Intellectual/Developmental Disability** | | |
|  |  |  |  |  |  |
|  | Dementia/Alzheimer’s |  |  | Neurodevelopmental Disorder |  |
|  | Other Neurological |  |  | Autism Spectrum Disorder |  |
|  | Head/Spinal Cord Injuries |  |  | Cerebral Palsy |  |
|  | Metabolic |  |  | Down Syndrome |  |
|  | Cardiovascular |  |  | Fetal Alcohol Syndrome |  |
|  | Musculoskeletal |  |  | Prader-Willi Syndrome |  |
|  | Respiratory |  |  | Spina Bifida |  |
|  | Hematologic/Oncologic |  |  | Tourette Syndrome |  |
|  | Psychiatric |  |  | Other; If other, specify: |  |
|  | Gastrointestinal |  |  |  |  |
|  | Genitourinary |  |  |  |  |
|  | Skin Conditions |  |  |  |  |
|  | Sensory |  |  |  |  |
|  | Infectious diseases |  |  |  |  |
|  | Seizure Disorder/Epilepsy |  |  |  |  |
|  | Congenital anomalies/Developmental Conditions |  |  |  |  |
|  | Other; If other, specify: |  |  |  |  |
|  |  |  |  |  |  |
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**Did member choose Agency with Choice for in-home services?** *(Attendant Care, Personal Care, Homemaker or Habilitation)*  Yes  No

**Did member choose Self-Directed Attendant Care?**  Yes  No

**What is member’s employment status?**

Retired

No Work History

Some Work History

Currently Employed Full Time

Currently Employed Part Time

Currently Seeking Employment

**What is member’s highest educational level?**

Attended Grade/Elementary School

Some High School

Graduated High School/GED

Some College/Technical School

Completed Technical School program

Bachelor’s Degree

Associates Degree

Graduate College Degree (Masters, Doctorate)

Considering/Interested in returning to school

**What is member’s current Level of Care?**

Class 1

Class 2

Class 3

Wandering/Dementia

Behavioral

Sub-Acute Medical

Respiratory/Vent

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are any of the medications listed under the medications section Antipsychotics?**

Yes  No

**Member’s Assigned Behavioral Health Code: \_\_\_\_\_\_**

**Behavioral Health Treatment Plan:**

Yes  No

**SUMMARY OF DISCUSSION:**

**Court Ordered Treatment (COT):**

Yes  No

**SUMMARY OF DISCUSSION:**

**Orientation/Memory:**

Check the following as they apply to the member’s Orientation/Memory:

Check as many as apply:

Appropriate

Alert

Forgetful

Lethargic

Confused

Unresponsive

Incoherent

Oriented to Person

Oriented to Place

Oriented to Time/Day

**Oriented X:**

1 ☐ 2 ☐ 3