

**1620 A - INITIAL CONTACT/VISIT STANDARD**

EFFECTIVE DATE: 02/14/96, 10/01/17, 06/01/21

APPROVAL DATE: 10/01/04, 02/01/05, 09/01/05, 10/01/07, 01/01/11, 05/01/12, 01/01/16,  
07/20/17, 05/28/20**I. PURPOSE**

This Policy applies to ALTCS E/PD, ALTCS DES/DDD (DDD) Contractors, and Fee-For-Service Tribal ALTCS; excluding Federal Emergency Services (FES). (For FES, refer to AMPM Chapter 1100). This Policy establishes an overview of Initial Contact/Visit Standards.

**II. DEFINITIONS**

<b>CASE MANAGERS</b>	Arizona licensed registered nurses in good standing, social workers, or individuals who possess a bachelor's degree in psychology, special education, or counseling and who have at least one year of Case Management experience, or individuals with a minimum of two years' experience in providing Case Management services to individuals who are elderly and/or individuals with physical or developmental disabilities and/or have been determined to have an SMI.
<b>CASE MANAGEMENT</b>	A collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes.
<b>DESIGNATED REPRESENTATIVE</b>	A parent, guardian, relative, advocate, friend, or other person, designated in writing by a client or guardian who, upon the request of the client or guardian, assists the client in protecting the client's rights and voicing the client's service needs as specified in A.A.C. R9-21-101(B).
<b>ENROLLMENT</b>	The process by which an eligible person becomes a member of a Contractor's plan.
<b>HEALTH CARE DECISION MAKER</b>	An individual who is authorized to make health care treatment decisions for the patient. As applicable to the particular situation, this may include a parent of an unemancipated minor or a person lawfully authorized to make health care treatment decisions pursuant to A.R.S. title 14, chapter 5, article 2 or 3; or A.R.S. §§ 8-514.05, 36-3221, 36-3231 or 36-3281.

**PERSON-CENTERED  
SERVICE PLAN  
(PCSP)**

A written plan developed through an assessment of functional need that reflects the services and supports (paid and unpaid) that are important for and important to the member in meeting the identified needs and preferences for the delivery of such services and supports. The Person-Centered Service Plan shall also reflect the member's strengths and preferences that meet the member's social, cultural and linguistic needs, individually identified goals and desired outcomes, and reflect risk factors (including risks to member rights) and measures in place to minimize them, including individualized back-up plans and other strategies as needed.

**PLANNING TEAM**

A defined group of individuals that shall include the member/Health Care Decision Maker and with the member's/Health Care Decision Maker's consent, the member's family, individual representative, Designated Representative, and any individuals important in the member's life, including but not limited to extended family members, friends, service providers, community resource providers, representatives from religious/spiritual organizations, and agents from other service systems like Department of Child Safety (DCS). The size, scope, and intensity of involvement of the team members are determined by the objectives of the Planning Team to best meet the needs and individual goals of the member.

**III. POLICY**

1. Within seven business days of a new member's Arizona Long Term Care Services (ALTCS) Enrollment, the assigned or designated Case Manager shall initiate contact with the member/Health Care Decision Maker and Designated Representative, even when a member is enrolled during a hospital stay. If the member resides in a nursing facility or residential setting or is in an inpatient stay, the contact shall inform the facility of the member's Enrollment. Initial contact may be made via telephone, a face-to-face visit, or by letter if the Case Manager is unable to contact the member by other approaches.
2. An on-site visit to initiate the PCSP shall be completed by the Case Manager within 12 business days of the member's Enrollment. If information obtained during the initial contact or from the Pre-Admission Screening Tool completed by AHCCCS during the eligibility determination indicates the member has more immediate needs for services, the on-site visit should be completed as soon as possible:
  - a. The on-site visit shall be conducted at the member's place of residence or institutional setting for members who are enrolled during a hospital stay in order to develop the member's PCSP. Confirmation of the scheduled on-site visit is recommended prior to the meeting,
  - b. The member shall be present for, and be included in, the on-site visit. The member's Health Care Decision Maker and Designated Representative (as

- applicable) shall be contacted for the PCSP meeting, including establishing service needs and setting goals, if the member is unable to participate,
- c. The member shall be afforded the option to determine whom should be part of the Planning Team. The Case Manager shall engage all members of the Planning Team to participate in the PCSP meeting, to the extent possible, and
  - d. Services shall be initiated within 30 days of the member's Enrollment. Refer to Exhibit 1620-1 for a chart of Case Management Timeframes.
3. In addition to the requirements specified in this Policy for initial contact, on-site review and service initiation, the assigned Case Manager shall also participate in proactive discharge planning and follow up activities for members enrolled during an hospital stay as specified in AMPM Policy 1020. Refer to AMPM Policy 1620-E for requirements regarding on-site reviews following a member's discharge from an inpatient stay in hospital.
  4. If the Case Manager is unable to locate/contact a member via telephone, visit or letter, or through information from the member's relatives, neighbors or others, another letter requesting that the member contact the Case Manager should be left at, or sent to, the member's residence. If there is no contact within 30 calendar days from the member's date of Enrollment, the case shall be referred to the member's ALTCS eligibility worker, via the Electronic Member Change Report (EMCR) process, for potential loss of contact. A hard copy of the EMCR may be found in AMPM Exhibit 1620-2.

Only when AHCCCS/DMPS staff is also unable to contact the member/Health Care Decision Maker or authorized representative, will the process of disenrolling the member be initiated.

5. All contact, whether attempted or successful, regarding an ALTCS member shall be documented in the member's case file.
6. The Case Manager is responsible for explaining the member's rights and responsibilities under the ALTCS program to the member/Health Care Decision Maker and Designated Representative (as applicable), including the procedures for filing a grievance and/or an appeal. A copy of these rights and responsibilities shall also be provided in writing. The member/Health Care Decision Maker shall sign and date a statement indicating receipt of the member rights and responsibilities in writing, that these rights and responsibilities have been explained to them and that they clearly understand them.