PERSON-CENTERED SERVICE PLAN SUPPLEMENT TO THE INDIVIDUALIZED FAMILY SERVICE PLAN

Member Name: Date of Birth: AHCCCS ID #: Date of Meeting:

III. PREFERENCES AND STRENGTHS

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).

REVIEW MEDICAL SUPPORTS AND INFORMATION FOR CHANGES:

Has medical supports information changed since the last meeting? ☐ Yes ☐ No

MEDICARE OR OTHER HEALTH INSURANCE:

Medicare or Other Health Insurance	Medicare Number or Policy Number	MC Part A	MC Part B	MC Part D – Plan Name	Name of Insured *(If member is not primary holder of insurance)*	Phone Number

MEDICAL/DENTAL/BEHAVIORAL PROVIDER INFORMATION:

Provider Name/Address	Phone Number	Provider Specialty	Last Visit	Next Visit	Transportation or Companion Care Needed?

Member Name: Date of Birth: AHCCCS ID #: Date of Meeting:

MEDICAL/DENTAL/BEHAVIORAL PROVIDER INFORMATION *(Continued)*:

Provider Name/Address	Phone Number	Provider Specialty	Last Visit	Next Visit	Transportation or Companion Care Needed?

Do you use alternative, traditional, or holistic healing? ☐ Yes ☐ No

Notes:

Member Name: _____ Date of Birth: _____ AHCCCS ID #: _____ Date of Meeting: _____

ADDITIONAL PROVIDER AND SUPPORT INFORMATION

REVIEW PROVIDER AND SUPPORT INFORMATION FOR CHANGES:

Has additional 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	Hemodialysis			
☐ Yes ☐ N/A	Home-Delivered Meals			
☐ Yes ☐ N/A	Hospice/Palliative Care			
☐ Yes ☐ N/A	Nursing			
☐ Yes ☐ N/A	Nutrition			
☐ 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			
☐ Yes ☐ N/A	Speech Therapy			
☐ Yes ☐ N/A	Vocational Rehabilitation			
☐ Yes ☐ N/A	Work Program			
☐ Yes ☐ N/A	Other:			

Member Name: Date of Birth: AHCCCS ID #: Date of Meeting:

MEDICATIONS

REVIEW MEDICATIONS FOR CHANGES:

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

Do you have any allergies? _____

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

Name of Medication	**Prescribing Physician**	**What is the Medication For?** *For BH Medication Include Psychoactive Drug Use Type: Antidepressant, Antipsychotic, Anxiolytic, Hypnotic, Mood Stabilizer*	**Dosage / Frequency**

Where are prescriptions filled? _____

Are you experiencing any side effects? Explain

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

Member Name: Date of Birth: AHCCCS ID #: Date of Meeting:

VISION/HEARING/SPEECH

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?

Member Name: Date of Birth: AHCCCS ID #: Date of Meeting:

List all covered medical supplies:

Medical Supplies	What are the Supplies Used For?	How Often are They Used?

Height (inches): _____ ☐ Estimated date recorded: _____ ☐ Not Available

Weight: _____ ☐ Estimated date recorded: _____ ☐ Not Available

Body Mass Index (BMI) *(pediatric members)*: _____

Document Body mass index 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/Dilated 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: _____

Notes:

Member Name:	Date of Birth:	AHCCCS ID #:	Date of Meeting:

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:

Member Name: Date of Birth: AHCCCS ID #: Date of Meeting:

VII. SERVICES AUTHORIZED

PAID SUPPORT

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.

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.

Additional notes from discussion:

SERVICE MODEL SELECTED:

☐ Traditional ☐ Agency with Choice ☐ Independent Provider (DDD) ☐ Self-Directed Attendant Care
☐ Spousal Attendant Care ☐ N/A

Member Name: Date of Birth: AHCCCS ID #: Date of Meeting:

NON-PAID SERVICES/SUPPORT

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 Home and Community Based Services (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/ Health Care Decision Maker
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree

Member Name: ______________________ Date of Birth: __________ AHCCCS ID #: ______________________ Date of Meeting: __________

Service & Provider	Service Frequency in Place Prior to This Assessment	Service Frequency Currently Assessed	Service Change	Start/End Date	Member/ Health Care Decision Maker
			☐ 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
			☐ 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

Member Name: Date of Birth: AHCCCS ID #: Date of Meeting:

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)*

Member Name: Date of Birth: AHCCCS ID #: Date of Meeting:

VIII. 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

- ☐ Aspiration and\or pneumonia infection _____
- ☐ Dehydration _____
- ☐ Choking _____
- ☐ Constipation _____
- ☐ Seizure _____
- ☐ Diabetes _____
- ☐ Dietary _____
- ☐ Medical restrictions _____
- ☐ Unsafe medication management _____
- ☐ Feeding tube _____
- ☐ Mobility _____
- ☐ Falling _____
- ☐ Serious or chronic health condition(s) _____
- ☐ Skin breakdown _____
- ☐ Oxygen use _____
- ☐ Ventilator/Trach dependent _____
- ☐ Heart problems; high or low blood pressure _____
- ☐ Allergies _____
- ☐ Unreported/reported pain _____
- ☐ Unreported/reported illness _____
- ☐ Refusing medical care _____
- ☐ Pregnancy _____
- ☐ ESRD or on dialysis _____
- ☐ Hepatitis C _____
- ☐ Other health or medical risks: _____
- ☐ Other health or medical risks: _____
- ☐ Other health or medical risks: _____
- ☐ Other health or medical risks: _____
- ☐ 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 _____
- ☐ Household chemical safety _____
- ☐ Lack of fire safety skills _____
- ☐ Lack of judgment or difficulty understanding consequences _____
- ☐ Lack of supervision _____
- ☐ Memory loss _____
- ☐ Mobility or ambulation _____
- ☐ Falls _____
- ☐ Safety and cleanliness of residence _____
- ☐ Vehicle safety _____
- ☐ Water temperature _____
- ☐ Other safety or self-help risks: _____
- ☐ Other safety or self-help risks: _____
- ☐ Other safety or self-help risks: _____

Member Name: Date of Birth: AHCCCS ID #: Date of Meeting:

MENTAL HEALTH, BEHAVIORAL AND LIFESTYLE RISKS

- ☐ Court involvement* _____
- ☐ Expressed suicidal thoughts _____
- ☐ Attempted suicide _____
- ☐ Extreme food or liquid seeking behavior _____
- ☐ Harm to animals _____
- ☐ High risk or illegal sexual behavior _____
- ☐ Illegal behavior _____
- ☐ Invades personal space _____
- ☐ Isolation/isolating behavior _____
- ☐ Wandering or Exit seeking behavior _____
- ☐ Past or potential police involvement _____
- ☐ Physical aggression _____
- ☐ Placing or ingesting non-edible objects or PICA _____
- ☐ Smoking _____
- ☐ Property destruction _____
- ☐ Self-abusive behaviors _____
- ☐ Substance abuse: drug, alcohol or other _____
- ☐ Inappropriate sexual behavior _____
- ☐ Unsafe use of flammable materials _____
- ☐ Inappropriate sexual behavior _____
- ☐ Unsafe use of flammable materials _____
- ☐ Use of objects as weapons _____
- ☐ Other mental health, behavioral or lifestyle risks: _____
- ☐ Other mental health, behavioral or lifestyle risks: _____
- ☐ Other mental health, behavioral or lifestyle risks: _____
- ☐ Other mental health, behavioral or lifestyle risks: _____
- ☐ Other mental health, behavioral or lifestyle risks: _____
- ☐ Military Service/Veteran _____
- ☐ Other life event risks: _____
- ☐ Other life event risks: _____
- ☐ Other life event risks: _____

FINANCIAL RISKS

- ☐ Financial exploitation or abuse _____
- ☐ Lack of individual resources _____
- ☐ Other financial risk: _____

** Can include court ordered protections, restrictions and treatment*

Member Name: Date of Birth: AHCCCS ID #: Date of Meeting:

IX. 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. 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 (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 (interventions that are working and not working)?

Member Name: Date of Birth: AHCCCS ID #: Date of Meeting:

IX. RISK ASSESSMENT *(Continued)*

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. 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 (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 (interventions that are working and not working)?

Member Name: Date of Birth: AHCCCS ID #: Date of Meeting:

IX. RISK ASSESSMENT *(Continued)*

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. 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 (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 (interventions that are working and not working)?

Member Name: _____ Date of Birth: _____ AHCCCS ID #: _____ Date of Meeting: _____

XI. 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						

Member Name: Date of Birth: AHCCCS ID #: Date of Meeting:

XII. 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.

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 of 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. That 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 DDD Support Coordinator 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 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 DDD Support Coordinator, _____, at _____. I also know that I can contact my DDD Support Coordinator at any time to discuss questions, issues, and/or concerns that I may have regarding my services. My DDD Support Coordinator will contact me within 3 working days. Once I have talked with my DDD Support Coordinator, he/she will give me a decision about that request within 14 days. If the DDD Support Coordinator 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:
Name:	Signature:	Name of Agency/Relationship:	Date:
Name:	Signature:	Name of Agency/Relationship:	Date:
Name:	Signature:	Name of Agency/Relationship:	Date:

Member Name: ______________________ Date of Birth: ____________ AHCCCS ID #: ______________________ Date of Meeting: ____________

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: Document when the PCSP was sent to the Member, Individual Representative and/or the Health Care Decision Maker, and other people involved in the plan.

I, ______________________________________ herby consent to the release of the following information from my PCSP or section(s) of my plan with the following individuals:

Name	Relationship to Member	Only the Following Information Can Be Released Under this Consent:	Date Sent
		☐ Entire Plan ☐ Member Profile ☐ Individual Setting ☐ Strengths/Preferences ☐ Individual Goals/Outcomes ☐ Service Authorized ☐ Risks ☐ Modifications to Plan ☐ Action Plan	
		☐ Entire Plan ☐ Member Profile ☐ Individual Setting ☐ Strengths/Preferences ☐ Individual Goals/Outcomes ☐ Service Authorized ☐ Risks ☐ Modifications to Plan ☐ Action Plan	
		☐ Entire Plan ☐ Member Profile ☐ Individual Setting ☐ Strengths/Preferences ☐ Individual Goals/Outcomes ☐ Service Authorized ☐ Risks ☐ Modifications to Plan ☐ Action Plan	
		☐ Entire Plan ☐ Member Profile ☐ Individual Setting ☐ Strengths/Preferences ☐ Individual Goals/Outcomes ☐ Service Authorized ☐ Risks ☐ Modifications to Plan ☐ Action Plan	
		☐ Entire Plan ☐ Member Profile ☐ Individual Setting ☐ Strengths/Preferences ☐ Individual Goals/Outcomes ☐ Service Authorized ☐ Risks ☐ Modifications to Plan ☐ Action Plan	

ACKNOWLEDGMENT OF MEMBER RIGHTS AND RESPONSIBILITIES

I (or my Health Care Decision Maker), ______________________________________, have received a copy of the Long Term Care Member Handbook I (or my Health Care Decision Maker) 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: ____________