ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

MANAGED RISK AGREEMENT
Services and/or Placement

Member's Name _____ AHCCCS ID NO _____

Support Coordinator's Name _____

Select the condition(s) for which a Managed Risk Agreement is needed

- ☐ Refuses an assessed service: *(List the service)* _____
- ☐ Member's choices create health and safety risks
- ☐ Risk to others as a result of a member's or responsible person's actions or decisions
- ☐ Chooses to not accept an available service (all or in part) or made decisions that impact the member's access to available services
- ☐ Exhibits behavior that puts the ability to access services at risk
- ☐ Other

Provide a detailed description of the condition or situation requiring a Managed Risk Assessment.

List any alternative service or placement options offered. Also indicate the member's or responsible person's choice with regards to options offered. *(If applicable.)*

Describe the plans the member or responsible person has to address the identified risk.

See page 2 for EOE/ADA/LEP/GINA disclosures

Describe Risk associated with the member's or responsible person's decision to refuse an assessed medically necessary service or placement.

Signature acknowledges the information above has been shared with the member or responsible person. The member or responsible person has made arrangements believed by them to be adequate to protect the health and safety of the member. The completed agreement will be maintained in the case file. Should a member or a member's responsible person refuse to sign the Managed Risk Agreement, the Support Coordinator will document "Refused to Sign".

Member's or responsible person's signature _____ Date _____

Signature of the person completing the form (Support Coordinator or District Nurse)

_____ Date _____

Copy: Member or responsible person
Member's file

Instructions for DDD-1530A FORFF
Managed Risk Agreement-Services and/or Placement

This form is completed by the District Nurse and/or the Support Coordinator. When a District Nurse has assessed the member as having skilled nursing needs and the member or responsible person is refusing all or part of the amount of the assessed Skilled Nursing service hours. This form is also used to document member's or responsible person's refusal of alternative services or placement options and/or to document choice to use one service in lieu of the assessed service.

A. Enter the Member's Name.

B. Enter AHCCCS ID Number.

C. Enter the Support Coordinator's Name.

D. Select the condition for which a Managed Risk Agreement is needed. If you check refused assessed service, list the service(s).

E. To the best of your ability, provide a detailed description of why a Managed Risk Agreement is required.
Example: The member has a tracheotomy and is assessed for Nursing. The family wants Attendant Care Instead. The member or responsible person refuses the Nursing and state that they will accept the responsibility of taking care of the member's medical needs.

F. List the alternative services and/or placement options offered to the member or responsible person. Also note the member's or responsible person's choice regarding the options offered.

G. Enter member or responsible person's plan to minimize the risk identified above.

H. To the best of your ability, enter any possible risks associated with the member's or responsible person's decision to not accept services/placement. **Example:** The member may be without paid support for a period of time thus increasing the risk.

I. Obtain signatures as directed. Should a member or a member's responsible person refuste to sign, the Support Coordinator will document "Refused to Sign" on the member's or responsible person's signature line.