ARIZONA DEPARTMENT OF ECONOMIC SECURITY Division of Developmental Disabilities

MANAGED RISK AGREEMENT Services and/or Placement

INSTRUCTIONS

The Support Coordinator or District Nurse shall discuss and complete all applicable sections of this form with the member or the member's responsible person when a condition below is identified. The Support Coordinator shall attach the completed form to the member's Person-Centered Service Plan or Individualized Family Service Plan. If the District Nurse completed the form, she/he will email the form to the Support Coordinator for attachment. Whomever completes this Managed Risk Agreement form shall complete the Managed Risk Agreement section in Focus from the information documented.

SECTION I. MEMBER INFORMATION		
Member's Name (Last, First, M.I.):	Date:	
Date of Birth: AHCC	CS ID:	
Support Coordinator Name:		
SECTIO	N II. INITIAL ASSESSMENT	
Select the condition(s) for which a Manage	ed Risk Agreement is needed:	
Member or responsible person refuses	an offered service (all or in part) or an alternative to an offered	
service. List the service(s):		
Member or responsible person refuses	all offered placement options.	
Member's or responsible person's choic placement, or caregivers.	ces or decisions impact member's access to available services,	
	to not accepting a Vendor Call when the Vendor has confirmed their as outlined in the Vendor Call? Yes No	
If yes, the Vendor Call #:	Service:	
A non-DDD member, exhibits behavior	that puts the ability to provide services to the member at risk.	
<u> </u>	by a District Nurse as needing nursing services and the member or rt) the offered amount of skilled nursing service hours.	

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

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List any alternative service or placement options offered. Also indicate the member's or choice with regards to options offered. (<i>If applicable.</i>)	responsible person's
Describe risk associated with the member's or responsible person's decision to refuse an necessary service or placement.	n assessed medically
Describe the plans the member or responsible person has to address the identified risk.	
Signature acknowledges the information above has been shared with the member or resmember or responsible person has made arrangements believed by them to be adequate and safety of the member. The completed agreement will be maintained in the case file. member's responsible person refuse to sign the Managed Risk Agreement, the Support Nurse will document "Refused to Sign."	e to protect the health Should a member or a
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 DDD-1530A FORFF (5-21) Page 3 of 5

SECTION III. RE-ASSESSMENTS

The person who initiated the Managed Risk Agreement shall conduct a re-assessment of the condition/ situation at future Planning Meetings as long as the Managed Risk Agreement remains in effect.

Date of the re-assessment:	
Have there been any changes to the condition or situation, including the Managed Risk Agreement? Yes No	identified risks, that required the
If yes, document the changes to the condition/situation, member's or medecisions, and/or the identified risks and plans to decrease the risks.	mber's responsible person choices or
,	
	N.
	No
Signature acknowledges the information above has been shared with the member or responsible person has made arrangements believed by ther and safety of the member. The completed agreement will be maintained member's responsible person refuse to sign the Managed Risk Agreeme Nurse will document "Refused to Sign."	n to be adequate to protect the health in the case file. Should a member or a
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

Reassessment #1

Page 4 of 5 DDD-1530A FORFF (5-21) Reassessment #2 Date of the re-assessment: Have there been any changes to the condition or situation, including the identified risks, that required the Managed Risk Agreement? If yes, document the changes to the condition/situation, member's or member's responsible person choices or decisions, and/or the identified risks and plans to decrease the risks. Is the Managed Risk Agreement still needed and in effect? Yes No 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 or District Nurse will document "Refused to Sign." Member's or responsible person's signature: ______ Date: _____

Signature of the person completing the form: ______ Date: ____

Copy: Member or responsible person Member's file

(Support Coordinator or District Nurse)

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Reassessment #3	
Date of the re-assessment:	
Have there been any changes to the condition or situation, including the identified risks, that re Managed Risk Agreement? Yes No	equired the
If yes, document the changes to the condition/situation, member's or member's responsible pedecisions, and/or the identified risks and plans to decrease the risks.	erson choices or
Is the Managed Risk Agreement still needed and in effect? Yes No	
Signature acknowledges the information above has been shared with the member or responsing member or responsible person has made arrangements believed by them to be adequate to pand safety of the member. The completed agreement will be maintained in the case file. Show member's responsible person refuse to sign the Managed Risk Agreement, the Support Coord Nurse will document "Refused to Sign."	rotect the health ld a member or a
Member's or responsible person's signature: Date	e:
Signature of the person completing the form: Date (Support Coordinator or District Nurse)	e:
Copy: Member or responsible person Member's file	

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities Customer Service Center at 1-844-770-9500; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local