ONGOING QUARTERLY PROGRESS REPORT (QPR)
PLAN OF CARE/TREATMENT PLAN: CERTIFICATION/RECERTIFICATION

INSTRUCTIONS: Qualified Vendor/Provider(s) must complete Plan of Care/Treatment Plan to receive authorization to provide therapy services. The Plan of Care must be sent to the member's Primary Care Physician to be certified. If the Plan of Care is the result of a recent evaluation, the provider must send the evaluation and the Certified Plan of Care to the Support Coordinator. ***If you do not have enough space in the specified areas, please include additional content to the addendum page.***

Therapy documentation includes the following: Evaluation of skills and progress meeting priorities and outcomes. Development of home programs and consultation with the member/ family/ other providers. Assisting members to acquire knowledge and skills, to increase or maintain independence, and to promote health and safety. Modeling/ teaching/ coaching parents and/or caregiver's specific techniques and approaches to everyday activities, within a member's routine. Collaboration with all team members/professionals involved in the member's life.

Date Received by Division: _____ Date of Report: _____

MEMBER INFORMATION

Member's Name *(Last, First, M.I.)*: _____

Date of Birth: _____ Assists No.: _____ AHCCCS ID: _____
(mm/dd/yyyy)

Diagnosis: - Choose an item - _____

Date of Initial/Most Recent Therapy Evaluation: _____ Support Coordinator Name: _____
(mm/dd/yyyy)

Responsible Person Name: _____ Relationship to Member: _____

Therapeutic Dosage:
Enter the amount and frequency of the number of visits requested for the duration of the treatment schedule. If a variable, tapering, and/or maintenance dosage schedule is requested within this Plan of Care/Treatment Plan, describe the clinical and functional endpoints expected to be met in the corresponding "Dosage Considerations" section

Amount *(Requested)*: _____ Frequency *(Requested)*: _____

Duration *(If applicable, Requested)*: _____ Total Units: _____

Dosage Considerations *(If applicable, Requested)*: _____

Model of Service *(i.e. Group, 1:1, Co-Treatment)*: _____

Special Considerations:
Enter and describe any additional information of clinical significance about the member's condition and/or comorbidities that would be a barrier to the member's ability to access or benefit from therapy services potentially delaying the estimated functional endpoints for discharge. (*e.g., Emotional/Behavioral Disorders)*

Please see addendum on page 12 to enter additional information
See page 11 for EOE/ADA disclosures

Member's Name: _____ Date of Birth: _____ DX: - Choose an item -

ATTENDANCE FOR SESSIONS
(For Progress Reporting Only)

Number of attended sessions: _____ Number of canceled sessions: _____

Reasons for cancelations:

BACKGROUND INFORMATION

Medical/Therapy History:
Please include medical information such as diagnosis, medications, and other pertinent medical information (i.e. seizures). Also include information regarding the history of therapy services.

Summary of Clinical Findings:
Please provide a summary of evaluation/treatment findings. Please provide any other assessments used to validate the submitted diagnosis code, if necessary and appropriate.

Prognostic Indicators:
List any other barriers that may alter the expected length of treatment. *(e.g., Therapy attendance and home program participation, Member's network of support (e.g., family/caregivers, friends, providers); Age; and, Therapies provided by the school)*

Member's Name: Date of Birth: DX: - Choose an item -

Discharge Criteria: *(ex. Treatment goals and objectives have been met, Skills are within normal and/or functional, limits or baseline levels, The member is unable to tolerate treatment, The member no longer requires skilled therapy services from a qualified Therapy provider, The member and/or caregiver/responsible person is unwilling to participate in treatment, non-compliant or requests discharge, Medical necessity is not established by a qualified healthcare provider, transition to maintenance program)*

INTEGRATED HEALTH CARE INFORMATION/COLLABORATION WITH OTHER PROVIDERS

Description: Include all other providers that you attempted to or did collaborate with over the quarter. This is required at quarterly progress reporting time.

QPR SUMMARY: CLINICAL IMPRESSION AND RECOMMENDATIONS

(For Quarterly Progress Reports Only)

Describe the member's clinical strengths and weaknesses within the QPR period:

- This section may also identify factors that may warrant follow-up through related services *(e.g., additional services, evaluation, etc.)*, or provide any additional information of clinical significance about the member's condition and that would impact the member's ability to access/benefit from therapy services.
- If changes to the member's goals/objective behavior(s) and/or therapy dosage are recommended a new Plan of Care/ Treatment Plan is required.
- If there is a recommended change in the level of service, please provide additional outcomes and/or explanation.

Member's Name: Date of Birth: DX: - Choose an item -

THERAPY GOALS AND OBJECTIVES

1. Goal/Objective Behavior
Include: targeted performance behavior, achievement criteria, and baseline measurement.

Long Term Goal: _____

Short Term Objective Behavior: _____

Date of Quarter 1 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	
Date of Quarter 2 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	
Date of Quarter 3 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

Member's Name: Date of Birth: DX: - Choose an item -

Date of Quarter 4 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

2. Goal/Objective Behavior
Include: targeted performance behavior, achievement criteria, and baseline measurement.

Long Term Goal: _____

Short Term Objective Behavior: _____

Date of Quarter 1 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	
Date of Quarter 2 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

Member's Name: Date of Birth: DX: - Choose an item -

Date of Quarter 3 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	
Date of Quarter 4 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

3. Goal/Objective Behavior
Include: targeted performance behavior, achievement criteria, and baseline measurement.

Long Term Goal: _____

Short Term Objective Behavior: _____

Date of Quarter 1 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

Member's Name: Date of Birth: DX: - Choose an item -

Date of Quarter 2 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	
Date of Quarter 3 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	
Date of Quarter 4 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

Member's Name: Date of Birth: DX: - Choose an item -

4. Goal/Objective Behavior
Include: targeted performance behavior, achievement criteria, and baseline measurement.

Long Term Goal: _____

Short Term Objective Behavior: _____

Date of Quarter 1 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	
Date of Quarter 2 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	
Date of Quarter 3 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

Member's Name: Date of Birth: DX: - Choose an item -

Date of Quarter 4 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

5. Goal/Objective Behavior
Include: targeted performance behavior, achievement criteria, and baseline measurement.

Long Term Goal: _____

Short Term Objective Behavior: _____

Date of Quarter 1 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	
Date of Quarter 2 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

Member's Name: Date of Birth: DX: - Choose an item -

Date of Quarter 3 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	
Date of Quarter 4 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

HOME PROGRAM GOALS AND OBJECTIVES

To maximize the benefit of this service, improve outcomes and adhere to legal liability standards, members/responsible person or other caregivers (paid/unpaid) are required to:

- Be present and actively participate in all therapy sessions; and,
- Carry out the home program.

Goals and/or objectives to support the generalization of therapy skills across settings	**Responsible Person**	**Progress**
1.		- Choose an item -
2.		- Choose an item -
3.		- Choose an item -
4.		- Choose an item -
5.		- Choose an item -

Member's Name: _____ Date of Birth: _____ DX: - Choose an item -

SIGNATURE SECTION: QUALIFIED PROVIDER(S)

Agency Name: _____ Phone Number: _____

1. Provider Name: _____

State of Arizona License No.: _____ NPI No.: _____

Signature *(Include credentials)*: _____ Date: _____

2. Provider Name: _____

State of Arizona License No.: _____ NPI No.: _____

Signature *(Include credentials)*: _____ Date: _____

SIGNATURE/CERTIFICATION SECTION: PRIMARY CARE PROVIDER

I certify that the above services are required and authorized by me and that the plan of care and therapies outlined above are medically necessary for the treatment schedule start and end dates identified on this Plan of Care Document.

My signature below indicates I have no changes to this plan of care.

Return Fax No.: _____ Email: _____

ATTN: _____

Primary Care Provider Name *(Last, First)*: _____

State of Arizona License No.: _____ NPI No.: _____

Signature *(Include credentials)*: _____ Date: _____

Member's Name: Date of Birth: DX: - Choose an item -

ADDENDUM