

## This is the Individualized Family Service Plan (IFSP)

For \_\_\_\_\_ and Family

Interim IFSP

Initial IFSP

Annual IFSP

Date: \_\_\_\_\_

Service Coordinator: \_\_\_\_\_

Team Lead: \_\_\_\_\_

**Our Mission – Early intervention builds upon and provides supports and resources to assist family members and caregivers to enhance children’s learning and development through everyday learning opportunities.**

Periodic Review Date: \_\_\_\_\_

Periodic Review Date: \_\_\_\_\_

Periodic Review Date: \_\_\_\_\_

Periodic Review Date: \_\_\_\_\_

Transition Planning Meeting Date: \_\_\_\_\_

Transition Conference Meeting Date: \_\_\_\_\_

### Child and Family

Child's Name (First, M.I., Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: Female Male Child ID No.: \_\_\_\_\_ AzEIP Eligibility Date: \_\_\_\_\_

Service Coordinator's Name: \_\_\_\_\_ Agency/Program: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Email Address: \_\_\_\_\_

#### With Whom the Child Resides

Parent Family Member Foster Parent Guardian

Name (First, M.I., Last): \_\_\_\_\_

Address (No., Street, City, County, State, ZIP Code): \_\_\_\_\_ Major cross streets or directions to the home: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Email Address: \_\_\_\_\_

Language used by the parent/caregiver: \_\_\_\_\_ Interpreter needed: Yes No If yes, what language? \_\_\_\_\_

School District: \_\_\_\_\_ Date Child is 2.6: \_\_\_\_\_

#### Additional Caregiver/Address

Parent Family Member Guardian

Name (First, M.I., Last): \_\_\_\_\_

Address (No., Street, City, County, State, ZIP Code) **If different than above:** Major cross streets or directions to the home: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Email Address: \_\_\_\_\_

Language used by the parent/caregiver: \_\_\_\_\_ Interpreter needed: Yes No If yes, what language? \_\_\_\_\_

#### Health Information

Primary Care Provider (PCP): \_\_\_\_\_ Phone No.: \_\_\_\_\_

Date vision screening conducted (Vision screening checklist): \_\_\_\_\_ Number of indicators or risk factors checked: \_\_\_\_\_

Comments, next step:

Date hearing screening conducted (Hearing screening tracking form is NOT a hearing screening): \_\_\_\_\_

Results of OAE (or other hearing screening): Left Ear \_\_\_\_\_ Right Ear \_\_\_\_\_

**If a hearing screening has not been conducted within 6 months, strategies to obtain a screening must be included.**

Comments, next step:

Please describe your child's current health status. Include diagnosis (if applicable), specialists involved, serious illnesses, seizures, hospitalizations, and medications taken regularly and how this may be impacting your child's development.

# Individualized Family Service Plan Child and Family Assessment

Child's Name (First, M.I., Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

## Summary of Child Development within Routines and Activities

This Child and Family Assessment will capture all areas of my child's development within the contexts of everyday routines and activities that are important to our family. We will discuss areas that we identify are going well and areas that are not going well, while discussing all areas of my child's development. I can follow along with my copy of the Child and Family Assessment Guide for Families.

Communication      Movement      Thinking/Learning      Social/Behavior      Self-help      Vision      Hearing

### Activity (check one):

Wake up	Dressing	Diapering/Toileting
Mealtime/Snacks	Outings	Play
Bath time	Bedtime/Naps	Other (describe): _____

### How is it going? (check one for each question):

For you?	Going well	Some concerns	A lot of concerns
For your child?	Going well	Some concerns	A lot of concerns
For other caregivers?	Going well	Some concerns	A lot of concerns

### Comments/Details:

1. Who is involved in this activity?

2. What is happening now?

3. Is this an activity in which you would like to receive support from your early intervention team?      Yes      No  
*If yes, what would it look like if it was going well?*

## Individualized Family Service Plan Child and Family Assessment

Child's Name (*First, M.I., Last*): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Summary of Child Development within Routines and Activities

Communication    Movement    Thinking/Learning    Social/Behavior    Self-help    Vision    Hearing

#### Activity (*check one*):

Wake up                      Dressing                      Diapering/Toileting  
Mealtime/Snacks            Outings                      Play  
Bath time                      Bedtime/Naps                Other (*describe*): \_\_\_\_\_

#### How is it going? (*check one for each question*):

For you?	Going well	Some concerns	A lot of concerns
For your child?	Going well	Some concerns	A lot of concerns
For other caregivers?	Going well	Some concerns	A lot of concerns

#### Comments/Details:

1. Who is involved in this activity?

2. What is happening now?

3. Is this an activity in which you would like to receive support from your early intervention team?    Yes    No  
*If yes, what would it look like if it was going well?*

## Individualized Family Service Plan Child and Family Assessment

Child's Name (*First, M.I., Last*): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Summary of Child Development within Routines and Activities

Communication    Movement    Thinking/Learning    Social/Behavior    Self-help    Vision    Hearing

#### Activity (*check one*):

Wake up                      Dressing                      Diapering/Toileting  
Mealtime/Snacks            Outings                      Play  
Bath time                    Bedtime/Naps                Other (*describe*): \_\_\_\_\_

#### How is it going? (*check one for each question*):

For you?	Going well	Some concerns	A lot of concerns
For your child?	Going well	Some concerns	A lot of concerns
For other caregivers?	Going well	Some concerns	A lot of concerns

#### Comments/Details:

1. Who is involved in this activity?

2. What is happening now?

3. Is this an activity in which you would like to receive support from your early intervention team?    Yes    No  
*If yes, what would it look like if it was going well?*

## Individualized Family Service Plan Child and Family Assessment

Child's Name (*First, M.I., Last*): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Summary of Child Development within Routines and Activities

Communication    Movement    Thinking/Learning    Social/Behavior    Self-help    Vision    Hearing

#### Activity (*check one*):

Wake up                      Dressing                      Diapering/Toileting  
Mealtime/Snacks            Outings                      Play  
Bath time                      Bedtime/Naps                Other (*describe*): \_\_\_\_\_

#### How is it going? (*check one for each question*):

For you?	Going well	Some concerns	A lot of concerns
For your child?	Going well	Some concerns	A lot of concerns
For other caregivers?	Going well	Some concerns	A lot of concerns

#### Comments/Details:

1. Who is involved in this activity?

2. What is happening now?

3. Is this an activity in which you would like to receive support from your early intervention team?    Yes    No  
*If yes, what would it look like if it was going well?*



## Child Indicators Summary

Child's Name (First, M.I., Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I-TEAMS ID No.: \_\_\_\_\_ Date of Rating: \_\_\_\_\_ Rating Indicator:    Entry    Exit    Review

Eligibility Categories:    Developmental Delay    Established Condition    Informed Clinical Opinion

IFSP Team Members <i>(Includes anyone contributing to the rating process)</i>	Roles

Sources of Supporting Evidence	Dates

**1. Positive Social Emotional Skills (Including Social Relationships)**

- **Relating with adults**
- **Relating with other children**
- **For older children, following rules related to groups or interacting with others**

1a. To what extent does this child show age-appropriate functioning across a variety of settings and situations on this outcome?

Completely		Sometimes		Emerging		Not Yet
7	6	5	4	3	2	1

1b. Describe skills or behaviors related to positive social-emotional skills (including positive social relationships).

Has the child made progress since the last rating?    Yes    No    N/A



## Child Indicators Summary

Child's Name (First, M.I., Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### 2. Acquiring and Using Knowledge and Skills

- **Thinking, reasoning, remembering, and problem solving**
- **Understanding symbols and language**
- **Understanding the physical and social worlds**

2a. To what extent does this child show age-appropriate functioning across a variety of settings and situations on this outcome?

Completely		Sometimes		Emerging		Not Yet
7	6	5	4	3	2	1

2b. Describe skills or behaviors related to acquiring and using knowledge and skills.

Has the child made progress since the last rating?    Yes    No    N/A

### 3. Taking Appropriate Action to Meet Needs

- **Taking care of basic needs** (e.g. showing interest in eating, dressing, feeding, toileting, etc.)
- **Getting from place to place (mobility) and using tools** (e.g. forks, strings attached to objects)
- **If older than 24 months, contributing to own health and safety** (e.g. follows rules, assists with hand washing, avoids inedible objects)

3a. To what extent does this child show age-appropriate functioning across a variety of settings and situations on this outcome?

Completely		Sometimes		Emerging		Not Yet
7	6	5	4	3	2	1

3b. Describe skills or behaviors related to taking appropriate action to meet needs.

Has the child made progress since the last rating?    Yes    No    N/A

## Individualized Family Service Plan Outcome for Child and Family

Child's Name (*First, M.I., Last*): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Outcome Number: \_\_\_\_\_

**Priority – What priority will this outcome address? (Refer to *Priorities* from the *Child and Family Assessment*)**

**Outcome – What will it look like when things are going well? (Refer to *Summary of Routines and Activities* and/or *Areas of Interest*)**

**Strategies – What specific steps and Natural Resources will help us meet this outcome? (Include people and ideas that will help with this activity or routine – refer to *Natural Resources*)**

### Outcome Status

At each review, as a team, we review this outcome and document the status. The IFSP team has decided to:

Complete    Continue    Discontinue    Revise    Date: \_\_\_\_\_

Describe:

Complete    Continue    Discontinue    Revise    Date: \_\_\_\_\_

Describe:

## Individualized Family Service Plan Outcome for Child and Family

Child's Name (*First, M.I., Last*): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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Describe:

Complete    Continue    Discontinue    Revise    Date: \_\_\_\_\_

Describe:

## Individualized Family Service Plan Outcome for Child and Family

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Outcome Number: \_\_\_\_\_

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Complete    Continue    Discontinue    Revise    Date: \_\_\_\_\_

Describe:

Complete    Continue    Discontinue    Revise    Date: \_\_\_\_\_

Describe:

## Individualized Family Service Plan Outcome for Child and Family

Child's Name (*First, M.I., Last*): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Outcome Number: \_\_\_\_\_

**Priority – What priority will this outcome address? (Refer to *Priorities* from the *Child and Family Assessment*)**

**Outcome – What will it look like when things are going well? (Refer to *Summary of Routines and Activities* and/or *Areas of Interest*)**

**Strategies – What specific steps and Natural Resources will help us meet this outcome? (Include people and ideas that will help with this activity or routine – refer to *Natural Resources*)**

### Outcome Status

At each review, as a team, we review this outcome and document the status. The IFSP team has decided to:

Complete    Continue    Discontinue    Revise    Date: \_\_\_\_\_

Describe:

Complete    Continue    Discontinue    Revise    Date: \_\_\_\_\_

Describe:

## Individualized Family Service Plan Transition

Child's Name (First, M.I., Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

School District: \_\_\_\_\_ AzEIP Eligibility Date: \_\_\_\_\_

Date Transition Planning Meeting Due (Refer to AzEIP Transition Timeline): \_\_\_\_\_ Date Transition Planning Meeting Completed: \_\_\_\_\_

Date Transition Conference Due (Refer to AzEIP Transition Timeline): \_\_\_\_\_ Date Transition Conference Completed: \_\_\_\_\_

**By initialing below, I acknowledge that the Transition Planning Meeting steps needed to support my child and family's transition from early intervention have been discussed:**

\_\_\_\_\_ My Service Coordinator explained that the purpose of the Transition Planning Meeting is to discuss and document all of the necessary steps to ensure my child and family has a smooth transition out of early intervention services at age 3.

\_\_\_\_\_ A vision screening checklist must have been completed within the past 12 months;

\_\_\_\_\_ Date of my child's last vision screening: \_\_\_\_\_

\_\_\_\_\_ A hearing screening must have been completed within the past 12 months;

\_\_\_\_\_ Date of my child's last hearing screening: \_\_\_\_\_

\_\_\_\_\_ If a hearing screening has not been completed within the past 12 months, we will obtain one no later than: \_\_\_\_\_

\_\_\_\_\_ I received information from my Service Coordinator to support me in obtaining a hearing screening for my child.

**My Service Coordinator and team discussed with me the services and supports that may be available to my child and family upon transition out of early intervention services, including tentative timelines, as documented below:**

\_\_\_\_\_ Preschool Options (i.e., developmental preschool, private or community preschools, Head Start): \_\_\_\_\_

\_\_\_\_\_ Community Resources (i.e., home visiting programs, parent support groups or trainings): \_\_\_\_\_

\_\_\_\_\_ Options available through my child's health insurance and/or other public agencies: \_\_\_\_\_

\_\_\_\_\_ My Service Coordinator discussed the need to provide informed consent before sharing information about my child and family with any parties involved with my child's transition process.

My family has the following questions, concerns and priorities regarding transitioning my child from early intervention services:

As a result of these questions, concerns and priorities, IFSP Outcome(s) were specifically developed to support my child and family. Refer to IFSP Outcome(s) number \_\_\_\_\_.

### PEA Notification

\_\_\_\_\_ I understand that my Service Coordinator will provide a notification including demographic information about my child and family to my local school district and the Arizona Department of Education (based on the AzEIP Transition Timeline), unless I opt out of this notification by signing the opt-out portion of the PEA Notification Referral form.

Date PEA Notification sent: \_\_\_\_\_ Date parent opted out of Notification: \_\_\_\_\_

## Individualized Family Service Plan Transition

Child's Name (*First, M.I., Last*): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Transition Conference Planning

\_\_\_\_\_ **I agree** to have a Transition Conference and understand my Service Coordinator must send an invitation to participate to a representative(s) from my local school district. Additionally, I would like the following people and/or programs invited to the Transition Conference:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

\_\_\_\_\_ **I do not agree** to have a Transition Conference and understand my Service Coordinator will not coordinate a meeting with my local school district.

Responsible Party Initials	Additional Activities Prior to Exit:	Date Achieved
	Child Exit Indicator summary completed.	
	My Service Coordinator and team provided me with an AzEIP Family Survey, and explained the importance of completing it.	
	My Service Coordinator provided me a copy of my child's record before exiting early intervention.	
	If my child is eligible for an AHCCCS Health Plan, my child will be referred to AHCCCS for continuum of services after the age of 3.	
	If my child is eligible for DDD, when my child turns 3 my family plans to: Remain enrolled in DDD Withdraw from DDD	
	If my child is not currently eligible for DDD, my Service Coordinator has discussed the DDD eligibility requirements, and my Service Coordinator and family plan to: Complete the DDD application process at this time Not complete the DDD application process at this time	
	Other:	
	Other:	
	Other:	

## Individualized Family Service Plan Services Needed to Make Progress Towards Outcomes

Child's Name (First, M.I., Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Outcome No.	Early Intervention Service	*Intensity	Frequency		Service Setting H = Home C = Community O = Other <i>(If other, complete the justification below)</i>	Method		Duration	
			No. of sessions	No. of minutes per session		TBEIS Identifier	Primary Method	Planned Start Date	Planned End Date
	Service Coordination				H C O				
					H C O				
					H C O				
					H C O				
					H C O				
					H C O				
					H C O				

**Select ONLY one Primary Service Setting:** H C O

*(Primary Setting is the setting in which the infant or toddler receives the most hours of an early intervention service.)*

**\*Intensity:** I = Individual UN = Multiple eligible children (2) UP = Multiple eligible children (3 or more)

### Justification of Early Intervention Outcomes that Cannot be Achieved Satisfactorily in a Natural Environment

Service	Location of Service	Service Provider
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If an early intervention service is not provided in the natural environment, what is the justification for the IFSP team's decision that outcomes cannot be achieved in the natural environment?

Explain how early intervention services will support the child's participation in routines and activities to meet the IFSP outcomes.

Explain the plan and timeline to move services into the natural environment.



## Individualized Family Service Plan Payment Arrangements for Services

Child's Name (First, M.I., Last): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Service Coordinator and family discussed use of family's public and/or private insurance:

Public Insurance:

AHCCCS Complete Care    CHP    AIHP    DDD/ALTCS    EPD/ALTCS    Tricare

Health Plan: \_\_\_\_\_

Private Insurance Plan: \_\_\_\_\_

**(Consent is required before billing public and private insurance)**

Early Intervention Service <i>(no acronyms)</i>	Discipline	*Funding Source(s) <i>(include all that apply)</i>

**\*Funding Source:**

1 = Medicaid (AHCCCS)

4 = Division of Developmental Disabilities (DDD)

2 = Private Insurance (PI)

5 = Arizona Long Term Care System (ALTCS)

3 = Arizona Early Intervention Program (AzEIP)

6 = Arizona State Schools for the Deaf and the Blind (ASDB)

**Other Services (in place or needed)**

Services such as medical, recreational, religious, social and other child related services not required or funded under early intervention, that contribute to this plan.

- Resources your family has that are helpful in meeting the needs of your child/family (e.g., respite, as covered under ALTCS).
- Resources that you are interested in to help your family (e.g., WIC, health care, etc.).

Resource(s), Service(s), and Support(s)	Check if needed	Payment Source	Steps to be Taken <i>(Include person responsible and timeline)</i>

## Individualized Family Service Plan Informed Consent by Parent(s) for Services

Child's Name (*First, M.I., Last*): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**I have participated in the development of this IFSP and understand that I can accept or refuse any or all of the services identified in the IFSP. I understand that my consent for services may be withdrawn at any time. Please initial and sign below.**

\_\_\_\_\_ 1a. I agree with the proposed IFSP as written. I further understand that my signature below indicates that: (a) I have been fully informed of the services being proposed and the reason for the proposal of services; (b) my service coordinator explained my rights under this program; and (c) I give consent to carry out this IFSP as written.

\_\_\_\_\_ 1b. I do not agree with the proposed IFSP as written (*Prior Written Notice form must be completed and given to the family*). However, I do consent to the following services/frequency:

\_\_\_\_\_ 2. My service coordinator explained my rights under this program.  
I  Accept  Decline a written copy of the AzEIP Family Rights Handbook.

\_\_\_\_\_ 3. I have received a copy of the AzEIP Family Survey (*Annual or Transition/Exit IFSP*).

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**In addition to the release of this IFSP to team members, I give my consent for a copy of this IFSP to be sent to the individuals or agencies listed below.**

Name of Individual/Agency ( <i>e.g., pediatrician, Early Head Start program</i> )	Purpose

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**I understand that I have agreed to disclose my IFSP to the person/agency listed above and that person/agency may not disclose this IFSP to anyone else without my consent. This consent is valid for one year unless I revoke it at any time.**



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

### **III. PREFERENCES AND STRENGTHS**

- a. Medical Supports and Information
- b. Medications
- c. Preventative Screening Services

### **VII. SERVICES AUTHORIZED**

- a. Paid Services / Supports
- b. Non-paid Supports

### **VIII. IDENTIFICATION OF RISKS**

### **IX. RISK ASSESSMENT**

### **XI. ACTION PLAN**

### **XII. INFORMED CONSENT**

### **XIII. NEXT MEETING INFORMATION**



Member Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

AHCCCS ID #: \_\_\_\_\_

Date of Meeting: \_\_\_\_\_

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

<b>PROVIDER NAME/ADDRESS</b>	<b>PHONE NUMBER</b>	<b>PROVIDER SPECIALTY</b>	<b>LAST VISIT</b>	<b>NEXT VISIT</b>	<b>TRANSPORTATION OR COMPANION CARE NEEDED?</b>

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

**SUMMARY OF DISCUSSION (Include effective dates of any changes to insurance coverage or providers):**

Member Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

AHCCCS ID #: \_\_\_\_\_

Date of Meeting: \_\_\_\_\_

**Additional Provider and Support Information**

**REVIEW PROVIDER AND SUPPORT INFORMATION FOR CHANGES:**

Has your 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	Habilitation Residential (Group Home – GH, Adult Developmental Home – ADH, Child Developmental Home – CDH)			
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			

Member Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

AHCCCS ID #: \_\_\_\_\_

Date of Meeting: \_\_\_\_\_

Has Provider?		Provider Type	Provider Agency	Provider Name	Contact Information
Yes	N/A	Respite			
Yes	N/A	Senior Programs			
Yes	N/A	Skilled Nursing Facility / Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-ID)			
Yes	N/A	Speech Therapy			
Yes	N/A	Vocational Rehabilitation			
Yes	N/A	Work Program			
Yes	N/A	Other:			

*\*Attendant care, Personal care, Homemaker*





Member Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

AHCCCS ID #: \_\_\_\_\_

Date of Meeting: \_\_\_\_\_

NAME OF MEDICATION	DOSAGE / FREQUENCY	WHY ARE YOU TAKING THIS MEDICATION? <i>(For BH medication include drug use type)</i>	IS THE MEDICATION EFFECTIVE (Y/N) <i>(If no, explain)</i>	SIDE EFFECTS (Y/N) <i>(If yes, explain)</i>	PRESCRIBING PHYSICIAN

Where are your prescriptions filled? \_\_\_\_\_

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: \_\_\_\_\_

MEDICAL OR ADAPTIVE EQUIPMENT	WHAT IS THE EQUIPMENT USED FOR?	HOW OFTEN IS IT USED?	WHO IS PROVIDING EQUIPMENT?

Has there been a change to your medical supplies since the last meeting?    Yes    No

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*): \_\_\_\_\_

Member Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

AHCCCS ID #: \_\_\_\_\_

Date of Meeting: \_\_\_\_\_

**PREVENTATIVE SCREENING SERVICES**

Have you had any of the following preventive services in the last year?

Annual Eye Exam/Dilated Retinal Exam (DRE)

Hemoglobin A1c (HbA1c)

Blood Pressure Screening

Hearing Test

Cancer Screening

Lipid Profile/Cholesterol Screening

Cervical Screening

Mammogram Screening

Colon Cancer Screening

Osteoporosis Screening

Dental Exam

Prostate Screening

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) (*refer to periodicity schedule*)

Sexually Transmitted Disease (STD) Education/Awareness/Protection

Family Planning Screening

Other: \_\_\_\_\_

General Health Exam

Other: \_\_\_\_\_

**SUMMARY OF DISCUSSION:**

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:*

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

Do you have any surgeries/procedures scheduled for the next six months?    Yes    No    *If yes, describe:*

If a child, when was the child's last well visit (EPSDT visit)? \_\_\_\_\_

Have you (member) been assessed for the need to receive an SMI Eligibility Determination?    Yes    No    N/A  
*(for members already determined SMI or for whom the member/HCDM has declined the option for SMI designation)*

SUMMARY OF DISCUSSION:

If SMI determined, has the member been assessed/referred for Special Assistance from the Office of Human Rights (OHR)?    Yes    No    *If no, explain why:*

Member Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

AHCCCS ID #: \_\_\_\_\_

Date of Meeting: \_\_\_\_\_

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## **VII. SERVICES AUTHORIZED**

### **Paid Services / Supports**

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.

Member Name:

Date of Birth:

AHCCCS ID #:

Date of Meeting:

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**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.**

SUMMARY OF 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/ HCDM
			None Increase Terminate Retroactive	New Reduce Suspend		Agree Disagree
			None Increase Terminate Retroactive	New Reduce Suspend		Agree Disagree
			None Increase Terminate Retroactive	New Reduce Suspend		Agree Disagree
			None Increase Terminate Retroactive	New Reduce Suspend		Agree Disagree
			None Increase Terminate Retroactive	New Reduce Suspend		Agree Disagree





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**

Allergies	_____	Unreported/reported illness	_____
Aspiration and/or pneumonia infection	_____	Unreported/reported pain	_____
Choking	_____	Unsafe medication management	_____
Constipation	_____	Ventilator/Trach dependent	_____
Dehydration	_____	Other Health or Medical Risks:	_____
Diabetes	_____		
Dietary	_____	Other Health or Medical Risks:	_____
End Stage Renal Disease (ESRD) or on dialysis	_____		
Feeding Tube	_____	Other Health or Medical Risks:	_____
Heart problems; high or low blood pressure	_____		
Hepatitis C	_____	Other Health or Medical Risks:	_____
Medical Restrictions	_____		
Oxygen use	_____	Other Health or Medical Risks:	_____
Pregnancy	_____		
Refusing medical care	_____	Other Health or Medical Risks:	_____
Seizures	_____		
Serious or chronic health condition(s)	_____	Other Health or Medical Risks:	_____
Skin breakdown	_____		

**Safety and Self-Help Risks**

Access to bodies of water	_____	Mobility or ambulation	_____
Access to medication	_____	Safety and cleanliness of residence	_____
Court involvement*	_____	Vehicle safety	_____
Does not or cannot evacuate a home or vehicle in an emergency	_____	Water temperature	_____
Exploitation	_____	Other Safety or Self-Help Risks:	_____
Falls	_____		
Household chemical safety	_____	Other Safety or Self-Help Risks:	_____
Lack of fire safety skills	_____		
Lack of judgment or difficulty understanding consequences	_____	Other Safety or Self-Help Risks:	_____
Lack of supervision	_____		
Memory loss	_____	Other Safety or Self-Help Risks:	_____

Member Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

AHCCCS ID #: \_\_\_\_\_

Date of Meeting: \_\_\_\_\_

### Mental Health, Behavioral and Lifestyle Risks

Attempted suicide	_____	Substance abuse: drug, alcohol or other	_____
Court involvement*	_____	Traumatic illness/injury	_____
Expressed suicidal thoughts	_____	Unsafe use of flammable materials	_____
Extreme food or liquid seeking behavior	_____	Use of objects as weapons	_____
Harm to animals	_____	Wandering or Exit seeking behavior	_____
High risk or illegal sexual behavior	_____	Other Mental Health, Behavioral or Lifestyle Risks:	_____
Illegal behavior	_____		_____
Inappropriate sexual behavior	_____	Other Mental Health, Behavioral or Lifestyle Risks:	_____
Invades personal space	_____		_____
Isolation/isolating behavior	_____	Other Mental Health, Behavioral or Lifestyle Risks:	_____
Military service/Veteran related illness or injury	_____		_____
Other Mental Health, Behavioral or Lifestyle Risks: <i>(loss of loved one, feeling sad, angry, or otherwise "not yourself"?)</i>	_____	Other Mental Health, Behavioral or Lifestyle Risks:	_____
Past or potential police involvement	_____		_____
Physical aggression	_____	Other Mental Health, Behavioral or Lifestyle Risks:	_____
Placing or ingesting non-edible objects or PICA	_____		_____
Property destruction	_____	Other Mental Health, Behavioral or Lifestyle Risks:	_____
Self-abusive behaviors	_____		_____
Smoking/vaping	_____		_____

### Financial Risks

Financial exploitation or abuse	_____	Other Financial Risk:	_____
Lack of individual resources	_____		_____

\* 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. If a risk is identified as EM, documentation shall include a description of how the risk is being effectively managed. 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/How is risk being effectively managed (*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/How is risk being effectively managed (*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. If a risk is identified as EM, documentation shall include a description of how the risk is being effectively managed. 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/How is risk being effectively managed (*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/How is risk being effectively managed (*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. If a risk is identified as EM, documentation shall include a description of how the risk is being effectively managed. 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/How is risk being effectively managed (*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/How is risk being effectively managed (*interventions that are working and not working*)?



Member Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

AHCCCS ID #: \_\_\_\_\_

**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: \_\_\_\_\_

**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 HCDM, and other people involved in the plan.

I, \_\_\_\_\_ hereby 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 Individual Setting Individual Goals/Outcomes Service Authorized Modifications to Plan	Member Profile Strengths/Preferences Risks Action Plan
		Entire Plan Individual Setting Individual Goals/Outcomes Service Authorized Modifications to Plan	Member Profile Strengths/Preferences Risks Action Plan
		Entire Plan Individual Setting Individual Goals/Outcomes Service Authorized Modifications to Plan	Member Profile Strengths/Preferences Risks Action Plan
		Entire Plan Individual Setting Individual Goals/Outcomes Service Authorized Modifications to Plan	Member Profile Strengths/Preferences Risks Action Plan
		Entire Plan Individual Setting Individual Goals/Outcomes Service Authorized Modifications to Plan	Member Profile Strengths/Preferences Risks Action Plan

Member Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

AHCCCS ID #: \_\_\_\_\_

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**Acknowledgment of Member Rights and Responsibilities**

I (or my HCDM), \_\_\_\_\_, have received a copy of the Long Term Care Member Handbook I (or my HCDM) 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: \_\_\_\_\_

Member Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

AHCCCS ID #: \_\_\_\_\_

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### XIII. NEXT MEETING INFORMATION

**NEXT REVIEW DATE (Check One):**

Not to exceed 90 days (*HCBS*)

Not to exceed 180 days (*Nursing Facility, ICF-ID, or DDD Group Home*)

Annual (*Acute Care Only*)

Date of Next Meeting: \_\_\_\_\_ Time: \_\_\_\_\_

Meeting Location/Address: \_\_\_\_\_