

Arizona Department of Economic Security
Division of Developmental Disabilities

Targeted/DD Only Plan/Review (Age 3 and Above)

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

Date: _____

Member's Guardian or Responsible Party:

Member Assist Number: _____

Have you applied for ALTCS? Yes No

When was the last LTC application submitted? _____

Was there an appeal? Yes No If no, why not?

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

Date: _____

If unlikely to become ALTCS eligible in the future, has the option of case closure been discussed? Yes No If not, provide a summary of the conversation?

Does the member reside in a residential placement?

Yes No

If so, what is the funding source?

Does the member receive any HCBS services? Yes No

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

Date: _____

If so, what is the funding source?

Is an interpreter needed? Yes No

If so, what language? _____

Team Assessment Summary

Summarize the discussion to the following:

What can you share about your past and current medical history?

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

Date: _____

What does your typical day look like?

What is the best part of your day? What is the hardest part of your day? What can make your day/week go well? What can make your day/week challenging?

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

Date: _____

What have you accomplished and/or setbacks since we last spoke?

What can you share about your family, friends and any community resources you are involved with?

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

Date: _____

Do you receive any Behavioral Health Services or Behavioral Health Supports?

Document the meeting type and frequency chosen by the Responsible Person: _____

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

Date: _____

Additional Information

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

Date: _____

Vision of the Future

What I want for my future (*short/long-term goals*):

What my family/guardian wants for my future:

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

Date: _____

Services

List the type and frequency of service(s) the member is receiving:

State-funded Indirect

State-funded Indirect

State-funded Indirect

State-funded Indirect

Action Items

Any follow-up needed: (*please include expected completion date and individual completing task*)

Completed

Completed

Completed

Completed

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

Date: _____

Member's Signature: _____

Date: _____

Responsible Person's Signature: _____

Date: _____

Responsible Person's Signature: _____

Date: _____

Support Coordinator's Signature: _____

Date: _____

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