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? _____

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

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?

See page 5 for EOE/ADA disclosures

Member's Name: _____ 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: _____ Date: _____

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

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

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

Member's Name: _____ Date: _____

Vision of the Future

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

What my family/guardian wants for my future:

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

Additional Information

Member's Name: _____ 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 Signature: _____ Date: _____

Responsible Person's Signature: _____ Date: _____

Responsible Person's Signature: _____ Date: _____

Support Coordinator's Signature: _____ Date: _____