ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

SUPPORTED LIVING PLANNING GUIDE

Date Developed: _____

Purpose: This guide is used to ensure all members and supporting team members understand what their roles and responsibilities are to receive successful supported living service support. The planning guide will be updated with all members when there is a change within the home (e.g. new contracted provider, home relocation, or someone moves in or out).

Home Address: _____ Home Name: _____

DDD Contracted Provider: _____

DDD Contracted Provider Contact Name: _____ Phone Number: _____

MEMBER	SUPPORT COORDINATOR

TEAM MEMBER'S NAME	RELATIONSHIP TO MEMBER	SIGNATURE

See page 6 for EOE/ADA disclosures

Please review the expectations and responsibilities below for members who reside in Supported Living and their responsible person *(as applicable)*:

- The responsible person's name is on the lease or deed.
- An agreed-upon schedule must be created, followed, and shared with the team. *(This should be in place prior to service starting.)*
- To identify a place to live.
- For paying rent, and all other bills including if a housemate moves out as applicable
- To apply for utilities, and identify any help from the community to pay for all expenses.
- To follow all the terms of the lease agreement.
- Contact the Supported Living vendor and/or Support Coordinator with any concerns about staff.
- Member must be able to self-administer medications or have natural supports to assist with this need. Self-administer means to do or take something yourself that would normally be done or given by someone else (including the management of medical devices).

I. FINANCES AND LEASE	COMMENTS/ACTION ITEMS
A. All member(s) must be on the lease, have lease agreements been signed?	
B. Does the qualified vendor have a role in holding, managing, or assisting the member with money management? If yes, describe what that role looks like, any goals, and if there is any additional documentation associated (i.e. ledgers).	
C. What utilities are shared in the house?	
D. Who is responsible for ensuring the utility is turned on and ongoing payment is made?	
E. Other Comments/Discussion:	

II. FOOD AND HOUSEHOLD	COMMENTS/ACTION ITEMS
A. Describe how often groceries and supplies will need to be purchased.	
B. Will member(s) share groceries or will each member be responsible for their own groceries? Please describe.	
C. Will member(s) share household supplies or will each member be responsible for their own household supplies? Please describe.	

II. FOOD AND HOUSEHOLD	COMMENTS/ACTION ITEMS
D. Will member(s) share hygiene supplies or will each member be responsible for their hygiene supplies? Please describe.	
E. Do member(s) need assistance with planning meals and shopping for groceries and supplies? If yes, describe the level of assistance, any goals, and who will be providing the support.	
F. Do member(s) need assistance with preparing their meals? If yes, describe the level of assistance, any goals, and who will be providing the support.	
G. Do member(s) need assistance with meeting any special diet requirements and/or food restrictions/ food allergies? If yes, describe the level of assistance, any goals, and who will be providing the support.	
H. Do member(s) need assistance with applying for and completing re-determinations for food stamps (if eligible)? If yes, describe the level of assistance, any goals, and who will be providing the support.	
I. Other Comments:	

III. HOUSE MAINTENANCE	COMMENTS/ACTION ITEMS
A. If there is a yard, do members need assistance with yard care? If yes, describe the level of assistance, any goals, and who will be providing the support.	
B. Do member(s) need assistance with maintaining the cleanliness of the home (i.e. disposing of expired food/ products)? If yes, describe the level of assistance, any goals, and who will be providing the support.	
C. Describe the required home maintenance that may be needed (i.e. light bulbs, smoke alarms, air filters, etc.). Do members need assistance with home maintenance? If yes, describe the level of assistance, any goals, and who will be providing the support.	
D. Do member(s) need assistance with communicating with the landlord when needed (i.e. repairs, questions, etc.)? If yes, describe the level of assistance, any goals, and who will be providing the support.	
E. Other Comments:	

* Note: If damage to the residence is caused by the provider, the provider agency is responsible for repairing the damage.

IV. TRANSPORTATION	COMMENTS/ACTION ITEMS
A. Do member(s) need assistance with public transportation (i.e. bus, ride-sharing service, light rail, etc.) to access their community and local events? If yes, describe the level of assistance, any goals, and who will be providing the support.	
B. Do the member(s) have their own vehicle? If yes, please describe any agreements around the use of the vehicle (i.e. drivers, gas, passengers, etc.). If yes, describe the level of assistance, any goals, and who will be providing the support.	
C. If the member(s) are unable to use public transportation or do not have their own vehicle, describe the level of assistance needed to access their community (i.e. gym, local stores, etc.), any goals, and who will be providing the support (i.e. family, friends, etc.)? Note: Please review the Qualified Vendor's policy on Transportation	
D. Other Comments:	

V. SOCIAL NETWORK CONNECTIONS AND HOUSEHOLD AGREEMENTS	COMMENTS/ACTION ITEMS
A. Do member(s) need assistance with maintaining connections to people that are important to them and planning activities inside or outside of the home? If yes, describe the level of assistance, any goals, and who will be providing the support.	
B. Has the team discussed household agreements(i.e. visitors, privacy, household management tasks, etc.)? If yes, who is assisting with the development of the household agreements, and what level of support is needed?	
C. If the member(s) are unable to use public transportation or do not have their own vehicle, describe the level of assistance needed to access their community (i.e. gym, local stores, etc.), any goals, and who will be providing the support (i.e. family, friends, etc.)? Note: Please review the Qualified Vendor's policy on Transportation	
D. Other Comments:	

VI. MEDICAL	COMMENTS/ACTION ITEMS
A. Do the member(s)need assistance with managing their prescribed medication? If yes, describe the level of assistance, any goals, and who will be providing the support.	
B. Do the member(s) need assistance with scheduling medical/dental appointments? If yes, describe the level of assistance, any goals, and who will be providing the support.	
C. Do the member(s) need assistance with therapy appointments? If yes, describe the level of assistance, any goals, and who will be providing the support.	
D. Do Direct Care Workers (DCWs) need additional training to support the member(s) medical needs? If yes, what training is required, describe the level of assistance to the member, any goals, and who will provide the training. Note: DCWs are unable to perform any skilled nursing tasks as outlined in the Division's skilled nursing matrix.	
E. Does medical documentation need to be maintained for each member? If yes, does the member(s) need assistance with maintaining their medical documentation? If yes, describe the level of assistance, any goals, and who will be providing the support.	
F. Do medication logs need to be maintained for each member? If yes, does the member need assistance with maintaining their medication log? If yes, describe the level of assistance, any goals, and who will be providing the support.	
G. Does the member(s) want to have their medical/medication information shared? If yes, who would they like it shared with? Does the member(s) need assistance with sharing their medical/medication information? If yes, describe the level of assistance, any goals, who will be providing the support, and if a HIPAA release is needed.	
H. Do the member(s) require medical supplies? If yes, does the member(s) need assistance with ordering/maintaining their medical supplies? If yes, describe the level of assistance, any goals, and who will be providing the support.	
I. Do the member(s) have any allergies (i.e. Latex, bees, etc.)? If yes, do they need assistance with managing their allergies? If yes, describe the level of assistance, any goals, and who will be providing the support.	
J. Other Comments:	

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