DDD PERSON CENTERED SERVICE PLAN

SUPPLEMENTAL DOCUMENTS *(Discuss/Complete as applicable)*:

- ☐ Advance Directives
- ☐ Advance Directives for Pets
- ☐ Assisted Living Facility Residency Agreement
- ☐ Behavioral Health Quarterly Reviews
- ☐ Community Intervener Member Assessment Tool
- ☐ Direct Care Service Acknowledgment Form
- ☐ Emergency Disaster Plan
- ☐ End of Life Treatment Plan
- ☐ HCBS Needs Tool (HNT)
- ☐ Managed Risk Agreement
- ☐ Member Contingency/Back-Up Plan
- ☐ Self-Directed Attendant Care Forms
- ☐ Spousal Acknowledgment Form
- ☐ Uniform Assessment Tool (UAT)

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

I. MEETING INFORMATION

Plan Revision Date: _____

I consent to the following individuals to be invited to the Planning Meeting/ be involved in the development of my Plan:		
NAME	**ATTEND MEETING**	**PROVIDED INPUT** ***(e.g. by phone, email)***
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Communication Preferences:

Contact Preference *(phone, mail, email, other)*: _____

Best Time to Contact: _____

Spoken Language: _____ Written Language: _____

Interpreter Needed? ☐ Yes ☐ No

Meeting location: _____

Was the member/HCDM asked to decide when and where the meeting took place? ☐ Yes ☐ No ☐ N/A

Did the member/HCDM consider meeting locations outside of the home? ☐ Yes ☐ No ☐ N/A

If no or N/A, explain why? _____

Where did the previous meeting take place? _____

List any changes to the member's contact information:

MEMBER/RESPONSIBLE PERSON CONTACT INFORMATION *(If applicable or if information has changed)*:

Health Care Decision Maker (HCDM) *(if applicable)*: _____

Designated Representative (DR) *(if applicable)*: _____

Power of Attorney *(if applicable)*: _____

Public Fiduciary *(if applicable)*: _____

Name of Social Security Payee *(if applicable)*: _____

Serious Mental Illness (SMI) Special Assistance Advocate *(if applicable)*: _____

Other: _____

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

Meeting notes or special considerations:

II. MEMBER PROFILE

Document brief background of the member's lived and life experiences *(e.g. place of birth, developmental, education, and employment history, justice system involvement, previous living situations)*:

Have you served in the military? ☐ Yes ☐ No

SUMMARY OF DISCUSSION:

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

How are things going *(since we last spoke/last review)*? What does a typical day/week 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 really well? What can make your day/week really challenging?

What can you tell me about your past medical history *(medical diagnosis, surgeries, significant treatments/illnesses, including dates, if possible)*?

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

Have there been any major changes in your life recently *(since we last spoke/last review)*?

What do you understand about your physical and/or behavioral health from your doctor or service providers?

Is there an area regarding your physical or behavioral health or services and supports related to your health that you want to work towards improving? ☐ Yes ☐ No *(If yes note in goal section as appropriate)*

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

III. PREFERENCES AND STRENGTHS

Documentation shall include key aspects of daily routines and rituals focus on the member's strengths and interests, outline the member's reaction to various communication styles, and identify the member's favorite things to do and experience during the day, as well as experiences that contribute to a bad day.

For individuals who are unable to express their preferences, the questions about the following may be asked of family members, friends, or others that know the member to help inform personal goal development and/or meaningful day activities.

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

SUMMARY OF DISCUSSION:

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

Medical Supports and Information

The following information may be filled out prior to the meeting, over the phone, or at the meeting, based on member or family preferences. At the planning meeting, you will be asked questions about what supports and services could assist you (or your family member). For the purpose of this document, medical supports include: health insurance, providers, medications, vision/hearing/speech, medical/adaptive equipment and/or supplies.

REVIEW MEDICAL SUPPORTS AND INFORMATION FOR CHANGES:

Has your Medicare or other health insurance information changed since the last meeting? ☐ Yes ☐ No

MEDICARE OR OTHER HEALTH INSURANCE

MEDICARE OR OTHER HEALTH INSURANCE	MEDICARE NUMBER OR POLICY NUMBER	MEDICARE PART A	MEDICARE PART B	MEDICARE PART C	MEDICARE PART D – PLAN NAME	NAME OF INSURED *(If member is not primary holder of insurance)*	PHONE NUMBER

Has your medical, dental, or behavioral health provider information changed since the last meeting? ☐ Yes ☐ No

MEDICAL/DENTAL/BEHAVIORAL PROVIDER INFORMATION

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

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			

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

HAS PROVIDER?	PROVIDER TYPE	PROVIDER AGENCY	PROVIDER NAME	CONTACT INFORMATION
☐ Yes ☐ N/A	Nursing			
☐ Yes ☐ N/A	Nutrition			
☐ Yes ☐ N/A	Occupational Therapy			
☐ Yes ☐ N/A	Physical Therapy			
☐ Yes ☐ N/A	Public Health Nurse			
☐ 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: _____

Medications

REVIEW MEDICATIONS FOR CHANGES:

Has your medication information changed since the last meeting? ☐ Yes ☐ No

Do you have any allergies (medication, food, seasonal)? ☐ Yes ☐ No *If yes, describe:*

List all current prescribed medications *(physical/behavioral health/ Outpatient Treatment Center (OTC)/vitamins/supplements)*. Use additional pages as needed:

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

Vision/Hearing/Speech

How would you describe your vision?

Check all that apply:

☐ No problem with vision
☐ Can see adequately with glasses
☐ Mild to moderate vision loss
☐ Vision severely impaired or member is unresponsive to visual cues
☐ Blindness
☐ Needs eye exam

How would you describe your hearing?

Check all that apply:

☐ No problem with hearing
☐ Can hear adequately with hearing device
☐ Mild to moderate hearing loss
☐ Hearing severely impaired or member is unresponsive to verbal cues
☐ Deaf
☐ Needs hearing evaluated

Has your medical or adaptive equipment changed since the last meeting? ☐ Yes ☐ No

Do you use an assistive device to accommodate a vision, hearing, or speech impairment? ☐ Yes ☐ No

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

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

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)*: _____

PREVENTATIVE SCREENING SERVICES

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

☐ Annual Eye Exam/Dilated Retinal Exam (DRE)
☐ Blood Pressure Screening
☐ Cancer Screening
☐ Cervical Screening
☐ Colon Cancer Screening
☐ Dental Exam
☐ Early and Periodic Screening, Diagnostic and Treatment (EPSDT) *(refer to periodicity schedule)*
☐ Family Planning Screening
☐ General Health Exam
☐ Hemoglobin A1c (HbA1c)
☐ Hearing Test
☐ Lipid Profile/Cholesterol Screening
☐ Mammogram Screening
☐ Osteoporosis Screening
☐ Prostate Screening
☐ Sexually Transmitted Disease (STD) Education/ Awareness/Protection
☐ Other: _____
☐ Other: _____

SUMMARY OF DISCUSSION**:**

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

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:*

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:

IV. INDIVIDUAL SETTING

The setting in which the member resides or receives services is the most integrated and least restrictive setting and affords the member to have full access to the benefits of community living. Documentation shall reflect the setting is of the individual's choosing, provides support to the member to integrate into their community of choice as defined by their interests, preferences, abilities and health and safety risks.

Home Life

Considerations: Questions should be modified appropriately to ensure age appropriateness and applicability to institutional setting types. For example, questions related to going out and leaving the home may not be applicable to members living in a skilled nursing facility, but other questions regarding visitors, picking staff to provide assistance and activities do apply to these settings.

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

DIRECTIONS FOR CASE MANAGER:

If answers to any of the above questions are 'negative' as a result of a health and safety risk, with the exception of questions that are not age appropriate or appropriate to the setting (i.e. institutional setting), a risk modification plan must be completed *(see section entitled "Modification to Plan through Restriction of Member's Rights")*. If answers to any of the above questions are 'negative' and there is no health or safety risks preventing the member from exercising the right, talk with the member about goal setting.

SUMMARY OF DISCUSSION:

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

LIVING ARRANGEMENT:

☐ Lives Alone
☐ Lives with Family/Others
☐ Nursing Facility (NF)
☐ Alternative HCBS Setting
☐ Behavioral Health Facility (BHF) or Unit
☐ Uncertified Setting
☐ Other _____

Describe current living/environment conditions:

Document alternative Home and Community-Based Settings (HCBS) considered by/offered to the member, including information that helped inform the choices selected and decisions made by the member *(e.g. preferences, needs, visits to other settings, etc.)*:

IF MEMBER EXPRESSES DISSATISFACTION WITH CURRENT LIVING SITUATION OR WANTS TO EXPLORE OTHER OPTIONS:

Do you have suggestions of what we could work on that could make your living arrangement better?

☐ Yes ☐ No *(if yes, note in goal section as appropriate)*

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

Daily Life (Programs/Employment/Education)

Considerations: Questions should be modified appropriately to ensure age appropriateness and applicability to institutional setting types. For example, questions related to a program may not be applicable to members living in a skilled nursing facility, but other questions regarding a meaningful day including deciding what to do every day, learning new skills and activities do apply to these settings.

FOR MEMBERS IN A DAY, ADULT DAY HEALTH PROGRAM OR EMPLOYMENT PROGRAM

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

DIRECTIONS FOR CASE MANAGER:

If answers to any of the above questions are “negative” as a result of a health and safety risk, with the exception of questions that are not age appropriate or appropriate to the setting (i.e. institutional setting), a risk modification plan must be completed *(see section entitled “Modifications to Plan through Restriction of Member’s Rights”)*. If answers to any of the above questions are “negative” and there is no health or safety risks preventing the member from exercising the right, talk with the member about goal setting.

Document alternative programs settings considered by/offered to the member including information that helped inform the choices selected and decisions made by the member (e.g. preferences, needs, visits to other settings, etc.):

IF MEMBER EXPRESSES DISSATISFACTION WITH PROGRAM OR WANTS TO EXPLORE OTHER OPTIONS:

Do you have suggestions of what we could work on that could make your program (e.g., day/employment/educational program) better? ☐ Yes *(if yes, note in goal section as appropriate)* ☐ No

Does member require assistance with community-based housing, employment and/or education (e.g. Housing Choice Voucher [formerly called HUD Section 8]; Utility Assistance; Vocational Rehabilitation; Social Security Administration (SSA); AHCCCS Freedom to Work)? ☐ Yes ☐ No

SUMMARY OF DISCUSSION:

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

V. INDIVIDUALIZED GOALS AND OUTCOMES

Considerations: *What do you want to start learning/doing now? What is something that interests you that we can help you do? Are you able to be as independent in your personal care and or healthcare as you would like to be? What might help you reach your goals?*

WHAT AREA OF YOUR LIFE WOULD YOU LIKE THE TEAM TO SUPPORT YOU IN:

(Goals are listed in order of priority. Use the additional pages as needed and number each goal accordingly)

☐ Health ☐ Home Life ☐ Daily Life

GOAL 1:	
OUTCOME:	
Where are they now *(at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)*?	
What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? *Support Coordinator should document members' active participation in goals progress or achievement.* A. B. C.	
WHO WILL DO:	**WHEN?**
A. B. C.	
PROGRESS ON GOAL *(Include progress updates from all planning team members and action items)*	

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

V. INDIVIDUALIZED GOALS AND OUTCOMES *(Continued)*

Is there another area of your life that you would like to work on? ☐ Health ☐ Home Life ☐ Daily Life

GOAL 2:

OUTCOME:

Where are they now *(at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)*?

What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? *Support Coordinator should document members' active participation in goals progress or achievement.*

A.

B.

C.

WHO WILL DO:	WHEN?
A. B. C.	

PROGRESS ON GOAL
(Include progress updates from all planning team members and action items)

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

V. INDIVIDUALIZED GOALS AND OUTCOMES *(Continued)*

Is there another area of your life that you would like to work on? ☐ Health ☐ Home Life ☐ Daily Life

GOAL 3:	
OUTCOME:	
Where are they now *(at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)*?	
What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? *Support Coordinator should document members' active participation in goals progress or achievement.* A. B. C.	
WHO WILL DO:	**WHEN?**
A. B. C.	
PROGRESS ON GOAL *(Include progress updates from all planning team members and action items)*	

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

V. INDIVIDUALIZED GOALS AND OUTCOMES *(Continued)*

Is there another area of your life that you would like to work on? ☐ Health ☐ Home Life ☐ Daily Life

GOAL 4:

OUTCOME:

Where are they now *(at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)*?

What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? *Support Coordinator should document members' active participation in goals progress or achievement.*

A.

B.

C.

WHO WILL DO:	WHEN?
A. B. C.	

PROGRESS ON GOAL
(Include progress updates from all planning team members and action items)

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

VI. ACTIVITIES OF DAILY LIVING

MOBILITY	☐ Independent	☐ Minimal	☐ Moderate	☐ Maximum
TRANSFERRING	☐ Independent	☐ Minimal	☐ Moderate	☐ Maximum
BATHING	☐ Independent	☐ Minimal	☐ Moderate	☐ Maximum
DRESSING	☐ Independent	☐ Minimal	☐ Moderate	☐ Maximum
GROOMING	☐ Independent	☐ Minimal	☐ Moderate	☐ Maximum
EATING	☐ Independent	☐ Minimal	☐ Moderate	☐ Maximum
TOILETING	☐ Independent	☐ Minimal	☐ Moderate	☐ Maximum
CONTINENT OF BLADDER	☐ No	☐ Partial	☐ Yes	
CONTINENT OF BOWEL	☐ No	☐ Partial	☐ Yes	
BEHAVIORS	☐ No ☐ Yes	**Type/frequency *(including interventions)*:**		

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

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.

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 ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend ☐ Retroactive		☐ Agree ☐ Disagree

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

List All Non-ALTCS Funded Services Provided by Payer Source *(i.e. Medicare)*		
NON-ALTCS FUNDED SERVICE	**RESPONSIBLE PARTY/ PAYER SOURCE**	**APPROXIMATE SERVICE FREQUENCY** ***(Example: Daily, Weekly, Monthly)***

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

Safety and Self-Help Risks

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

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

Mental Health, Behavioral and Lifestyle Risks

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

Financial Risks

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

** 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 #: Date of Meeting:

X. MODIFICATIONS TO PLAN THROUGH RESTRICTION OF MEMBER'S RIGHTS

This section is only applicable if a member's rights are being restricted. Decisions regarding necessary modification of conditions related to home and community-based settings must be made with the member/HCDM prior to being implemented. Modification made to this plan by the planning team cannot be made without the member/HCDM's involvement.

Describe the modification to the plan that is restricting the member's rights:

Identify the specific and individualized need that has been identified through the assessments of functionalized need *(Uniform Assessment Tool (UAT), HCBS Needs tool, Risk Assessment Tool)*:

Document the positive interventions and supports used prior to any modifications to the Person-Centered Service Plan (PCSP):

Document less intrusive methods of meeting the need that have been tried but did not work:

Include a clear description of the condition that is directly proportionate to the specific assessed need:

Include a timeline for the regular collection and review of data to measure the ongoing effectiveness of the modification:

Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated:

Describe the assurance that the interventions and supports will cause no harm to the individual:

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 #:

XII. INFORMED CONSENT

Documentation must show that the PCSP is finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. An electronic signature in lieu of a wet signature is an acceptable method for obtaining consent and/or acknowledgement. My providers must receive a copy of the portions of the PCSP that explain how I want my services delivered and any restrictions agreed to by the PCSP team.

My PCSP has been reviewed with me by my case manager. I know what services I will be getting and how often. All changes in the services I was getting have been explained to me. I have marked my agreement and/or disagreement with each service authorized in this plan. I know that any reductions, terminations or suspensions (stopping for a set time frame) of my current services will begin no earlier than 10 days from the date of this plan. I know that I can ask for this to be sooner.

If I do not agree with some or all of the services that have been authorized in this plan, I have noted that in this plan. I know that my case manager will send me a letter that tells me why the service(s) I asked for was denied, reduced, suspended, or terminated. That letter will tell me how to appeal the decision that has been made about my services. The letter will also tell me how I can receive continued services.

My DDD Support Coordinator has told me how the appeal process works. I know how I can appeal service changes I do not agree with. I know that I can change my mind later about services I agree with today. I know that if I change my mind before the changes go into effect, I will get a letter that tells me the reason my services changed. The letter will also tell me about my appeal rights, including how to receive continued services.

I know that I can ask for another PCSP meeting to go over my needs and any changes to this plan that are needed. I can contact my DDD Support Coordinator, _____, at _____. I also know that I can contact my DDD Support Coordinator at any time to discuss questions, issues, and/or concerns that I may have regarding my services. My DDD Support Coordinator will contact me within 3 working days. Once I have talked with my DDD Support Coordinator, he/she will give me a decision about that request within 14 days. If the DDD Support Coordinator is not able to make a decision about my request within 14 days, s/he will send me a letter to let me know more time is needed to make a decision.

_____ _____
Member/Health Care Decision Maker Signature Date

_____ _____
Individual Representation Signature *(Agency with Choice Only)* Date

_____ _____
Case Manager/Support Coordinator Signature Date

Other Attendees Responsible for Plan Implementation:			
Name:	Signature:	Name of Agency/Relationship:	Date:
Name:	Signature:	Name of Agency/Relationship:	Date:
Name:	Signature:	Name of Agency/Relationship:	Date:

Member Name: ______________________ Date of Birth: ______________ AHCCCS ID #: ______________

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, ______________________________ herby 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 ☐ Member Profile ☐ Individual Setting ☐ Strengths/Preferences ☐ Individual Goals/Outcomes ☐ Service Authorized ☐ Risks ☐ Modifications to Plan ☐ Action Plan	
		☐ Entire Plan ☐ Member Profile ☐ Individual Setting ☐ Strengths/Preferences ☐ Individual Goals/Outcomes ☐ Service Authorized ☐ Risks ☐ Modifications to Plan ☐ Action Plan	
		☐ Entire Plan ☐ Member Profile ☐ Individual Setting ☐ Strengths/Preferences ☐ Individual Goals/Outcomes ☐ Service Authorized ☐ Risks ☐ Modifications to Plan ☐ Action Plan	
		☐ Entire Plan ☐ Member Profile ☐ Individual Setting ☐ Strengths/Preferences ☐ Individual Goals/Outcomes ☐ Service Authorized ☐ Risks ☐ Modifications to Plan ☐ Action Plan	
		☐ Entire Plan ☐ Member Profile ☐ Individual Setting ☐ Strengths/Preferences ☐ Individual Goals/Outcomes ☐ Service Authorized ☐ Risks ☐ Modifications to Plan ☐ Action Plan	

Member Name: Date of Birth: AHCCCS ID #:

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 #:

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: _____

Member Name: Date of Birth: AHCCCS ID #:

FOR CASE MANAGER USE ONLY

Placement: ☐ D ☐ H ☐ Q ☐ Z

MAJOR DIAGNOSIS
(Must have at least one but allow up to three)

CHRONIC DISEASE	INTELLECTUAL/DEVELOPMENTAL DISABILITY
☐ Dementia/Alzheimer's	☐ Neurodevelopmental Disorder
☐ Other Neurological	☐ Autism Spectrum Disorder
☐ Head/Spinal Cord Injuries	☐ Cerebral Palsy
☐ Metabolic	☐ Down Syndrome
☐ Cardiovascular	☐ Fetal Alcohol Syndrome
☐ Musculoskeletal	☐ Prader-Willi Syndrome
☐ Respiratory	☐ Spina Bifida
☐ Hematologic/Oncologic	☐ Tourette Syndrome
☐ Psychiatric	☐ Other; If other, specify: _____
☐ Gastrointestinal	☐ _____
☐ Genitourinary	☐ _____
☐ Skin Conditions	
☐ Sensory	
☐ Infectious diseases	
☐ Seizure Disorder/Epilepsy	
☐ Congenital anomalies/Developmental Conditions	
☐ Other; If other, specify: _____	
☐ _____	
☐ _____	

Member Name: Date of Birth: AHCCCS ID #:

Did member choose agency with choice for in-home services? *(Attendant Care, Personal Care, Homemaker or Habilitation)*
☐ Yes ☐ No

Did member choose self-directed attendant care? ☐ Yes ☐ No

What is member's employment status?

☐ Retired
☐ No Work History
☐ Currently Employed Full Time
☐ Currently Employed Part Time
☐ Currently Seeking Employment

What is member's highest educational level?

☐ Attended Grade/Elementary School
☐ Some High School
☐ Graduated High School/GED
☐ Some College/Technical School
☐ Completed Technical School program
☐ Bachelor's Degree
☐ Associates Degree
☐ Graduate College Degree (Masters, Doctorate)
☐ Considering/Interested in returning to school

What is member's current level of care?

☐ Class 1
☐ Class 2
☐ Class 3
☐ Wandering/Dementia
☐ Behavioral
☐ Sub-Acute Medical
☐ Respiratory/Vent
☐ Other: _____

Member Name: Date of Birth: AHCCCS ID #:

Are any of the medications listed under the medications section antipsychotics? ☐ Yes ☐ No

Member's assigned behavioral health code: _____

Behavioral Health Treatment Plan: ☐ Yes ☐ No

Notes:

Court Ordered Treatment (COT): ☐ Yes ☐ No

Notes:

ORIENTATION/MEMORY:

Check the following as they apply to the member's Orientation/Memory:

Check as many as apply:

☐ Appropriate
☐ Alert
☐ Forgetful
☐ Lethargic
☐ Confused
☐ Unresponsive
☐ Incoherent
☐ Oriented to Person
☐ Oriented to Place
☐ Oriented to Time/Day

ORIENTED X:

☐ 1 ☐ 2 ☐ 3