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

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

III. PREFERENCES AND STRENGTHS

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?

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

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

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			
☐ 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: _____

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**

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

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:

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)
- ☐ 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**:**

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:

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:

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: __________

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
			☐ 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 #:

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:

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:
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 #: ______________________ 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, ______________________________________ 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: _____