Arizona Department of Economic Security
Division of Developmental Disabilities

Change of PCSP

Member Name _____ AHCCCS ID _____

Support Coordinator _____ Date _____

This document is an extension of the PCSP, which is a living document and to be utilized when changes to the PCSP are requested outside of scheduled initial or annual planning meetings or 90-day planning review meetings. Any changes must be approved by the member or the responsible person. An initial or annual planning meeting shall be documented on the full PCSP document and 90-day planning review meetings shall be documented on a Planning Review Meeting document. A member or responsible person may request a full PCSP at any time.

I. Type of Change

Check the appropriate boxes to indicate the type(s) of changes made:

☐ Goals or Outcomes
☐ Enhanced Staffing Ratios
☐ Temporary Out of State
☐ Service Plan
☐ Medications
☐ Indirect Services (e.g. school, BH, etc.)
☐ Other (Specify): _____

Exclusions:

1. Major life changes/transitions (e.g., death of a family member, loss of home, new risks or rights restrictions, major hospitalizations, quality of care concerns) require thorough planning and should be discussed during an in-person meeting with the planning team.
2. Changes related to AzEIP services must be updated on the IFSP.

See page 10 for EOE/ADA disclosures

II. Description of Change(s)

Describe the reason for change, who requested the change and what changes are being made.

III. Individual Goals And Outcomes

☐ Check here if there are not any changes with goals and outcomes.

Update one section for each goal and outcome that has changed.

Indicate the type of change: ☐ Revised ☐ New ☐ Discontinued

Goal #:

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.)? The Support Coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	**When?**
A.	
B.	
C.	

Indicate the type of change: ☐ Revised ☐ New ☐ Discontinued

Goal #:

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.)? The Support Coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	**When?**
A.	
B.	
C.	

Indicate the type of change: ☐ Revised ☐ New ☐ Discontinued

Goal #:

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.)? The Support Coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	**When?**
A.	
B.	
C.	

Indicate the type of change: ☐ Revised ☐ New ☐ Discontinued

Goal #:

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.)? The Support Coordinator should document member's active participation in goal progress or achievement.

A.

B.

C.

Who will do what:	**When?**
A.	
B.	
C.	

IV. Services Authorized

☐ Check here if there are not any changes with the service plan.

If there are any changes, specify all services agreed upon, new, changed and existing.

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

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

V. Action Plan

Documentation must reflect the individuals responsible for monitoring the PCSP and provide updates on action items from the previous PCSP or Planning Meeting Review. 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 Completed	Comments

VI. Consent/Signature

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 Support Coordinator will send me a letter that tells me why the service(s) I asked for was denied, reduced, suspended, or terminated. The 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 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 the 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 have 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 Support Coordinator _____ at _____.
I also know that I can contact my Support Coordinator at any time to discuss questions, issues, and/or concerns that I may have regarding my services and/or related to fraud, waste, and abuse.

My Support Coordinator will contact me within 3 working days. Once I have talked with my Support Coordinator, he/she will give me a decision about that request within 14 days. If my 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's Signature _____ Date _____

Responsible Person's Signature _____ Date _____

Support Coordinator's Signature _____ Date _____