

## Planning Meeting Review

Member Name (Last, First, M.I.) \_\_\_\_\_ AHCCCS ID \_\_\_\_\_

Support Coordinator \_\_\_\_\_ Date \_\_\_\_\_

The member's eligibility is:    **ALTCS**      Targeted      DDD (state funded)

This document is an extension of the PCSP, which is a living document and to be utilized during 90-day planning review meetings. The member or responsible person may request the full PCSP to be updated at any time.

### I. Meeting Information

Attendee Name	Invited	Attended	Provided Input (e.g., by phone, email)
	Yes    No	Yes    No	
	Yes    No	Yes    No	
	Yes    No	Yes    No	
	Yes    No	Yes    No	
	Yes    No	Yes    No	
	Yes    No	Yes    No	
	Yes    No	Yes    No	
	Yes    No	Yes    No	
	Yes    No	Yes    No	
	Yes    No	Yes    No	
	Yes    No	Yes    No	

### Review Type:

1st 90 Day	2nd 90 Day	3rd 90 Day
180-day ( <i>in alternative residential setting, over age 12 &amp; no BH involvement</i> )		
10-Day Change in Community Setting	10-Day Post-Discharge	
30-day post placement	Other/Special Teaming ( <i>Specify</i> ) _____	

### Meeting Location Type:

Member Home	Community: _____
Virtual	Alternative Service Setting: _____

If virtual, did the responsible person request this option, and is the member eligible for a virtual meeting?    **Yes**      **No**  
 If no explain: \_\_\_\_\_

Address (No, Street, City, State, Zip Code): \_\_\_\_\_

The following options are available ONLY for DD-Only, Targeted, or LTC/Acute Care Only:

Phone      Letter

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**Describe observations and interactions with the member.** (e.g., appearance of the member, how the member engaged in the review meeting, what was occurring during the meeting, environment). **The member must be present for the meeting.**

Comments:

## II. Plan Review And Team Feedback

A. What changes have occurred in your life since we last met?

B. Are you satisfied with the current living situation, or would you like to explore other options?

Document discussion and outcome:

C. Are you receiving the assessed services regularly?      Yes      No

If no, please tell me about your experience with the supports and services in place and any gaps or barriers.

D. Have there been any changes to the indirect services (school, BH, etc.)?      Yes      No

If yes, what recent updates or changes should we know about?

E. In what ways are the long-term care services meeting - or not meeting - your needs?

F. What has your experience been with your current providers?

**III. Medical Supports And Information**  
**(Document all changes in the Discussion section.)**

Have you experienced any changes to your medical condition(s)? Yes      No  
Document discussion and any changes if applicable:

Have there been any medical or dental appointments since the last meeting? Yes      No  
Document discussion and any changes if applicable:

Have there been any medication changes (*including psychotropic medications*) since the last meeting? Yes      No  
Document discussion and any changes if applicable:

Have you been hospitalized, including Emergency Room visits, in the last 90 days for a medical issue/concern? Yes      No  
Document discussion and any changes if applicable:

Have there been any changes to your behavioral health needs and/or services?  
Document discussion and any changes if applicable:

Yes No

Have there been any behavioral incidents since the last meeting that involved police, crisis calls, or incident reports?  
Document discussion and any changes if applicable:

Yes No

Does the member need a behavior plan? If yes, describe the plan to develop and implement a Behavior Plan and include action items in Section IX?  
Document discussion and any changes if applicable:

Yes No NA

If you have a Behavior Plan, is it current and effective?  
Document discussion and any changes if applicable:

Yes No NA

**IV. Individual Goals And Outcomes**

Review and write each goal and outcome from the current plan. Indicate if any goals were added, revised or discontinued.

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Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items)*:

Changes:      No Changes Needed      Revised      New      Discontinued

If new, complete the following:

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.	

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items):*

Changes:      No Changes Needed      Revised      New      Discontinued

If new, complete the following:

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B.

C.

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

Goal #:

Outcome:

Progress (*Include progress updates from all planning team members and action items*):

Changes:      No Changes Needed      Revised      New      Discontinued

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B.

C.

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

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items):*

Changes:      No Changes Needed      Revised      New      Discontinued

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B.

C.

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

Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items):*

Changes:      No Changes Needed      Revised      New      Discontinued

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

Goal #:

Outcome:

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B.	
C.	

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C.	

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Who will do what:	When?
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B.	
C.	

Goal #:

Outcome:

Progress (*Include progress updates from all planning team members and action items*):

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C.	

Goal #:

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Goal #:

Outcome:

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Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items):*

Changes:      No Changes Needed      Revised      New      Discontinued

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Who will do what:	When?
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Goal #:

Outcome:

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Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items):*

Changes:      No Changes Needed      Revised      New      Discontinued

If new, complete the following:

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A.	
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Goal #:

Outcome:

Progress *(Include progress updates from all planning team members and action items):*

Changes:      No Changes Needed      Revised      New      Discontinued

If new, complete the following:

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.	

**V. Current Services Authorized**

Check here if the member does not have any 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
			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
			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
			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

Was the Home and Community Based Service Needs Tool reviewed?

Yes      No      NA

Describe any changes made, the services and provider options discussed, and if updated service assessment tools have been completed:

**VI. Service Model Selected**

Have any changes been made to the service model selected? Yes No N/A

If yes, what service model was selected?

- Traditional Agency with Choice Independent Provider (DDD)
- Parents as Paid Caregiver Spousal Attendant Care N/A

**VII. Risks**

Are there any new risks or changes to the existing identified risks? Yes No

Date New Risk Identified \_\_\_\_\_

For any new risks describe the changes:

What is the risk?

Describe the risk. What does it look like for the Member? Frequency? Location? Duration?

Contributing Factors:

What is currently working to prevent the risk/how is risk being effectively managed? (Interventions that are working and not working?)

**VIII. Member Rights Restrictions  
(Only update this section if there is an existing, new or modified member rights restriction that has been approved through the Program Review Committee)**

Describe any existing member rights restrictions.

Discuss if the existing member rights restriction is still necessary or can be terminated.

Describe any new or modified member's rights restrictions that have been approved through PRC since the last meeting:



**X. Next Meeting Information**

**Next Meeting Due Date** \_\_\_\_\_

**Next Meeting Scheduled Date** \_\_\_\_\_ **Time** \_\_\_\_\_

Annual      1st 90-Day      2nd 90-Day      3rd 90-Day

180-day (in alternative residential setting, over age 12 & no BH involvement)

Other/Special Teaming (*Specify*) \_\_\_\_\_

**Type of Meeting:**                      Virtual                      In-Person

If virtual, did the responsible person request this option, and is the member eligible for virtual meetings (*e.g., not receiving services through the PPCG, Spouse, or Independent Provider service model*)?

Yes      No      If no, explain: \_\_\_\_\_

The following options are ONLY available for DD-Only, Targeted, or LTC/Acute Care Only:

Phone              Letter

**If in person, specify the address and type of setting:**

Address \_\_\_\_\_

Type of Setting:

Member Home                      Community Setting \_\_\_\_\_

Alternative Service Setting: \_\_\_\_\_

**XI. Consent/Signature**

Documentation must show that this review of the PCSP is finalized and agreed to, with the informed consent of the member 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 acknowledgment. My providers must receive a copy of the portions of the plan that explain how I want my services delivered and any restrictions agreed to by the PCSP team. My Support Coordinator has provided me with information about fraud, waste, and abuse, including how to report abuse, neglect, exploitation, and other critical incidents.

This plan has been reviewed with me by my Support Coordinator. My Support Coordinator discussed service options available to me, including information that helped inform the choices selected, decisions made, and reflected in this document. 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 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.

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Member's Signature _____	Date _____
Responsible Person's Signature _____	Date _____
Second Responsible Person's Signature (when there is one) _____	Date _____
Support Coordinator's Signature _____	Date _____

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