ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

This is the
INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

For _____ and Family

☐ Interim IFSP ☐ Initial IFSP ☐ Annual IFSP

Date: _____

Service Coordinator: _____

Team Lead: _____

Our Mission – Early intervention builds upon and provides supports and resources to assist family members and caregivers to enhance children's learning and development through everyday learning opportunities.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

☑ IFSP Type:
☑ IFSP Date:

CHILD AND FAMILY

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

Gender: ☐ Female ☐ Male Child ID No.: _____ AzEIP Eligibility Date: _____

Service Coordinator's Name: _____ Agency/Program: _____

Phone No.: _____ Email Address: _____

With Whom the Child Resides

☐ Parent ☐ Family Member ☐ Foster Parent ☐ Guardian

Name *(First, M.I., Last)*: _____

Address *(No., Street, City, County, State, ZIP Code)*: Major cross streets or directions to the home:

_____ _____

Phone No.: _____ Email Address: _____

Language used by the parent/caregiver: _____ Interpreter needed: ☐ Yes ☐ No If yes, what language? _____

School District: _____ Date Child is 2.6: _____

Additional Caregiver/Address

☐ Parent ☐ Family Member ☐ Guardian

Name *(First, M.I., Last)*: _____

Address *(No., Street, City, County, State, ZIP Code)* ***If different than above***: Major cross streets or directions to the home:

_____ _____

Phone No.: _____ Email Address: _____

Language used by the parent/caregiver: _____ Interpreter needed: ☐ Yes ☐ No If yes, what language? _____

Health Information

Primary Care Provider (PCP): _____ Phone No.: _____

Date vision screening conducted *(Vision screening checklist)*: _____ Number of indicators or risk factors checked: _____

Comments, next step:

Date hearing screening conducted *(Hearing screening tracking form is NOT a hearing screening)*: _____

Results of OAE *(or other hearing screening)*: Left Ear _____ Right Ear _____

If a hearing screening has not been conducted within 6 months, strategies to obtain a screening must be included.

Comments, next step:

Please describe your child's current health status. Include diagnosis (if applicable), specialists involved, serious illnesses, seizures, hospitalizations, and medications taken regularly and how this may be impacting your child's development.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
CHILD AND FAMILY ASSESSMENT

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

Summary of Child Development within Routines and Activities

This Child and Family Assessment will capture all areas of my child's development within the contexts of everyday routines and activities that are important to our family. We will discuss areas that we identify are going well and areas that are not going well, while discussing all areas of my child's development. I can follow along with my copy of the Child and Family Assessment Guide for Families.

☐ Communication ☐ Movement ☐ Thinking/Learning ☐ Social/Behavior ☐ Self-help ☐ Vision ☐ Hearing

Activity *(check one)*:

☐ Wake up	☐ Dressing	☐ Diapering/Toileting
☐ Mealtime/Snacks	☐ Outings	☐ Play
☐ Bath time	☐ Bedtime/Naps	☐ Other *(describe)*: _____

How is it going? *(check one for each question)*:

For you?	☐ Going well	☐ Some concerns	☐ A lot of concerns
For your child?	☐ Going well	☐ Some concerns	☐ A lot of concerns
For other caregivers?	☐ Going well	☐ Some concerns	☐ A lot of concerns

Comments/Details:

1. Who is involved in this activity?

2. What is happening now?

3. Is this an activity in which you would like to receive support from your early intervention team? ☐ Yes ☐ No
   If yes, what would it look like if it was going well?

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Arizona Early Intervention Program (AzEIP)

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
CHILD AND FAMILY ASSESSMENT

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

Summary of Child Development within Routines and Activities

☐ Communication ☐ Movement ☐ Thinking/Learning ☐ Social/Behavior ☐ Self-help ☐ Vision ☐ Hearing

Activity *(check one)*:

☐ Wake up	☐ Dressing	☐ Diapering/Toileting
☐ Mealtime/Snacks	☐ Outings	☐ Play
☐ Bath time	☐ Bedtime/Naps	☐ Other *(describe)*: _____

How is it going? *(check one for each question)*:

For you?	☐ Going well	☐ Some concerns	☐ A lot of concerns
For your child?	☐ Going well	☐ Some concerns	☐ A lot of concerns
For other caregivers?	☐ Going well	☐ Some concerns	☐ A lot of concerns

Comments/Details:

1. Who is involved in this activity?

2. What is happening now?

3. Is this an activity in which you would like to receive support from your early intervention team? ☐ Yes ☐ No
   If yes, what would it look like if it was going well?

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☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
CHILD AND FAMILY ASSESSMENT

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

Summary of Child Development within Routines and Activities

☐ Communication ☐ Movement ☐ Thinking/Learning ☐ Social/Behavior ☐ Self-help ☐ Vision ☐ Hearing

Activity *(check one)*:

☐ Wake up	☐ Dressing	☐ Diapering/Toileting
☐ Mealtime/Snacks	☐ Outings	☐ Play
☐ Bath time	☐ Bedtime/Naps	☐ Other *(describe)*: _____

How is it going? *(check one for each question)*:

For you?	☐ Going well	☐ Some concerns	☐ A lot of concerns
For your child?	☐ Going well	☐ Some concerns	☐ A lot of concerns
For other caregivers?	☐ Going well	☐ Some concerns	☐ A lot of concerns

Comments/Details:

1. Who is involved in this activity?

2. What is happening now?

3. Is this an activity in which you would like to receive support from your early intervention team? ☐ Yes ☐ No
   If yes, what would it look like if it was going well?

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
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☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
CHILD AND FAMILY ASSESSMENT

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

Summary of Child Development within Routines and Activities

☐ Communication ☐ Movement ☐ Thinking/Learning ☐ Social/Behavior ☐ Self-help ☐ Vision ☐ Hearing

Activity *(check one)*:

☐ Wake up	☐ Dressing	☐ Diapering/Toileting
☐ Mealtime/Snacks	☐ Outings	☐ Play
☐ Bath time	☐ Bedtime/Naps	☐ Other *(describe)*: _____

How is it going? *(check one for each question)*:

For you?	☐ Going well	☐ Some concerns	☐ A lot of concerns
For your child?	☐ Going well	☐ Some concerns	☐ A lot of concerns
For other caregivers?	☐ Going well	☐ Some concerns	☐ A lot of concerns

Comments/Details:

1. Who is involved in this activity?

2. What is happening now?

3. Is this an activity in which you would like to receive support from your early intervention team? ☐ Yes ☐ No
   If yes, what would it look like if it was going well?

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
CHILD AND FAMILY ASSESSMENT

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

Natural Resources

List the people and resources that support your family *(e.g., friends, neighbors, extended family, neighborhood play groups, community activities, parks, social, church or other faith-based groups)*:

Areas of Interest

Check items your family would like more information about:

- ☐ Places where my child can play with other children in the community
- ☐ Childcare
- ☐ Clothing, food, etc.
- ☐ Housing Assistance
- ☐ Health care and/or health insurance for my child
- ☐ My child's diagnosis or disability
- ☐ Talking with other parents
- ☐ Parent support/ training/advocacy
- ☐ Other: _____
- ☐ Other: _____

Priorities

From the Summary of Routines and Activities and Areas of Interest, ask the family to identify which are the most important areas to address in the next 3-6 months. Include the resources that are in place, or could be put in place, to support the priority.

Priorities	Natural Resources

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

☑ IFSP Type:
☑ IFSP Date:

CHILD INDICATORS SUMMARY

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

I-TEAMS ID No.: _____ Date of Rating: _____ Rating Indicator: ☐ Entry ☐ Exit ☐ Review

Eligibility Categories: ☐ Developmental Delay ☐ Established Condition ☐ Informed Clinical Opinion

IFSP TEAM MEMBERS *(Includes anyone contributing to the rating process)*	**ROLES**

SOURCES OF SUPPORTING EVIDENCE	**DATES**

1. POSITIVE SOCIAL-EMOTIONAL SKILLS *(Including Social Relationships)*

- **Relating with adults**
- **Relating with other children**
- **For older children, following rules related to groups or interacting with others**

1a. To what extent does this child show age-appropriate functioning across a variety of settings and situations on this outcome?

Completely		**Sometimes**		**Emerging**		**Not Yet**
☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

1b. Describe skills or behaviors related to positive social-emotional skills (including positive social relationships).

Has the child made progress since the last rating? ☐ Yes ☐ No ☐ N/A

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☑ IFSP Type:
☑ IFSP Date:

CHILD INDICATORS SUMMARY

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

2. ACQUIRING AND USING KNOWLEDGE AND SKILLS

- **Thinking, reasoning, remembering, and problem solving**
- **Understanding symbols and language**
- **Understanding the physical and social worlds**

2a. To what extent does this child show age-appropriate functioning across a variety of settings and situations on this outcome?

Completely		Sometimes		Emerging		Not Yet
☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

2b. Describe skills or behaviors related to acquiring and using knowledge and skills.

Has the child made progress since the last rating? ☐ Yes ☐ No ☐ N/A

3. TAKING APPROPRIATE ACTION TO MEET NEEDS

- **Taking care of basic needs** *(e.g. showing interest in eating, dressing, feeding, toileting, etc.)*
- **Getting from place to place (mobility) and using tools** *(e.g. forks, strings attached to objects)*
- **If older than 24 months, contributing to own health and safety** *(e.g. follows rules, assists with hand washing, avoids inedible objects)*

3a. To what extent does this child show age-appropriate functioning across a variety of settings and situations on this outcome?

Completely		Sometimes		Emerging		Not Yet
☐ 7	☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

3b. Describe skills or behaviors related to taking appropriate action to meet needs.

Has the child made progress since the last rating? ☐ Yes ☐ No ☐ N/A

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
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☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
OUTCOME FOR CHILD AND FAMILY

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

Outcome Number: _____

Priority – What priority will this outcome address? *(Refer to **Priorities** from the **Child and Family Assessment**)*

Outcome – What will it look like when things are going well? *(Refer to **Summary of Routines and Activities** and/or **Areas of Interest**)*

Strategies – What specific steps and Natural Resources will help us meet this outcome? *(Include people and ideas that will help with this activity or routine – refer to **Natural Resources**)*

Outcome Status

At each review, as a team, we review this outcome and document the status. The IFSP team has decided to:

☐ Complete ☐ Continue ☐ Discontinue ☐ Revise Date: _____

Describe:

☐ Complete ☐ Continue ☐ Discontinue ☐ Revise Date: _____

Describe:

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
OUTCOME FOR CHILD AND FAMILY

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

Outcome Number: _____

Priority – What priority will this outcome address? *(Refer to **Priorities** from the **Child and Family Assessment**)*

Outcome – What will it look like when things are going well? *(Refer to **Summary of Routines and Activities** and/or **Areas of Interest**)*

Strategies – What specific steps and Natural Resources will help us meet this outcome? *(Include people and ideas that will help with this activity or routine – refer to **Natural Resources**)*

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☐ Complete ☐ Continue ☐ Discontinue ☐ Revise Date: _____

Describe:

☐ Complete ☐ Continue ☐ Discontinue ☐ Revise Date: _____

Describe:

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
OUTCOME FOR CHILD AND FAMILY

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

Outcome Number: _____

Priority – What priority will this outcome address? *(Refer to **Priorities** from the **Child and Family Assessment**)*

Outcome – What will it look like when things are going well? *(Refer to **Summary of Routines and Activities** and/or **Areas of Interest**)*

Strategies – What specific steps and Natural Resources will help us meet this outcome? *(Include people and ideas that will help with this activity or routine – refer to **Natural Resources**)*

Outcome Status

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Describe:

☐ Complete ☐ Continue ☐ Discontinue ☐ Revise Date: _____

Describe:

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
OUTCOME FOR CHILD AND FAMILY

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

Outcome Number: _____

Priority – What priority will this outcome address? *(Refer to **Priorities** from the **Child and Family Assessment**)*

Outcome – What will it look like when things are going well? *(Refer to **Summary of Routines and Activities** and/or **Areas of Interest**)*

Strategies – What specific steps and Natural Resources will help us meet this outcome? *(Include people and ideas that will help with this activity or routine – refer to **Natural Resources**)*

Outcome Status

At each review, as a team, we review this outcome and document the status. The IFSP team has decided to:

☐ Complete ☐ Continue ☐ Discontinue ☐ Revise Date: _____

Describe:

☐ Complete ☐ Continue ☐ Discontinue ☐ Revise Date: _____

Describe:

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN TRANSITION

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

School District: _____ AzEIP Eligibility Date: _____

Date Transition Planning Meeting Due *(Refer to AzEIP Transition Timeline)*: _____ Date Transition Planning Meeting Completed: _____

Date Transition Conference Due *(Refer to AzEIP Transition Timeline)*: _____ Date Transition Conference Completed: _____

By initialing below, I acknowledge that the Transition Planning Meeting steps needed to support my child and family's transition from early intervention have been discussed:

_____ My Service Coordinator explained that the purpose of the Transition Planning Meeting is to discuss and document all of the necessary steps to ensure my child and family has a smooth transition out of early intervention services at age 3.

_____ A vision screening checklist must have been completed within the past 12 months;
Date of my child's last vision screening: _____

_____ A hearing screening must have been completed within the past 12 months;
Date of my child's last hearing screening: _____

_____ If a hearing screening has not been completed within the past 12 months,
we will obtain one no later than: _____

_____ I received information from my Service Coordinator to support me in obtaining a hearing screening for my child.

My Service Coordinator and team discussed with me the services and supports that may be available to my child and family upon transition out of early intervention services, including tentative timelines, as documented below:

_____ Preschool Options *(i.e., developmental preschool, private or community preschools, Head Start)*: _____

_____

_____ Community Resources *(i.e., home visiting programs, parent support groups or trainings)*: _____

_____

_____ Options available through my child's health insurance and/or other public agencies: _____

_____

_____ My Service Coordinator discussed the need to provide informed consent before sharing information about my child and family with any parties involved with my child's transition process.

My family has the following questions, concerns and priorities regarding transitioning my child from early intervention services:

As a result of these questions, concerns and priorities, IFSP Outcome(s) were specifically developed to support my child and family. Refer to IFSP Outcome(s) number _____.

PEA NOTIFICATION

_____ I understand that my Service Coordinator will provide a notification including demographic information about my child and family to my local school district and the Arizona Department of Education (based on the AzEIP Transition Timeline), unless I opt out of this notification by signing the opt-out portion of the PEA Notification Referral form.

Date PEA Notification sent: _____ Date parent opted out of Notification: _____

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN TRANSITION

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

TRANSITION CONFERENCE PLANNING

_____ **I agree** to have a Transition Conference and understand my Service Coordinator must send an invitation to participate to a representative(s) from my local school district. Additionally, I would like the following people and/or programs invited to the Transition Conference:

1. _____
2. _____
3. _____
4. _____

_____ **I do not agree** to have a Transition Conference and understand my Service Coordinator will not coordinate a meeting with my local school district.

Responsible Party Initials	Additional Activities Prior to Exit:	Date Achieved
	Child Exit Indicator summary completed.	
	My Service Coordinator and team provided me with an AzEIP Family Survey, and explained the importance of completing it.	
	My Service Coordinator provided me a copy of my child's record before exiting early intervention.	
	If my child is eligible for an AHCCCS Health Plan, my child will be referred to AHCCCS for continuum of services after the age of 3.	
	If my child is eligible for DDD, when my child turns 3 my family plans to: ☐ Remain enrolled in DDD ☐ Withdraw from DDD	
	If my child is not currently eligible for DDD, my Service Coordinator has discussed the DDD eligibility requirements, and my Service Coordinator and family plan to: ☐ Complete the DDD application process at this time ☐ Not complete the DDD application process at this time	
	Other:	
	Other:	
	Other:	

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
SERVICES NEEDED TO MAKE PROGRESS TOWARDS OUTCOMES

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

Outcome No.	Early Intervention Service	*Intensity	Frequency		Service Setting H = Home C = Community O = Other *(If other, complete the justification below)*	Method TL = Team Lead JV = Joint Visits TC = Team Conferencing NTL = Non Team Lead	Duration	
			No. of sessions	No. of minutes per session			Planned Start Date	Planned End Date
	Service Coordination				☐ H ☐ C ☐ O			
					☐ H ☐ C ☐ O			
					☐ H ☐ C ☐ O			
					☐ H ☐ C ☐ O			
					☐ H ☐ C ☐ O			
					☐ H ☐ C ☐ O			
					☐ H ☐ C ☐ O			

Select ONLY one Primary Service Setting: ☐ H ☐ C ☐ O

(Primary Setting is the setting in which the infant or toddler receives the most hours of an early intervention service.)

***Intensity: I** = Individual **UN** = Multiple eligible children (2) **UP** = Multiple eligible children (3 or more)

JUSTIFICATION OF EARLY INTERVENTION OUTCOMES THAT CANNOT BE ACHIEVED SATISFACTORILY IN A NATURAL ENVIRONMENT

Service _____ Location of Service _____ Service Provider _____

If an early intervention service is not provided in the natural environment, what is the justification for the IFSP team's decision that outcomes cannot be achieved in the natural environment?

Explain how early intervention services will support the child's participation in routines and activities to meet the IFSP outcomes.

Explain the plan and timeline to move services into the natural environment.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
PAYMENT ARRANGEMENTS FOR SERVICES

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

☐ Service Coordinator and family discussed use of family's public and/or private insurance:

☐ Public Insurance:

☐ AHCCCS ☐ CMDP ☐ IHS ☐ DDD/ALTCS ☐ Other *(e.g., EPD/ALTCS)*: _____

Health Plan: _____

☐ Private Insurance Plan: _____

(Consent is required before billing public and private insurance)

Early Intervention Service *(no acronyms)*	**Discipline**	***Funding Source(s)** *(include all that apply)*

***Funding Source:**

1 = Medicaid (AHCCCS/CMDP)
2 = Private Insurance (PI)
3 = Arizona Early Intervention Program (AzEIP)
4 = Division of Developmental Disabilities (DDD)
5 = Arizona Long Term Care System (ALTCS)
6 = Arizona State Schools for the Deaf and the Blind (ASDB)

Other Services *(in place or needed)*

Services such as medical, recreational, religious, social and other child related services not required or funded under early intervention, that contribute to this plan.

- Resources your family has that are helpful in meeting the needs of your child/family *(e.g., respite, as covered under ALTCS)*.
- Resources that you are interested in to help your family *(e.g., WIC, health care, etc.)*.

Resource(s), Service(s), and Support(s)	**Check if needed**	**Payment Source**	**Steps to be Taken** *(Include person responsible and timeline)*
	☐		
	☐		
	☐		
	☐		
	☐		

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
INFORMED CONSENT BY PARENT(S) FOR SERVICES

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

I have participated in the development of this IFSP and understand that I can accept or refuse any or all of the services identified in the IFSP. I understand that my consent for services may be withdrawn at any time. Please initial and sign below.

_____ 1a. I agree with the proposed IFSP as written. I further understand that my signature below indicates that: (a) I have been fully informed of the services being proposed and the reason for the proposal of services; (b) my service coordinator explained my rights under this program; and (c) I give consent to carry out this IFSP as written.

_____ 1b. I do not agree with the proposed IFSP as written *(Prior Written Notice form must be completed and given to the family)*. However, I do consent to the following services/frequency:

_____ 2. My service coordinator explained my rights under this program.
I ☐ Accept ☐ Decline a written copy of the AzEIP Family Rights Handbook.

_____ 3. I have received a copy of the AzEIP Family Survey *(Annual or Transition/Exit IFSP)*.

_____ _____ _____ _____
Parent Signature Date Parent Signature Date

In addition to the release of this IFSP to team members, I give my consent for a copy of this IFSP to be sent to the individuals or agencies listed below.

Name of Individual/Agency *(e.g., pediatrician, Early Head Start program)*	**Purpose**

Parent Signature: _____ Date: _____

I understand that I have agreed to disclose my IFSP to the person/agency listed above and that person/agency may not disclose this IFSP to anyone else without my consent. This consent is valid for one year unless I revoke it at any time.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Arizona Early Intervention Program (AzEIP)

☑ IFSP Type:
☑ IFSP Date:

INDIVIDUALIZED FAMILY SERVICE PLAN
IFSP TEAM

Child's Name *(First, M.I., Last)*: _____ Date of Birth: _____

The following team members participated in the development of this IFSP. Each individual understands the plan as it applies to their role in providing services. All team members understand that the IFSP must be reviewed at least every 6 months and can be revised at any time by the request of any team member, including the family. List team members, present or not, who contributed to the development of the IFSP.

IFSP TEAM MEMBERS				
Service Coordination	**Discipline/Role**	**Agency/Program**	**Phone No.**	**Initial if present**
Team Lead	**Discipline/Role**	**Agency/Program**	**Phone No.**	**Initial if present**
IFSP Team Member	**Discipline/Role**	**Agency/Program**	**Phone No.**	**Initial if present**
IFSP Team Member	**Discipline/Role**	**Agency/Program**	**Phone No.**	**Initial if present**
IFSP Team Member	**Discipline/Role**	**Agency/Program**	**Phone No.**	**Initial if present**

Core Team Members	Discipline/Role

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

III. PREFERENCES AND STRENGTHS

a. Medical Supports and Information
b. Medications
c. Preventative Screening Services

VII. SERVICES AUTHORIZED

a. Paid Services / Supports
b. Non-paid Supports

VIII. IDENTIFICATION OF RISKS

IX. RISK ASSESSMENT

XI. ACTION PLAN

XII. INFORMED CONSENT

XIII. NEXT MEETING INFORMATION

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: _____