Division of Developmental Disabilities

Therapy Service Process
Plan of Care 02/2021

TRUE NORTH

All Arizonans who qualify receive timely DES services and achieve their potential

SYNOPSIS- PLAN OF CARE

- The Division of Developmental Disabilities (DDD) has implemented the requirement of a Plan of Care (POC)
- The POC will need to be certified by the member's PCP
- The certified Plan of Care (CPOC) has replaced the medical prescription/referral for ongoing Therapy services

THERAPY SERVICES DEFINED

Medically necessary activities to develop, improve, or restore functions/skills

- **Occupational Therapy:** Addresses the use of the body for daily activities
- **Physical Therapy:** Addresses movement of the body related to walking, standing, balance and other movements
- **Speech Therapy:** Addresses receptive and expressive language, articulation, eating, swallowing, social communication and pragmatic language

DDD Medical Policy Manual Chapter 1200 Section 1250-E. Services and Settings Therapies (Rehabilitative and Habilitative)

- DDD requires that therapy services are the appropriate:
  - Type
  - Frequency
  - Intensity
  - Duration for the individual needs of the member

DDD Medical Policy Manual Chapter 1200 Section 1250-E. Services and Settings Therapies (Rehabilitative and Habilitative)

- Documentation is read by other providers and claim reviewers from varying backgrounds and experience
- Notes and reports must:
  - Be clear and legible
  - Justify medical necessity
  - Contain the required information for clinical management and reimbursement

THERAPY SERVICES: OT, PT, ST

- Authorized based on medical necessity and individual needs
- Factors considered when approving services:
  - Development/functional skills
  - Medical conditions
  - Member’s network of support (Family/caregivers, friends, providers, etc.)
  - Age
  - Therapies provided by the school

THERAPY SERVICES PROCESS

The above graphic will be explained in greater detail in subsequent slides.

THERAPY SERVICES PROCESS

- **Identify Potential Therapy Need-** Support Coordinator (SC) will utilize a Therapy Screening Tool to assist with conversations between the SC, the member and the responsible person
- If a potential need is identified, the SC instructs the member/responsible person to obtain a **discipline-specific** evaluation medical prescription/referral
- Upon receipt of the evaluation medical prescription/referral, the SC updates the ALTCS Member Service Plan and a Vendor Call is initiated

PLAN OF CARE

- Ongoing Therapy services must relate directly to a POC, also known as the treatment plan
  - Developed by the evaluating therapist
- The Centers for Medicare and Medicaid Services (CMS) states the POC shall contain, ***at a* minimum**:
  - Diagnoses
  - Long term treatment goals for the entire episode of care
  - Proposed type of service or interventions
  - Amount
  - Duration
  - Frequency of therapy services

PLAN OF CARE

- **POC's are directly related** to objective findings consistent with an evaluation
- The POC is established by a
  - Physical Therapist
  - Occupational Therapist
  - Speech-Language Pathologist
- A POC must
  - Document the date of establishment
  - Contain the signature and professional identity or credentials of the therapist who developed the POC
  - Be **established** and **certified** before the therapy treatment can begin

PLAN OF CARE

NOTE:

- There must be a POC for **each therapy service** if a member is receiving treatment in multiple disciplines (e.g. PT, OT and/or SLP)
- Each therapist **must** independently establish the impairment/dysfunction that is being treated and the associated functional outcomes/goals

DEVISING A PLAN OF CARE

- Create an individualized plan for each member based on evaluation/assessment.
- Establish a treatment program with specific evidence-based interventions to treat the member's needs
- Examples include:
  - Therapeutic exercise
  - Functional training
  - Manual therapy techniques
  - NDT
  - SOS
  - Adaptive DEVICES/EQUIPMENT NEEDS
  - Modalities

DEVISING A PLAN OF CARE

- Establish anticipated functional goals, expected outcomes and any predicted level of improvement.
  - Include goal baselines and timelines
- Determine frequency and duration of care
- The POC must include a prognosis statement with clearly established and defined discharge criteria

CERTIFICATION OF PLAN OF CARE

- Establishing the POC is different than **certifying** the POC.
- The Center for Medicare and Medicaid Services (CMS) states that POC certification requires a **dated signature** by the primary care provider (PCP) for the patient/client (i.e. DDD member). DDD requires the documentation of the PCP National Provider Identifier (NPI #).
  - The PCP can be a physician/non-physician practitioner

CERTIFICATION OF PLAN OF CARE

- Example statements placed under the dated physician's/non-physician practitioner's signature and NPI number:
  - "As of the date of this evaluation, I certify the pertinent medical history and the need for skilled services that have been completed in consultation with the evaluating therapist under this plan."
  - "I certify the need for these services furnished under this plan of treatment while under my care."

CERTIFICATION OF PLAN OF CARE

In order to avoid an error when submitting the CPOC documentation to DDD, the following must be included:

- Establish and complete the initial POC
- Include your signature
- List your professional identification (i.e. PT, OT, etc.),
- Include date the POC was established
- Ensure that the POC is certified (recertified when appropriate) with a dated physician/non-physician practitioner signature and NPI number.

PLAN OF CARE- NEXT STEPS

- The CPOC is the medical prescription/referral for ongoing therapy services
- The Qualified Vendor (QV) must provide the member's SC with a copy of the CPOC prior to the SC authorizing ongoing services.
  - Submission via the FTP site

PLAN OF CARE- NEXT STEPS

- The SC must receive the CPOC within **three (3)** **weeks** of the completion of the discipline-specific evaluation
- The authorization start date is based on the date the PCP signs the POC

UPDATE TO THE PLAN OF CARE

Updating the POC at end of the certification period:

- If objective therapy data and clinical judgment confirm the need for ongoing services, the Qualified Vendor needs to provide the member's PCP with an updated POC for recertification.
- Recertification of the POC is required at the end of the certification period.
- In order to assist in avoiding access to care issues, DDD is suggesting the qualified vendors to update the POC 30-days in advance of the authorization/certification period end date.

UPDATE TO THE PLAN OF CARE

- If the QV determines an evaluation is needed, a request to the member's SC is required
- Evaluations are required at a minimum every three (3) years
- If objective therapy data and clinical judgment do NOT support the need for ongoing therapy, documentation should include a:
  - Discharge Note
  - Home Functional Maintenance Plan

SYNOPSIS- UPDATING THE POC

- In order to assist in avoiding access to care issues, DDD is suggesting the qualified vendors to update the POC 30-days in advance of the authorization/certification period end date.
  - Updates are based on objective findings and current functional status
- Submit the updated POC to the member's PCP for certification (PCP dated signature and NPI number)
- Submit the CPOC to the SC within three (3) week of the completion of the discipline-specific evaluation

TIMELINE FOR CPOC PROCESS

- The Qualified Vendor (QV) must provide the member's SC with a copy of the CPOC prior to the SC authorizing ongoing services.
- Authorizations for all DDD members are expected to be based on a CPOC no later than **March 31, 2021**
- In order to assist in avoiding access to care issues, DDD is suggesting the qualified vendors to update the POC 30-days in advance of the authorization/certification period end date

EVALUATION TRIGGERS

An evaluation may be considered and a referral/creation of authorization for evaluation to a Qualified Vendor, if the:

- SC identifies and observes a limitation in a functional area.
- Treating qualified provider or other licensed healthcare professional (within the scope of licensure) identifies a limitation in a functional area
- Caregiver and/or responsible party identifies a limitation in a functional area

EVALUATION TRIGGERS

- The member presents a change in medical status that is not rehabilitative
- The member has not had an evaluation within the last three (3) years
- There is a Qualified Vendor change and the member has not had an evaluation within the last (1) year
- Prior to redetermination of eligibility (age three (3), age six (6), eighteen (18)) or at the time of redetermination as determined appropriate

THERAPY SERVICES PROCESS- OVERVIEW

- SC, member/responsible person identify potential need and obtain medical prescription/referral for evaluation
- Vendor Call and Qualified Vendor Identified
- Evaluation performed, POC developed and submitted to PCP for certification (dated signature and NPI number)

THERAPY SERVICES PROCESS- OVERVIEW

- PCP certifies the POC and returns it to the therapy qualified vendor
- The CPOC is sent to the SC (within 3 weeks of completion of evaluation)
- SC enters the authorization for ongoing services in FOCUS

END OF CERTIFICATION PERIOD

- Reassess and update the POC **prior** to the end of the certification and authorization
- In order to assist in avoiding access to care issues, DDD is suggesting the qualified vendors to update the POC 30-days in advance of the authorization/certification period end date.
- If continued services are medically necessary, submit the updated POC to the PCP for certification
- Upon receipt of CPOC, submit to the SC via the FTP site

POINTS TO REMEMBER

- Certification of a POC is **required** for all ongoing therapy services
- The dated PCP signature and NPI number on the POC completes the certification requirements and proves that a physician/licensed medical provider is involved in the member's care and available to certify the plan

POINTS TO REMEMBER

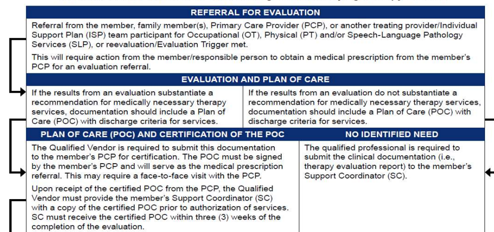
- Authorizations for all DDD members are expected to be based on a CPOC no later than **March 31, 2021.**

- Qualified Vendors providing therapy services are not required to use the new Evaluation/Plan of Care (Evaluation-POC) or Quarterly Progress Report (QPR)/Plan of Care (POC) form. The DDD Evaluation-POC and DDD QPR-POC is available to QVs who may not have their own clinical form or access to an electronic medical record (EMR) system. For those QVs who opt to use their own forms or EMR, the DDD Evaluation-POC and DDD QPR-POC can be used as a reference since it contains the minimally required information, i.e., the member's treatment diagnosis, long-term treatment goals as well as the type, amount, duration, and frequency of therapy services.

Please refer to subsequent slides for report samples.

DOCUMENTATION FLOW CHART FOR ESTABLISHING AND RECERTIFYING THERAPY SERVICES

A link to the Documentation Flow Chart (guide) can be found in the DDD Providers & Vendors website under the Therapy Process Update Resources.



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Division of Developmental Disabilities

DOCUMENTATION GUIDELINES: OCCUPATIONAL, PHYSICAL, AND SPEECH-LANGUAGE PATHOLOGY THERAPY SERVICES

Documentation Flowchart for Establishing and Recertifying Therapy Services

REFERRAL FOR EVALUATION

Referral from the member, family member(s), Primary Care Provider (PCP), or another treating provider/Individual Support Plan (ISP) team participant for Occupational (OT), Physical (PT) and/or Speech-Language Pathology Services (SLP), or reevaluation/Evaluation Trigger met.

This will require action from the member/responsible person to obtain a medical prescription from the member's PCP for an evaluation referral.

EVALUATION AND PLAN OF CARE

If the results from an evaluation substantiate a recommendation for medically necessary therapy services, documentation should include a Plan of Care (POC) with discharge criteria for services.	If the results from an evaluation do not substantiate a recommendation for medically necessary therapy services, documentation should include a Plan of Care (POC) with discharge criteria for services.
PLAN OF CARE (POC) AND CERTIFICATION OF THE POC	**NO IDENTIFIED NEED**
The Qualified Vendor is required to submit this documentation to the member's PCP for certification. The POC must be signed by the member's PCP and will serve as the medical prescription referral. This may require a face-to-face visit with the PCP. Upon receipt of the certified POC from the PCP, the Qualified Vendor must provide the member's Support Coordinator (SC) with a copy of the certified POC prior to authorization of services. SC must receive the certified POC within three (3) weeks of the completion of the evaluation.	The qualified professional is required to submit the clinical documentation (i.e., therapy evaluation report) to the member's Support Coordinator (SC).

https://des.az.gov/sites/default/files/media/DDD-2087A.pdf?time=1612560947658

Please refer to the following DDD website for these forms, as well as other Therapy resources: https://des.az.gov/services/disabilities/developmental-disabilities/vendors-providers/therapy-services-faq

EVALUATION REPORT & POC

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Division of Developmental Disabilities

EVALUATION REPORT

PLAN OF CARE/TREATMENT PLAN: CERTIFICATION/RECERTIFICATION

INSTRUCTIONS: Qualified Vendor/Provider(s) must complete Plan of Care/Treatment Plan to receive authorization to provide therapy services. The Plan of Care must be sent to the member's Primary Care Physician to be certified. If the Plan of Care is the result of a recent evaluation, the provider must send the evaluation and the Certified Plan of Care to the Support Coordinator. ***If you do not have enough space in the specified areas, please include additional content to the addendum page.***

Therapy documentation includes the following: Evaluation of skills and progress meeting priorities and outcomes. Development of home programs and consultation with the member/ family/ other providers. Assisting members to acquire knowledge and skills, to increase or maintain independence, and to promote health and safety. Modeling/ teaching/ coaching parents and/or caregiver's specific techniques and approaches to everyday activities, within a member's routine. Collaboration with all team members/professionals involved in the member's life.

Date Received by Division: ______ Date of Report: ______

MEMBER INFORMATION

Member's Name *(Last, First, M.I.)*: ______

Date of Birth *(mm/dd/yyyy)*: ______ Assists No.: ______ AHCCCS ID: ______

Diagnosis: - Choose an item - ICD Code/CPT Code: ______

Date of Initial/Most Recent Therapy Evaluation *(mm/dd/yyyy)*: ______ Support Coordinator Name: ______

Responsible Person Name: ______ Relationship to Member: ______

Therapeutic Dosage:
Enter the amount and frequency of the number of visits requested for the duration of the treatment schedule. If a variable, tapering, and/or maintenance dosage schedule is requested within this Plan of Care/Treatment Plan, describe the clinical and functional endpoints expected to be met in the corresponding "Dosage Considerations" section.

Amount *(Requested)*: ______ Frequency *(Requested)*: ______

Duration *(If applicable, Requested)*: ______ Total Units: ______

Dosage Considerations *(If applicable, Requested)*: ______

Model of Service *(i.e. Group, 1:1, Co-Treatment)*: ______

Special Considerations:
Enter and describe any additional information of clinical significance about the member's condition and/or comorbidities that would be a barrier to the member's ability to access or benefit from therapy services potentially delaying the estimated functional endpoints for discharge. *(e.g., Emotional/Behavioral Disorders)*

Please see addendum on page 6 to enter additional information

See page 6 for EOE/ADA disclosures

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Member's Name: ______ Date of Birth: ______ DX: - Choose an item -

BACKGROUND INFORMATION

Medical/Therapy History:
Please include medical information such as diagnosis, medications, and other pertinent medical information (i.e. seizures). Also include information regarding the history of therapy services.

Summary of Clinical Findings:
Please provide a summary of evaluation findings. Please provide any other standardized assessments used to validate the submitted diagnosis code, if necessary and appropriate. ***If you do not have enough space in the specified areas, please include additional content to the addendum page.***

Validity and/or Limitations of this Assessment:
Please provide a summary of validity and/or limitations of the evaluation findings *(e.g., obstacles; description of standardized assessments utilized; and adaptations to original standardized assessments).*

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Member's Name: ______ Date of Birth: ______ DX: - Choose an item -

Prognostic Indicators:
List any other barriers that may alter the expected length of treatment. *(e.g., Therapy attendance and home program participation, Member's network of support (e.g., family/caregivers, friends, providers); Age; and, Therapies provided by the school)*

Discharge Criteria: *(ex. Treatment goals and objectives have been met, Skills are within normal and/or functional, limits or baseline levels, The member is unable to tolerate treatment, The member no longer requires skilled therapy services from a qualified Therapy provider, The member and/or caregiver/responsible person is unwilling to participate in treatment, non-compliant or requests discharge, Medical necessity is not established by a qualified healthcare provider, transition to maintenance program)*

As Appropriate, Recommendations and Purpose for Equipment (ex. Augmentative Device):
List any other recommendations, as appropriate and medically necessary.

Please refer to the following DDD website for these forms, as well as other Therapy resources: https://des.az.gov/services/disabilities/developmental-disabilities/vendors-providers/therapy-services-faq

EVALUATION REPORT & POC

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Member's Name: Date of Birth: DX: - Choose an item -

THERAPY GOALS AND OBJECTIVES

1. **Goal/Objective Behavior**
   Include: targeted performance behavior, achievement criteria, and baseline measurement.
   Long Term Goal:
   Short Term Objective Behavior:
   Skilled Treatment/Interventions:
2. **Goal/Objective Behavior**
   Include: targeted performance behavior, achievement criteria, and baseline measurement.
   Long Term Goal:
   Short Term Objective Behavior:
   Skilled Treatment/Interventions:
3. **Goal/Objective Behavior**
   Include: targeted performance behavior, achievement criteria, and baseline measurement.
   Long Term Goal:
   Short Term Objective Behavior:
   Skilled Treatment/Interventions:
4. **Goal/Objective Behavior**
   Include: targeted performance behavior, achievement criteria, and baseline measurement.
   Long Term Goal:
   Short Term Objective Behavior:
   Skilled Treatment/Interventions:
5. **Goal/Objective Behavior**
   Include: targeted performance behavior, achievement criteria, and baseline measurement.
   Long Term Goal:
   Short Term Objective Behavior:
   Skilled Treatment/Interventions:
6. **Goal/Objective Behavior**
   Include: targeted performance behavior, achievement criteria, and baseline measurement.
   Long Term Goal:
   Short Term Objective Behavior:
   Skilled Treatment/Interventions:
7. **Goal/Objective Behavior**
   Include: targeted performance behavior, achievement criteria, and baseline measurement.
   Long Term Goal:
   Short Term Objective Behavior:
   Skilled Treatment/Interventions:
8. **Goal/Objective Behavior**
   Include: targeted performance behavior, achievement criteria, and baseline measurement.
   Long Term Goal:
   Short Term Objective Behavior:
   Skilled Treatment/Interventions:

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Member's Name: Date of Birth: DX: - Choose an item -

9. **Goal/Objective Behavior**
   Include: targeted performance behavior, achievement criteria, and baseline measurement.
   Long Term Goal:
   Short Term Objective Behavior:
   Skilled Treatment/Interventions:

HOME PROGRAM GOALS AND OBJECTIVES

To maximize the benefit of this service, improve outcomes and adhere to legal liability standards, members/responsible person or other caregivers (paid/unpaid) are required to:

- Be present and actively participate in all therapy sessions; and,
- Carry out the home program.

Goals and/or objectives to support the generalization of therapy skills across settings	Responsible Person
1.	
2.	
3.	
4.	
5.	

SIGNATURE SECTION: QUALIFIED PROVIDER(S)

Agency Name: Phone Number:
1. Provider Name:
State of Arizona License No.: NPI No.:
Signature *(Include credentials)*: Date:
2. Provider Name:
State of Arizona License No.: NPI No.:
Signature *(Include credentials)*: Date:

SIGNATURE/CERTIFICATION SECTION: PRIMARY CARE PROVIDER

I certify that the above services are required and authorized by me and that the plan of care and therapies outlined above are medically necessary for the treatment schedule start and end dates identified on this Plan of Care Document.
My signature below indicates I have no changes to this plan of care.

Return Fax No.: Email:
ATTN:
Primary Care Provider Name *(Last, First)*:
State of Arizona License No.: NPI No.:
Signature *(Include credentials)*: Date:

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Member's Name: Date of Birth: DX: - Choose an item -

ADDENDUM

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602-771-2893; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local

Please refer to the following DDD website for these forms, as well as other Therapy resources: https://des.az.gov/services/disabilities/developmental-disabilities/vendors-providers/therapy-services-faq

ONGOING QUARTERLY PROGRESS REPORTS & POC

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Division of Developmental Disabilities

ONGOING QUARTERLY PROGRESS REPORT (QPR)
PLAN OF CARE/TREATMENT PLAN: CERTIFICATION/RECERTIFICATION

INSTRUCTIONS: Qualified Vendor/Provider(s) must complete Plan of Care/Treatment Plan to receive authorization to provide therapy services. The Plan of Care must be sent to the member's Primary Care Physician to be certified. If the Plan of Care is the result of a recent evaluation, the provider must send the evaluation and the Certified Plan of Care to the Support Coordinator. ***If you do not have enough space in the specified areas, please include additional content to the addendum page.***

Therapy documentation includes the following: Evaluation of skills and progress meeting priorities and outcomes. Development of home programs and consultation with the member/ family/ other providers. Assisting members to acquire knowledge and skills, to increase or maintain independence, and to promote health and safety. Modeling/ teaching/ coaching parents and/or caregiver's specific techniques and approaches to everyday activities, within a member's routine. Collaboration with all team members/professionals involved in the member's life.

Date Received by Division: ______ Date of Report: ______

MEMBER INFORMATION

Member's Name *(Last, First, M.I.)*: ______

Date of Birth *(mm/dd/yyyy)*: ______ Assists No.: ______ AHCCCS ID: ______

Diagnosis: - Choose an item -

Date of Initial/Most Recent Therapy Evaluation *(mm/dd/yyyy)*: ______ Support Coordinator Name: ______

Responsible Person Name: ______ Relationship to Member: ______

Therapeutic Dosage:
Enter the amount and frequency of the number of visits requested for the duration of the treatment schedule. If a variable, tapering, and/or maintenance dosage schedule is requested within this Plan of Care/Treatment Plan, describe the clinical and functional endpoints expected to be met in the corresponding "Dosage Considerations" section

Amount *(Requested)*: ______ Frequency *(Requested)*: ______

Duration *(If applicable, Requested)*: ______ Total Units: ______

Dosage Considerations *(If applicable, Requested)*: ______

Model of Service *(i.e. Group, 1:1, Co-Treatment)*: ______

Special Considerations:
Enter and describe any additional information of clinical significance about the member's condition and/or comorbidities that would be a barrier to the member's ability to access or benefit from therapy services potentially delaying the estimated functional endpoints for discharge. *(e.g., Emotional/Behavioral Disorders)*

Please see addendum on page 12 to enter additional information
See page 11 for EOE/ADA disclosures

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Member's Name: ______ Date of Birth: ______ DX: - Choose an item -

ATTENDANCE FOR SESSIONS
(For Progress Reporting Only)

Number of attended sessions: ______ Number of canceled sessions: ______

Reasons for cancelations:

BACKGROUND INFORMATION

Medical/Therapy History:
Please include medical information such as diagnosis, medications, and other pertinent medical information (i.e. seizures). Also include information regarding the history of therapy services.

Summary of Clinical Findings:
Please provide a summary of evaluation/treatment findings. Please provide any other assessments used to validate the submitted diagnosis code, if necessary and appropriate.

Prognostic Indicators:
List any other barriers that may alter the expected length of treatment. *(e.g., Therapy attendance and home program participation, Member's network of support (e.g., family/caregivers, friends, providers); Age; and, Therapies provided by the school)*

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Member's Name: ______ Date of Birth: ______ DX: - Choose an item -

Discharge Criteria: *(ex. Treatment goals and objectives have been met, Skills are within normal and/or functional, limits or baseline levels, The member is unable to tolerate treatment, The member no longer requires skilled therapy services from a qualified Therapy provider, The member and/or caregiver/responsible person is unwilling to participate in treatment, non-compliant or requests discharge, Medical necessity is not established by a qualified healthcare provider, transition to maintenance program)*

INTEGRATED HEALTH CARE INFORMATION/COLLABORATION WITH OTHER PROVIDERS

Description: Include all other providers that you attempted to or did collaborate with over the quarter. This is required at quarterly progress reporting time.

QPR SUMMARY: CLINICAL IMPRESSION AND RECOMMENDATIONS
(For Quarterly Progress Reports Only)

Describe the member's clinical strengths and weaknesses within the QPR period:

- This section may also identify factors that may warrant follow-up through related services *(e.g., additional services, evaluation, etc.)*, or provide any additional information of clinical significance about the member's condition and that would impact the member's ability to access/benefit from therapy services.
- If changes to the member's goals/objective behavior(s) and/or therapy dosage are recommended a new Plan of Care/ Treatment Plan is required.
- If there is a recommended change in the level of service, please provide additional outcomes and/or explanation.

Please refer to the following DDD website for these forms, as well as other Therapy resources: https://des.az.gov/services/disabilities/developmental-disabilities/vendors-providers/therapy-services-faq

ONGOING QUARTERLY PROGRESS REPORTS & POC

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Member's Name: | Date of Birth: | DX: - Choose an item -

THERAPY GOALS AND OBJECTIVES

1. **Goal/Objective Behavior**
   Include: targeted performance behavior, achievement criteria, and baseline measurement.

Long Term Goal:

Short Term Objective Behavior:

Date of Quarter 1 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

Date of Quarter 2 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

Date of Quarter 3 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

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Member's Name: | Date of Birth: | DX: - Choose an item -

Date of Quarter 4 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

2. **Goal/Objective Behavior**
   Include: targeted performance behavior, achievement criteria, and baseline measurement.

Long Term Goal:

Short Term Objective Behavior:

Date of Quarter 1 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

Date of Quarter 2 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

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Member's Name: | Date of Birth: | DX: - Choose an item -

Date of Quarter 3 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

Date of Quarter 4 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

3. **Goal/Objective Behavior**
   Include: targeted performance behavior, achievement criteria, and baseline measurement.

Long Term Goal:

Short Term Objective Behavior:

Date of Quarter 1 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

Please refer to the following DDD website for these forms, as well as other Therapy resources: https://des.az.gov/services/disabilities/developmental-disabilities/vendors-providers/therapy-services-faq

ONGOING QUARTERLY PROGRESS REPORTS & POC

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Member's Name: Date of Birth: DX: - Choose an item -

Date of Quarter 2 QPR (mm/dd/yyyy):	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	
Date of Quarter 3 QPR (mm/dd/yyyy):	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	
Date of Quarter 4 QPR (mm/dd/yyyy):	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

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Member's Name: Date of Birth: DX: - Choose an item -

4. **Goal/Objective Behavior**
   Include: targeted performance behavior, achievement criteria, and baseline measurement.

Long Term Goal:

Short Term Objective Behavior:

Date of Quarter 1 QPR (mm/dd/yyyy):	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	
Date of Quarter 2 QPR (mm/dd/yyyy):	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	
Date of Quarter 3 QPR (mm/dd/yyyy):	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

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Member's Name: Date of Birth: DX: - Choose an item -

Date of Quarter 4 QPR (mm/dd/yyyy):	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

5. **Goal/Objective Behavior**
   Include: targeted performance behavior, achievement criteria, and baseline measurement.

Long Term Goal:

Short Term Objective Behavior:

Date of Quarter 1 QPR (mm/dd/yyyy):	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	
Date of Quarter 2 QPR (mm/dd/yyyy):	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

Please refer to the following DDD website for these forms, as well as other Therapy resources: https://des.az.gov/services/disabilities/developmental-disabilities/vendors-providers/therapy-services-faq

ONGOING QUARTERLY PROGRESS REPORTS & POC

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Member's Name: Date of Birth: DX: - Choose an item -

Date of Quarter 3 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	
Date of Quarter 4 QPR *(mm/dd/yyyy)*:	
Skilled Treatment/ Intervention(s)	
Modification(s) to Treatment/ Intervention(s)	
Objective Data Assessment	

HOME PROGRAM GOALS AND OBJECTIVES

To maximize the benefit of this service, improve outcomes and adhere to legal liability standards, members/responsible person or other caregivers (paid/unpaid) are required to:

- Be present and actively participate in all therapy sessions; and,
- Carry out the home program.

Goals and/or objectives to support the generalization of therapy skills across settings	Responsible Person	Progress
1.		- Choose an item -
2.		- Choose an item -
3.		- Choose an item -
4.		- Choose an item -
5.		- Choose an item -

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Member's Name: Date of Birth: DX: - Choose an item -

SIGNATURE SECTION: QUALIFIED PROVIDER(S)

Agency Name: Phone Number:

1. Provider Name:

State of Arizona License No.: NPI No.:

Signature *(Include credentials)*: Date:

2. Provider Name:

State of Arizona License No.: NPI No.:

Signature *(Include credentials)*: Date:

SIGNATURE/CERTIFICATION SECTION: PRIMARY CARE PROVIDER

I certify that the above services are required and authorized by me and that the plan of care and therapies outlined above are medically necessary for the treatment schedule start and end dates identified on this Plan of Care Document.

My signature below indicates I have no changes to this plan of care.

Return Fax No.: Email:

ATTN:

Primary Care Provider Name *(Last, First)*:

State of Arizona License No.: NPI No.:

Signature *(Include credentials)*: Date:

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602-771-2893; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local

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Member's Name: Date of Birth: DX: - Choose an item -

ADDENDUM

Please refer to the following DDD website for these forms, as well as other Therapy resources: https://des.az.gov/services/disabilities/developmental-disabilities/vendors-providers/therapy-services-faq

Thank You

Please refer to the following DDD website for these forms, as well as other Therapy resources: https://des.az.gov/services/disabilities/developmental-disabilities/vendors-providers/therapy-services-faq