I. **MEETING INFORMATION**
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III. **PREFERENCES AND STRENGTHS**
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 b. Medications
 c. Preventative Screening Services
IV. **INDIVIDUAL SETTING**
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VII. **SERVICES AUTHORIZED**
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VIII. **IDENTIFICATION OF RISKS**
IX. **RISK ASSESSMENT**
X. **MODIFICATIONS TO THE PLAN**
XI. **ACTION PLAN**
XII. **INFORMED CONSENT**
XIII. **NEXT MEETING INFORMATION**

SUPPLEMENTAL DOCUMENTS (DISCUSS/COMPLETE AS APPLICABLE):

☐ Advance Directives
☐ Advance Directives for Pets
☐ Assisted Living Facility Residency Agreement
☐ Behavioral Health Quarterly Reviews
☐ Community Intervener Member Assessment Tool
☐ Direct Care Service Acknowledgment Form
☐ Emergency Disaster Plan
☐ End of Life Treatment Plan
☐ Gap report
☐ HCBS Needs Tool (HNT)
☐ Managed Risk Agreement
☐ Member Contingency/Back-Up Plan
☐ Self-Directed Attendant Care Forms
☐ Spousal Acknowledgment Form
☐ Uniform Assessment Tool (UAT)

MEMBER NAME	*DATE OF BIRTH*	*AHCCCS ID #*	*DATE OF MEETING*

I. MEETING INFORMATION

Plan Revision Date: ____________

I CONSENT TO THE FOLLOWING INDIVIDUALS TO BE INVITED TO THE PLANNING MEETING/BE INVOLVED IN THE DEVELOPMENT OF MY PLAN:		
NAME	ATTENDED MEETING	PROVIDED INPUT (E.G. BY PHONE, EMAIL)
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Meeting location: ____

Was the member asked to decide when and where the meeting took place? ☐ Yes ☐ No ☐ N/A

Did the member consider meeting locations outside of the home? ☐ Yes ☐ No ☐ N/A

If no or N/A, explain why? ____

Where did the previous meeting take place? ____

List any changes to the member's contact information:

MEMBER/RESPONSIBLE PERSON CONTACT INFORMATION (IF APPLICABLE OR IF INFORMATION HAS CHANGED):

Health Care Decision Maker (If applicable): ____

Designated representative (if applicable): ____

Power of Attorney (If applicable): ____

Public Fiduciary (If applicable): ____

Name of Social Security Payee (If applicable): ____

SMI Special Assistance Advocate (if applicable): ____

Other: ____

MEETING NOTES OR SPECIAL CONSIDERATIONS:

MEMBER NAME	*DATE OF BIRTH*	*AHCCCS ID #*	*DATE OF MEETING*

II. MEMBER PROFILE

Document brief background/member's life experiences (e.g. place of birth, developmental, education, and employment history, justice system involvement, previous living situations):

Have you served in the military? ☐ Yes ☐ No

Notes:

How are things going (since we last spoke/last review)? What does a typical day/week look like? What is the best part of your day? What is the hardest part of your day? What can make your day/week go really well? What can make your day/week really challenging?

Any major changes in your life recently (since we last spoke/last review)?

What do you understand about your physical and/or mental health from your doctor or service providers?

Is there an area regarding your physical or mental health or services and supports related to your health that you want to work towards improving?

☐ Yes ☐ No (if yes note in goal section as appropriate)

MEMBER NAME	*DATE OF BIRTH*	*AHCCCS ID #*	*DATE OF MEETING*

III. PREFERENCES AND STRENGTHS

Documentation shall include key aspects of daily routines and rituals focus on the member's strengths and interests, outline the member's reaction to various communication styles, and identify the member's favorite things to do and experience during the day, as well as experiences that contribute to a bad day.

- *What are you good at? What would others say you are good at? What do others like and admire about you?*
- *Who do you like providing your support? What about them makes them a good supporter/service provider? What is something important about you for us to know?*
- *Are there activities you used to enjoy doing that you can no longer do?*
- *What makes you happy currently?*
- *Anything that has happened recently that makes you feel good or proud?*
- *What traditions and practices (e.g. family, cultural, religious.) are important to you?*
- *Do you have any beliefs or preferences that affect the care you receive (e.g. religious or other feelings and beliefs, such as a preference for natural healers)?*
- *Do you have the support available to ensure that your preferences are met?*
- *Do you prefer to do activities alone or interact with people? Do you prefer 1 on 1, small group or large group activities?*
- *What is important for us to know, and your providers to know, about how you communicate?*
- *How do you express yourself? What can we do to make sure that you understand what others are saying to you?*

FOR INDIVIDUALS WHO ARE UNABLE TO EXPRESS THEIR PREFERENCES, THE QUESTIONS ABOUT THE FOLLOWING MAY BE ASKED OF FAMILY MEMBERS, FRIENDS, OR OTHERS THAT KNOW THE MEMBER TO HELP INFORM PERSONAL GOAL DEVELOPMENT AND/OR MEANINGFUL DAY ACTIVITIES.

- *Marital and Familial history*
- *Employment/Professional/Educational history*
- *Hobbies/Community Involvement/Clubs*
- *Favorite Music Style/Movies/Books/Sports*

SUMMARY OF CONVERSATION:

MEMBER NAME	*DATE OF BIRTH*	*AHCCCS ID #*	*DATE OF MEETING*

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).

REVIEW MEDICAL SUPPORTS AND INFORMATION FOR CHANGES:

Has medical supports information changed since the last meeting? ☐ Yes ☐ No

MEDICARE OR OTHER HEALTH INSURANCE

MEDICARE OR OTHER HEALTH INSURANCE	MEDICARE NUMBER OR POLICY NUMBER	MC PART A	MC PART B	MC PART D – PLAN NAME	NAME OF INSURED *(IF MEMBER IS NOT PRIMARY HOLDER OF INSURANCE)*	PHONE NUMBER

MEDICAL/DENTAL/BEHAVIORAL PROVIDER INFORMATION

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

Notes:

MEMBER NAME	*DATE OF BIRTH*	*AHCCCS ID #*	*DATE OF MEETING*

ADDITIONAL PROVIDER AND SUPPORT INFORMATION:

REVIEW PROVIDER AND SUPPORT INFORMATION FOR CHANGES:

Has additional 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	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			
☐ Yes ☐ N/A	Respite			
☐ Yes ☐ N/A	Senior Programs			
☐ Yes ☐ N/A	Skilled Nursing Facility			
☐ Yes ☐ N/A	Speech Therapy			
☐ Yes ☐ N/A	Vocational Rehabilitation			
☐ Yes ☐ N/A	Work Program			
☐ Yes ☐ N/A	Other:			

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?

List all current prescribed medications/behavioral health /OTC/vitamins/supplements use additional pages as needed:

NAME OF MEDICATION	PRESCRIBING PHYSICIAN	WHAT IS THE MEDICATION FOR? FOR BH MEDICATION INCLUDE PSYCHOACTIVE DRUG USE TYPE: ANTIDEPRESSANT, ANTIPSYCHOTIC, ANXIOLYTIC, HYPNOTIC, MOOD STABILIZER	DOSAGE / FREQUENCY

Where are prescriptions filled?

Are you experiencing any side effects? Explain

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*

List all covered medical supplies:

MEDICAL SUPPLIES	WHAT ARE THE SUPPLIES USED FOR?	HOW OFTEN ARE THEY USED?

Height (inches): ________ ☐ EstimatedDate recorded: ___________________ ☐ Not Available

Weight: ________ ☐ EstimatedDate recorded: ___________________ ☐ Not Available

BMI (pediatric members): ______ Document BMI education for Pediatric members (if applicable):

PREVENTATIVE SCREENING SERVICES

Have you had any of the following preventive services in the last year?

☐ Annual Eye Exam/DRE
☐ Blood Pressure Screening
☐ Cancer Screening
☐ Cervical Screening
☐ Colon Cancer Screening
☐ Dental Exam
☐ EPSDT (refer to periodicity schedule)
☐ Family Planning Screening
☐ General Health Exam
☐ HbA1c
☐ Hearing Test
☐ Lipid Profile/Cholesterol Screening
☐ Mammogram Screening
☐ Osteoporosis Screening
☐ Prostate Screening
☐ STD Education/Awareness/Protection
☐ Other: ____________________
☐ Other: ____________________

Notes:

MEMBER NAME	*DATE OF BIRTH*	*AHCCCS ID #*	*DATE OF MEETING*

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:

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)?

Does the member's behavioral diagnosis and functional status indicate a need for an SMI Eligibility Determination?
☐ Yes ☐ No ☐ N/A (for members already determined SMI)

If SMI determined, does member require Special Assistance from the Office of Human Rights (OHR)?
☐ Yes ☐ No

MEMBER NAME	*DATE OF BIRTH*	*AHCCCS ID #*	*DATE OF MEETING*

IV. INDIVIDUAL SETTING

The setting in which the member resides or receives services is the most integrated and least restrictive setting and affords the member to have full access to the benefits of community living. Documentation shall reflect the setting is of the individual's choosing, provides support to the member to integrate into their community of choice as defined by their interests, preferences, abilities and health and safety risks.

HOME LIFE

Considerations: Questions should be modified appropriately to ensure age appropriateness and applicability to institutional setting types. For example, questions related to going out and leaving the home may not be applicable to members living in a skilled nursing facility, but other questions regarding visitors, picking staff to provide assistance and activities do apply to these settings.

- *Did you pick where you live?*
- *Did you get to pick the people you live with?*
- *Do you pick who helps you at home?*
- *Are you allowed to eat when and what you want?*
- *Do you have a key to your home?*
- *Can you close and lock your bedroom and bathroom door?*
- *Do you get out of the house and do things? Do you pick what you do when you go out? Are you allowed to leave your home at any time?*
- *Are you able to handle your own finances? Can you get money when you need or want it?*
- *Do you get to visit or meet with people who do not live in your home?*
- *Do you decide everyday what you want to do?*
- *Are you able to use the phone without assistance? Do you get to use a phone or computer to talk privately with people that you want to when you want to?*
- *Can you safely and freely move around your home? Are there any concerns with your home life/neighborhood?*
- *Do you want to learn about or visit other potential places to live?*

DIRECTIONS FOR CASE MANAGER:
If answers to any of the above questions are 'negative' as a result of a health and safety risk, with the exception of questions that are not age appropriate or appropriate to the setting (i.e. institutional setting), a risk modification plan must be completed see section entitled 'Modification to Plan through Restriction of Member's Rights). If answers to any of the above questions are 'negative' and there is no health or safety risks preventing the member from exercising the right, talk with the member about goal setting.

Notes:

MEMBER NAME	*DATE OF BIRTH*	*AHCCCS ID #*	*DATE OF MEETING*

LIVING ARRANGEMENT:

☐ Lives Alone
☐ Lives with Family/Others
☐ Nursing Facility
☐ Alternative HCBS Setting
☐ Behavioral Health Facility or Unit
☐ Uncertified Setting
☐ Other ___________________________

DESCRIBE CURRENT LIVING/ENVIRONMENT CONDITIONS:

Document alternative home and community-based settings considered by/offered to the member, including information that helped inform the choices selected and decisions made by the member (e.g. preferences, needs, visits to other settings, etc.):

IF MEMBER EXPRESSES DISSATISFACTION WITH CURRENT LIVING SITUATION OR WANTS TO EXPLORE OTHER OPTIONS:

Do you want to begin looking at how we can work towards positive changes around your living arrangement? ☐ Yes ☐No (if yes, note in goal section as appropriate)

MEMBER NAME	*DATE OF BIRTH*	*AHCCCS ID #*	*DATE OF MEETING*

DAILY LIFE (*PROGRAMS/EMPLOYMENT/ EDUCATION*)

Considerations: Questions should be modified appropriately to ensure age appropriateness and applicability to institutional setting types. For example, questions related to a program may not be applicable to members living in a skilled nursing facility, but other questions regarding a meaningful day including deciding what to do every day, learning new skills and activities do apply to these settings.

- *What do you do during the day? Do you decide everyday what you want to do?*
- *Are you in school? If not, are you interested in continuing your education?*
- *If you are in school, do you get to decide what you do after school?*
- *What do you want to do for work? Do you want a paying job or a volunteer job? Is anyone currently helping you find a job? If you have a job, are you receiving a paycheck?*
- *Are you interested in improving or learning any new skills related to work, education, hobbies, etc.?*

FOR MEMBERS IN A DAY, ADULT DAY HEALTH PROGRAM OR EMPLOYMENT PROGRAM

- *Are you in a program during the day? Did you get to pick the program you go to? Do you pick who helps you at the program?*
- *Do you decide everyday what you want to do? Do you get out to do things? Do you get to pick what you do when you go out?*
- *Can you get money when you need or want it for outings or food?*
- *Do you get to visit or meet with people who do not participate in your program?*
- *Can you safely and freely move about your program? Do you have any concerns about your program?*
- *Do you want to learn about or visit other potential programs?*
- *Do you have any concerns with how you spend your day? If yes, how would you like to spend your day?*

DIRECTIONS FOR CASE MANAGER:
If answers to any of the above questions are "negative" as a result of a health and safety risk, with the exception of questions that are not age appropriate or appropriate to the setting (i.e. institutional setting), a risk modification plan must be completed (see section entitled "Modifications to Plan through Restriction of Member's Rights). If answers to any of the above questions are "negative" and there is no health or safety risks preventing the member from exercising the right, talk with the member about goal setting.

Document alternative programs settings considered by/offered to the member including information that helped inform the choices selected and decisions made by the member (e.g. preferences, needs, visits to other settings, etc.):

IF MEMBER EXPRESSES DISSATISFACTION WITH PROGRAM OR WANTS TO EXPLORE OTHER OPTIONS:

Do you want to begin looking at how we can work towards positive changes around your program?
☐ Yes ☐ No (if yes, note in goal section as appropriate)

Does member require assistance with community based Housing, Employment and/or Education (e.g. Housing Choice Voucher [formerly called HUD Section 8]; Utility Assistance; Vocational Rehabilitation; SSA; AHCCCS Freedom to Work)? ☐ Yes ☐ No

Notes:

MEMBER NAME	*DATE OF BIRTH*	*AHCCCS ID #*	*DATE OF MEETING*

V. INDIVIDUALIZED GOALS AND OUTCOMES

IS THERE AN AREA OF YOUR LIFE THAT YOU WOULD LIKE TO WORK ON?

☐ Health ☐ Home Life ☐ Daily Life

GOAL:	
OUTCOME:	
Where are they now (at the time of this plan)?	
What needs to be done?	
A.	
B.	
C.	
WHO WILL DO:	**WHEN?**
A.	
B.	
C.	

IS THERE ANOTHER AREA OF YOUR LIFE THAT YOU WOULD LIKE TO WORK ON?

☐ Health ☐ Home Life ☐ Daily Life

GOAL:	
OUTCOME:	
Where are they now (at the time of this plan)?	
What needs to be done?	
A.	
B.	
C.	
WHO WILL DO:	**WHEN?**
A.	
B.	
C.	

PROGRESS ON GOALS

MEMBER NAME	*DATE OF BIRTH*	*AHCCCS ID #*	*DATE OF MEETING*

VI. ACTIVITIES OF DAILY LIVING

MOBILITY	☐ Independent		☐ Minimal	☐ Moderate	☐ Maximum
TRANSFERRING	☐ Independent		☐ Minimal	☐ Moderate	☐ Maximum
BATHING	☐ Independent		☐ Minimal	☐ Moderate	☐ Maximum
DRESSING	☐ Independent		☐ Minimal	☐ Moderate	☐ Maximum
GROOMING	☐ Independent		☐ Minimal	☐ Moderate	☐ Maximum
EATING	☐ Independent		☐ Minimal	☐ Moderate	☐ Maximum
TOILETING	☐ Independent		☐ Minimal	☐ Moderate	☐ Maximum
CONTINENT OF BLADDER	☐ No		☐ Partial		☐ Yes
CONTINENT OF BOWEL	☐ No		☐ Partial		☐ Yes
BEHAVIORS	☐ No	☐ Yes	**Type/Frequency (including interventions):**		

Effective Date: 06/01/21
Approval Date: 06/23/20, 04/01/21

MEMBER NAME	*DATE OF BIRTH*	*AHCCCS ID #*	*DATE OF MEETING*

VII. SERVICES AUTHORIZED

PAID SUPPORT

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.

Are you satisfied with the long term care services and supports? Do your current services meet your support needs? Are you satisfied with the providers? Have there been any gaps in services? What support do you need from your provider (s) to help accomplish your personal goals?

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.

Do you understand your roles and responsibilities? Are you satisfied with the supports you receive from the provider agency (or Fiscal Employer Agent) to help you direct and manage your care? Do you need some additional training to assist you in directing/managing your own care?

Additional Notes from 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 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/HEALTH CARE DECISION MAKER**
			☐ 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

☐ Aspiration and\or pneumonia infection ________
☐ Dehydration ________
☐ Choking ________
☐ Constipation ________
☐ Seizures ________
☐ Diabetes ________
☐ Dietary ________
☐ Medical Restrictions ________
☐ Unsafe medication management _______
☐ Feeding Tube ________
☐ Serious or chronic health condition(s) ________
☐ Skin breakdown ________
☐ Oxygen use ________
☐ Ventilator/Trach dependent ______
☐ Heart problems; high or low blood pressure ________
☐ Allergies _______
☐ Unreported/reported pain ________
☐ Unreported/reported illness ________
☐ Refusing medical care ________
☐ Pregnancy ________
☐ ESRD or on dialysis ________
☐ Hepatitis C ________
☐ 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 ________
☐ Household chemical safety ______
☐ Lack of fire safety skills ________
☐ Lack of judgment or difficulty understanding consequences ________
☐ Lack of supervision ________
☐ Memory loss ________
☐ Mobility or ambulation ________
☐ Falls ________
☐ Safety and cleanliness of residence ________
☐ Vehicle safety ________
☐ Water temperature ________
☐ Other safety or self-help risks:
____
____

MENTAL HEALTH, BEHAVIORAL AND LIFESTYLE RISKS

☐ Court involvement* ________
☐ Expressed Suicidal Thoughts ________
☐ Attempted Suicide ________
☐ Extreme food or liquid seeking behavior ________
☐ Harm to animals ________
☐ High risk or illegal sexual behavior ________
☐ Illegal behavior ________
☐ Invades personal space ________
☐ Isolation/isolating behavior ______
☐ Wandering or Exit seeking behavior ________
☐ Past or potential police involvement ________
☐ Physical aggression ________
☐ Placing or ingesting non-edible objects or PICA ________
☐ Smoking ________
☐ Property destruction ________
☐ Self-abusive behaviors ________
☐ Substance Abuse: drug, alcohol or other________
☐ Inappropriate sexual behavior ____
☐ Unsafe use of flammable materials ________
☐ Use of objects as weapons ________
☐ Other Mental Health, Behavioral or Lifestyle Risks:
____
____
☐ Military Service/Veteran ________
☐ Other life event 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. RISKS 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. 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 (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 ***(INTERVENTIONS THAT ARE WORKING AND NOT WORKING)?***

MEMBER NAME	*DATE OF BIRTH*	*AHCCCS ID #*

X. MODIFICATIONS TO PLAN THROUGH RESTRICTION OF MEMBER'S RIGHTS

This section is only applicable if a member's rights are being restricted. Decisions regarding necessary modification of conditions related to home and community-based settings must be made with the member/Health Care Decision Maker prior to being implemented. Modification made to this plan by the planning cannot be made without the member/Health Care Decision Maker's involvement.

DESCRIBE THE MODIFICATION TO THE PLAN THAT IS RESTRICTING THE MEMBER'S RIGHTS:

IDENTIFY THE SPECIFIC AND INDIVIDUALIZED NEED THAT HAS BEEN IDENTIFIED THROUGH THE ASSESSMENTS OF FUNCTIONALIZED NEED (UAT, HCBS NEEDS TOOL, RISK ASSESSMENT TOOL):

DOCUMENT THE POSITIVE INTERVENTIONS AND SUPPORTS USED PRIOR TO ANY MODIFICATIONS TO THE PERSON-CENTERED SERVICE PLAN:

DOCUMENT LESS INTRUSIVE METHODS OF MEETING THE NEED THAT HAVE BEEN TRIED BUT DID NOT WORK:

INCLUDE A CLEAR DESCRIPTION OF THE CONDITION THAT IS DIRECTLY PROPORTIONATE TO THE SPECIFIC ASSESSED NEED:

INCLUDE A TIMELINE FOR THE REGULAR COLLECTION AND REVIEW OF DATA TO MEASURE THE ONGOING EFFECTIVENESS OF THE MODIFICATION:

INCLUDE ESTABLISHED TIME LIMITS FOR PERIODIC REVIEWS TO DETERMINE IF THE MODIFICATION IS STILL NECESSARY OR CAN BE TERMINATED:

DESCRIBE THE ASSURANCE THAT THE INTERVENTIONS AND SUPPORTS WILL CAUSE NO HARM TO THE INDIVIDUAL:

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 #*

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.

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 case manager 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 ALTCS Case Manager, ____, at ____________________. I also know that I can contact my Case Manager at any time to discuss questions, issues, and/or concerns that I may have regarding my services. My Case Manager will contact me within 3 working days. Once I have talked with my Case Manager, he/she will give me a decision about that request within 14 days. If the Case Manager 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*

MEMBER NAME	*DATE OF BIRTH*	*AHCCCS ID #*

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 Health Care Decision Maker, and other people involved in the plan.*

I, ________________________________ hereby consent to the release of the following information from my My PCSP or section(s) of my plan with the following individuals:

NAME	RELATIONSHIP TO MEMBER	ONLY THE FOLLOWING INFORMATION CAN BE RELEASE UNDER THIS CONSENT:	DATE SENT
		☐ Entire Plan ☐ Member Profile ☐ Individual Setting ☐ Strengths/Preferences ☐ Individual Goals/Outcomes ☐ Services Authorized ☐Risks ☐ Modifications to Plan ☐ Action Plan	
		☐ Entire Plan ☐ Member Profile ☐ Individual Setting ☐ Strengths/Preferences ☐ Individual Goals/Outcomes ☐ Services Authorized ☐ Risks ☐ Modifications to Plan ☐ Action Plan	
		☐ Entire Plan ☐ Member Profile ☐ Individual Setting ☐ Strengths/Preferences ☐ Individual Goals/Outcomes ☐ Services Authorized ☐ Risks ☐ Modifications to Plan ☐ Action Plan	
		☐ Entire Plan ☐ Member Profile ☐ Individual Setting ☐ Strengths/Preferences ☐ Individual Goals/Outcomes ☐ Services Authorized ☐ Risks ☐ Modifications to Plan ☐ Action Plan	
		☐ Entire Plan ☐ Member Profile ☐ Individual Setting ☐ Strengths/Preferences ☐ Individual Goals/Outcomes ☐ Services Authorized ☐Risks ☐ Modifications to Plan ☐ Action Plan	

_______________	_______________	_______________
MEMBER NAME	*DATE OF BIRTH*	*AHCCCS ID #*

ACKNOWLEDGMENT OF MEMBER RIGHTS AND RESPONSIBILITIES

I (or my Health Care Decision Maker), ___________________________, have received a copy of the Long Term Care Member Handbook. I (or my Health Care Decision Maker) 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: ____

MEMBER NAME	*DATE OF BIRTH*	*AHCCCS ID #*

FOR CASE MANAGER USE ONLY

Placement: ☐ D ☐ H ☐ Q ☐ Z

MAJOR DIAGNOSIS (*MUST HAVE AT LEAST ONE BUT ALLOW UP TO 3*)	
CHRONIC DISEASE	**INTELLECTUAL/DEVELOPMENTAL DISABILITY**
☐ Dementia/Alzheimer's	☐ Neurodevelopmental Disorder
☐ Other Neurological	☐ Autism Spectrum Disorder
☐ Head/Spinal Cord Injuries	☐ Cerebral Palsy
☐ Metabolic	☐ Down Syndrome
☐ Cardiovascular	☐ Fetal Alcohol Syndrome
☐ Musculoskeletal	☐ Prader-Willi Syndrome
☐ Respiratory	☐ Spina Bifida Tourette Syndrome
☐ Hematologic/Oncologic	☐ Other; If other, specify:
☐ Psychiatric	☐ ______________________
☐ Gastrointestinal	☐ ______________________
☐ Genitourinary	☐ ______________________
☐ Skin Conditions	
☐ Sensory	
☐ Infectious diseases	
☐ Seizure Disorder/Epilepsy	
☐ Congenital anomalies/Developmental Conditions	
☐ Other; If other, specify:	
☐ ______________________	
☐ ______________________	
☐ ______________________	

MEMBER NAME	*DATE OF BIRTH*	*AHCCCS ID #*

DID MEMBER CHOOSE AGENCY WITH CHOICE FOR IN-HOME SERVICES? *(Attendant Care, Personal Care, Homemaker or Habilitation)* ☐ Yes ☐ No

DID MEMBER CHOOSE SELF-DIRECTED ATTENDANT CARE? ☐ Yes ☐ No

WHAT IS MEMBER'S EMPLOYMENT STATUS?

☐ Retired
☐ No Work History
☐ Some Work History
☐ Currently Employed Full Time
☐ Currently Employed Part Time
☐ Currently Seeking Employment

WHAT IS MEMBER'S HIGHEST EDUCATIONAL LEVEL?

☐ Attended Grade/Elementary School
☐ Some High School
☐ Graduated High School/GED
☐ Some College/Technical School
☐ Completed Technical School program
☐ Bachelor's Degree
☐ Associates Degree
☐ Graduate College Degree (Masters, Doctorate)
☐ Considering/Interested in returning to school

WHAT IS MEMBER'S CURRENT LEVEL OF CARE?

☐ Class 1
☐ Class 2
☐ Class 3
☐ Wandering/Dementia
☐ Behavioral
☐ Sub-Acute Medical
☐ Respiratory/Vent
☐ Other: ______________________

_______________________________ *MEMBER NAME* _______________ *DATE OF BIRTH* _______________ *AHCCCS ID #*

ARE ANY OF THE MEDICATIONS LISTED UNDER THE MEDICATIONS SECTION ANTIPSYCHOTICS?

☐ Yes ☐ No

MEMBER'S ASSIGNED BEHAVIORAL HEALTH CODE: ______

BEHAVIORAL HEALTH TREATMENT PLAN:

☐ Yes ☐ No

Notes:

COURT ORDERED TREATMENT (COT):

☐ Yes ☐ No

Notes:

ORIENTATION/MEMORY:

Check the following as they apply to the member's Orientation/Memory:

Check as many as apply:

☐ Appropriate
☐ Alert
☐ Forgetful
☐ Lethargic
☐ Confused
☐ Unresponsive
☐ Incoherent
☐ Oriented to Person
☐ Oriented to Place
☐ Oriented to Time/Day

ORIENTED X:

☐ 1 ☐ 2 ☐ 3