Member's Name	AHCCCS ID #	Date

Next Review Date: (check one)	
☐	Not to exceed 90 days *(HCBS)*
☐	Not to exceed 180 days *(Nursing Facility or DDD Group Home)*
☐	Annual (Acute Care Only)

I CHOOSE THE FOLLOWING SERVICE MODEL:
(Check "N/A" for members not receiving Attendant Care, Personal Care, Homemaker, or Habilitation)

☐ **TRADITIONAL** ☐ **AGENCY WITH CHOICE** ☐ **SELF-DIRECTED ATTENDANT CARE** ☐ **INDEPENDENT PROVIDER** *(DDD MEMBERS)* ☐ **N/A**

SERVICE & PROVIDER	SERVICE FREQUENCY IN PLACE PRIOR TO THIS ASSESSMENT	SERVICE FREQUENCY CURRENTLY ASSESSED	SERVICE CHANGE *(check one)*			START/ END DATE	MEMBER/ REPRESENTATIVE *(check one)*
			☐ None	☐ New	☐ Increase		☐ Agree
			☐ Reduce	☐ Terminate	☐ Suspend		☐ Disagree
			☐ None	☐ New	☐ Increase		☐ Agree
			☐ Reduce	☐ Terminate	☐ Suspend		☐ Disagree
			☐ None	☐ New	☐ Increase		☐ Agree
			☐ Reduce	☐ Terminate	☐ Suspend		☐ Disagree
			☐ None	☐ New	☐ Increase		☐ Agree
			☐ Reduce	☐ Terminate	☐ Suspend		☐ Disagree
			☐ None	☐ New	☐ Increase		☐ Agree
			☐ Reduce	☐ Terminate	☐ Suspend		☐ Disagree

COMMENTS:

Service Plan Acknowledgement: My service plan 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 above. 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 above. 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.

Effective Dates: 02/01/09, 03/01/13, 01/01/16, 10/01/17
Revision Dates: 03/01/13, 01/01/16, 07/25/17

Member's Name *AHCCCS ID #* *Date*

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.

CASE MANAGER: *Please list all non-ALTCS funded services provided by payer source (i.e. Medicare). Attach a separate page if more lines are needed. Please do not include informal/natural supports, as they are listed on the HNT.*

NON-ALTCS FUNDED SERVICE	RESPONSIBLE PARTY/PAYER SOURCE	APPROXIMATE SERVICE FREQUENCY *(EXAMPLE: DAILY, WEEKLY, MONTHLY)*

I know that I can ask for another service planning meeting to go over my needs and any changes to this plan that are needed. I can contact my case manager _____ at (____) _____-_____. I also know that I can contact my case manager at any time to discuss any questions, issues, and/or concerns that I may have regarding my services. My case manager will contact me within three working days. Once I have talked with my case manager, s/he 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/Legal Representative Signature *Date*

Individual Representative Signature (Agency with Choice only) *Date*

Case Manager Signature *Date*

OTHER ATTENDEES: *(Attendees please note that by signing below, you are saying you participated in today's service planning meeting and not attesting to whether or not you are in agreement/disagreement with this service plan)*

Name	*Signature*	*Name of Agency/Relationship*	*Date*

Case Managers: *Please document when the service plan was sent to the Member/Guardian/Designated Representative,* [1]

Name *Date*

Effective Dates: 02/01/09, 03/01/13, 01/01/16, 10/01/17
Revision Dates: 03/01/13, 01/01/16, 07/25/17

Member's Name	*AHCCCS ID #*	*Date*

*Exhibit 1620-13 is also available in Spanish. See Appendix K, Select ALTCS Case Management Forms in Spanish.