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Effective Dates: 06/01/21, 01/25/23, 10/01/23, UPON PUBLISHING
Approval Dates: 06/23/20, 04/01/21, 11/03/22, 07/18/23, XX/XX/XX

SUPPLEMENTAL DOCUMENTS/DOCUMENTATION (DISCUSS/COMPLETE/DOCUMENT AS APPLICABLE):

- ☐ Advance Directives
- ☐ Advance Directives for Pets
- ☐ Assisted Living Facility (ALF) Residency Agreement (AMPM Exhibit 1620-15)
- ☐ Behavioral Health Quarterly Reviews
- ☐ Behavioral Health Treatment Plan
- ☐ CommunityCares Closed-Loop Referral System (CLRS)[1]
- ☐ Community Intervener Member Assessment Tool
- ☐ Direct Care Service Acknowledgment Form
- ☐ Emergency Disaster Plan
- ☐ End of Life Treatment Plan
- ☐ Home and Community Based Services (HCBS) Needs Tool (HNT) (AMPM Exhibit 1620-17)
- ☐ Home and Community Based Services Scheduling Tool (AMPM Exhibit 1620-24)[2]
- ☐ Managed Risk Agreement
- ☐ Member Contingency/Back-Up Plan
- ☐ Minor Caregiver Options Discussion Guide and Decision Roadmap (AMPM Exhibit 1620-21)[3]
- ☐ Parents as Paid Caregivers Acknowledgement of Understanding (AMPM Exhibit 1620-22)[4]
- ☐ Self-Directed Attendant Care Forms
- ☐ ~~Spousal~~ Spouse Attendant Care Acknowledgment of Understanding ~~Form~~ (AMPM Exhibit 1620-12)
- ☐ Social Isolation and Loneliness Screening Tool[5](AMPM Exhibit 1620-11)
- ☐ Uniform Assessment Tool (UAT) and Guidelines[6] (AMPM Exhibit 1620-3)

[1] CommunityCares (CLRS) added as "new" supplemental assessment to the person-centered planning process used to screen and refer members for social risk factors of health. In alignment with National Committee for Quality Assurance (NCQA) Long Term Services and Supports (LTSS) Standards and Elements G-3 and H-15
[2] Companion to the HNT Tool, to support assessment based upon the member's day-to-day schedule.
[3] Document to support the selection of caregiver options for minor members including the parents as paid caregiver service model option.
[4] Attestation form that is required to be reviewed and signed by the parent participating in the parents as paid caregiver service model option.
[5] Incorporated to align with the Whole Person Care priorities of social isolation for ALTCS members.
[6] Adding complete title of the Exhibit.

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Approval Dates: 06/23/20, 04/01/21, 11/03/22, 07/18/23, XX/XX/XX

I. MEETING INFORMATION

Person-Centered Service Plan Revision Date: _____

I CONSENT ~~TO~~ FOR 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~~,~~ OR EMAIL)*
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

COMMUNICATION PREFERENCES:		
Contact Preference *(phone, mail, email, other)*:		
Best Time to Contact:		
Spoken Language		
Written Language:		
Cultural and Language Needs:[7]		
Interpreter Needed?	☐ Yes ☐ No ☐ N/A	
Meeting location:		
Was the member/Health Care Decision Maker (HCDM) asked to decide when and where the meeting took place?	☐ Yes ☐ No ☐ N/A	
Did the member/HCDM 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:		

[7] Added per 1 Element F Factor 10

Effective Dates: 06/01/21, 01/25/23, 10/01/23, UPON PUBLISHING
Approval Dates: 06/23/20, 04/01/21, 11/03/22, 07/18/23, XX/XX/XX

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

MEMBER/RESPONSIBLE PERSON CONTACT INFORMATION *(IF APPLICABLE OR IF INFORMATION HAS CHANGED)*	
Health Care Decision Maker (HCDM) (If applicable):	
Designated Representative (DR) (if applicable):	
Power of Attorney (If applicable):	
Public Fiduciary (If applicable):	
Name of Social Security Payee (If applicable):	
Serious Mental Illness (SMI) Special Assistance Advocate (if applicable):	
Other:	

MEETING NOTES OR SPECIAL CONSIDERATIONS:

II. MEMBER PROFILE

~~Document (~~In the summary of discussion below, document a[8] brief background of the member's lived and life experiences (e.g., place of birth, developmental history, education, and employment history, justice system involvement, previous living situations):

Summary of Discussion (e.g., lived/life experiences including cultural or spiritual beliefs)[9]: _____

_____

_____

Have you served in the military? ☐ Yes ☐ No

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?

What can you tell me about your past medical history (medical diagnosis, surgeries, significant treatments/illnesses, and past medications[10], including dates, if possible)?

Have there been any major changes in your life recently (since we last spoke/last review)? ☐ Yes ☐ No[11]

[8] Language added to clarify where the member's background of lived/life experiences is to be documented.
[9] Added for clarity of what the summary should be describing and to align with National Committee for Quality Assurance (NCQA) Long Term Services and Supports (LTSS) 1 Element F Factor 10.
[10] Added to current list of past medical history examples for clarification.
[11] Added to indicate a change in condition.

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

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

Is there an area regarding your physical or behavioral 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)

Are you interested in learning about or receiving life planning information and resources (*e.g., member or responsible person's will, end of life plan, advanced directives*)? [12] ☐ Yes ☐ No

Have you completed any Life Planning Activities (*e.g., completing member or responsible person's Will, end of life plan, advanced directives)?*[13] ☐ Yes ☐ No

Summary of Discussion*:*

SUMMARY OF DISCUSSION: *(include what is being reviewed/discussed above, as well as any resources offered/provided)*[14]**:**

III. PREFERENCES AND STRENGTHS

Documentation shall include key aspects of daily routines and rituals which 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, as well as what does and does not work for the member[15].

- *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, but would like to?*
- *What makes you happy currently?*
- *Anything that has happened recently that makes you feel good or proud?*
- *What health beliefs and behaviors*[16] ~~*traditions and practices*~~ *(e.g., family, cultural, religious, traditions~~.~~) are important to you?*

[12] Added to promote review/discussion of life planning information and resources.
[13] Added to promote review/discussion of life planning activities.
[14] Language added to ensure the documentation of additional information reviewed/discussed within this section, including resources offered/provided.
[15] Language added in support of new requirements under 2024 AZ SB 1618.
[16] Language added to support NCQA LTSS 1 Element F Factor 9

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

- *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?*
- *Do you have activities that you like to participate in or groups that you belong to?* [17]
- *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?*
- *Are you registered to vote? If no, are you interested in registering?*

SUMMARY OF DISCUSSION: _____

_____

_____

FOR MEMBERS[18] ~~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 DISCUSSION:

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 this document, medical support includes 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 and if so, why?

[17] Additional discussion point added for the case managers.
[18] Changed per policy standard throughout the exhibit.

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

☐ Yes ☐ No

SUMMARY OF DISCUSSION[19]:

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 and if so, why?
☐ Yes ☐ No

SUMMARY OF DISCUSSION[20]:

[19] Added to promote the documentation of discussions with members as it relates to changes to medical supports and other medical information.
[20] Added to promote the documentation of discussions with members as it relates to changes to medical supports and other medical information.

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

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

SUMMARY OF DISCUSSION (Include effective dates of any changes to insurance coverage or providers): _____

_____

_____

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 (ALF)			
☐ Yes ☐ N/A	Behavioral Health Services			
☐ Yes ☐ N/A	Community Health Representative (CHR)			
☐ 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 (OT)			
☐ Yes ☐ N/A	Physical Therapy (PT)			

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

HAS PROVIDER?	PROVIDER TYPE	PROVIDER AGENCY	PROVIDER NAME	CONTACT INFORMATION
☐ Yes ☐ N/A	Public Health Nurse			
☐ Yes ☐ N/A	Respite			
☐ Yes ☐ N/A	Senior Programs			
☐ Yes ☐ N/A	Skilled Nursing Facility (SNF)/Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID)			
☐ Yes ☐ N/A	Speech Therapy (ST)			
☐ Yes ☐ N/A	Vocational Rehabilitation (VR)			
☐ Yes ☐ N/A	Work Program			
☐ Yes ☐ N/A	Other:			

**Attendant care, Personal care, Homemaker*

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/over the counter/vitamins/ supplements). Use additional pages as needed: [21]

NAME OF MEDICATION	DOSAGE/ FREQUENCY	WHY ARE YOU TAKING THIS MEDICATION? (FOR BH MEDICATION INCLUDE DRUG USE TYPE)[22]	IS THE MEDICATION EFFECTIVE (Y/N) IF NO, EXPLAIN	SIDE EFFECTS (Y/N) IF YES, EXPLAIN	PRESCRIBING PHYSICIAN	CHECK ONLY IF CLASSIFIED AS A PSYCHOTROPIC MEDICATION
						☐
						☐
						☐
						☐

[21] Added psychotropic medication

[22] Typo corrected. Replaced "OR" with "For"

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

Where are your prescriptions filled?

Are you taking your medications as prescribed? ☐ Yes ☐ No If not, why? What support/assistance would help you to do so?

Are you taking antipsychotic medications?[23] ☐ Yes ☐ No

Do you experience any other adverse side effects that are not necessarily tied to a specific medication?[24]
☐ Yes ☐ No

SUMMARY OF DISCUSSION: _____

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

[23] Added to documents the use of antipsychotic medications.
[24] Added to allow for the documentation of other adverse side effects

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

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?

Has there been a change to your medical supplies since the last meeting? ☐ Yes ☐ No

Do you have any issues with your medical supply deliveries? ☐ Yes ☐ No[25]

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

BMI ~~(pediatric members)~~: Document BMI education (e.g., counseling for nutrition and physical activity)[26] for ~~Pediatric~~ members ~~(if applicable)~~:

[25] Added question regarding service delivery.

[26] Examples, including but not limited to, "counseling for nutrition and physical activity" added for clarification.

PREVENTATIVE SCREENING SERVICES

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

☐ Annual Eye Exam/Diabetic Retinal Exam (DRE)
☐ Blood Pressure Screening
☐ Cancer Screening
☐ Cervical Screening
☐ Colon Cancer Screening
☐ Dental Exam
☐ Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)/Well-Care Visit (refer to periodicity schedule)
☐ Family Planning ~~Screening~~
☐ General Health Exam
☐ Hemoglobin A1C (HbA1c) – Diabetes Screening
☐ Hearing Test
☐ Lipid Profile/Cholesterol Screening
☐ Mammogram Screening
☐ Osteoporosis Screening
☐ Prostate Screening
☐ Sexually Transmitted ~~Disease~~ Infection (ST~~D~~)I) Education/Awareness/Protection
☐ Other: _____
☐ Other: _____

SUMMARY OF DISCUSSION: _____

_____

_____

Flu Vaccination: ☐ No ☐ Yes Date: _____

COVID Vaccination: ☐ No ☐ Yes Date: _____

Pneumonia Vaccination: ☐ No ☐ Yes Date: _____

Have you stayed overnight as a patient in a hospital? ☐ Yes ☐ No
If yes, describe frequency and circumstances (below).

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 below.~~:~~

Do you have any surgeries/procedures scheduled for the next six months? ☐ Yes ☐ No
If yes, describe below:

If a child, when was the child's last well care visit (EPSDT visit)? Date: _____

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)

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

SUMMARY OF DISCUSSION:

If determined SMI, has the member been assessed/referred for Special Assistance from the Office of Human Rights (OHR)?
☐ Yes ☐ No If no, explain why:

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 full access to the benefits of community living. Documentation shall reflect the setting is of the member~~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 shall~~hould~~ 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?*
- *Do you feel safe in your home?*
- *Do you like the people you interact with each day?*[27]
- ~~-~~*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 people who do not live in your home?*
- *Do you have people or friends who have common interests that you do things with?*
- *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?*

[27] Added to suggested an opportunity to consider additional insights into member care.

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

- *Do you have people that you can talk to who are not individuals that provide services to you? Are these individuals you trust and you can depend on-to be there for you?*[28]
- *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?*
- Are you currently experiencing any concerns related to food, money, personal safety, housing, or transportation?

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.

SUMMARY OF DISCUSSION: _____

_____

_____

LIVING ARRANGEMENTS			
☐	Lives Alone	☐	Behavioral Health Facility or Unit
☐	Lives with Family/Other	☐	Uncertified Setting
☐	Nursing Facility (NF)	☐	Homeless
☐	Alternative HCBS Setting	☐	Other:

DESCRIBE CURRENT LIVING/ENVIRONMENT CONDITIONS:

Document alternative Home and Community-Based Settings (HCBS) 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.~~):

SUMMARY OF DISCUSSION: _____

_____

_____

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

Do you have suggestions of what we could work on that could make your living arrangement better?

[28] Three new bullets added to this section which aim to address social isolation and loneliness.

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

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

DAILY LIVE (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 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 quests are "negative" because 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 are 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 have suggestions of what we could work on that could make your program (e.g., day/ employment/educational program) better? ☐ Yes (*if yes, note in goal section as appropriate*) ☐ No

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

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 If yes, document community assistance requested and resources provided below.[29]

SUMMARY OF DISCUSSION: _____

_____

_____

V. INDIVIDUALIZED GOALS AND OUTCOMES

DIRECTIONS FOR CASE MANAGER: For members utilizing the parents as a paid caregiver service model option, there must be at least one member-directed and individualized goal focused on community engagement with peers in community settings.[30]

Considerations: *What do you want to start learning/doing now? What is something that interests you that we can help you do? Are you able to be as independent in your personal care and/or healthcare as you would like to be? What might help you reach your goals?*

WHAT AREA OF YOUR LIFE WOULD YOU LIKE THE TEAM TO SUPPORT YOU IN? (*Goals are listed in order of priority. Use additional pages as needed and number each goal accordingly*).

☐ Health ☐ Home Life ☐ Daily Life

GOAL #1:	
OUTCOME:	**TARGET COMPLETION DATE:**[31]
Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)? _____	
What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.)? ~~The case manager should document members' active participation in goal progress or achievement.~~[32]	
A.	
B.	
C.	

[29] Added language for confirmation of resource provision.
[30] Added reminder for case managers that members using the PPCG service model option should have a personal goal around interaction with peers in community settings.
[31] Added to support NCQA CM LTSS accreditation – NCQA Standard LTSS 1I: Person Centered Assessments.
[32] Moved below under "PROGRESS ON GOAL"

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

WHO WILL DO:	WHEN?
A.	
B.	
C.	

PROGRESS ON GOAL
The case manager shall- document the members' active participation in goal progress or achievement as their self-management plan[33] ***(i~~I~~nclude progress updates from all planning team members and action items)***:

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

☐ Health ☐ Home Life ☐ Daily Life

GOAL #2:	
OUTCOME:	**TARGET DATE:**
Where are they now (at the time of this plan, including any barriers impacting/preventing the member from completing or achieving their goal)?	
What actions will the team take to support the member in achieving/reaching their goal, including re-assessing goals, interventions, strategies for goal success, etc.? ~~The case manager shall document members active participation in goal progress or achievement:.~~	
A.	
B.	
C.	

WHO WILL DO:	WHEN?
A.	
B.	
C.	

[33] Revised to support NCQA CM LTSS accreditation-NCQA Standard LTSS K4: Development and communication of self management plans.

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

PROGRESS ON GOAL
The case manager shall document members active participation in goal progress or achievement as their self-management plan ~~*(Include*~~ *(Include* ***progress updates from all planning team members and action items)***:

IS THERE ANOTHER AREA OF YOUR LIFE THAT YOU WOULD LIKE TO WORK ON? ☐ Yes ☐ No

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):**	

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

VII. SERVICES AUTHORIZED

PAID SERVICES/SUPPORTS
Documentation shall reflect the service options and provider options provided and discussed with the member/HCDM.[34] Documentation shall also 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 current 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?

SUMMARY OF DISCUSSION: _____

_____

_____

For members~~individuals~~ living in their own home, ensure all service models have been discussed using ALTCS Member Service Options Decision Tree or the Minor Caregiver Options: Discussion Guide and Decision Roadmap.[35]

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 support 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?

SUMMARY OF DISCUSSION: _____

_____

_____

[34] Added to promote the documentation of service/provider options discussed/provided.
[35] Adding reference to the discussion guide and roadmap to support the selection of caregivers options including the parent as paid caregiver service model option.

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

SERVICE MODEL SELECTED

☐ Traditional ☐ Agency with Choice ☐ Independent Provider (DDD) ☐ Parents as Paid Caregiver[36]
☐ Self-Directed Attendant Care (EPD)[37] ☐ Spousal Attendant Care ☐ N/A

NON-PAID SERVICES/SUPPORTS

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 member~~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?

SUMMARY OF DISCUSSION (~~*list out*~~*including non-paid "natural supports" involved in member's life*)**:**

[36] Added PPCG to the list
[37] Clarified right now the model is limited to EPD

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

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

LIST ALL NON-ALTCS FUNDED SERVICES PROVIDED BY PAYER SOURCE *(~~I~~E.G., MEDICARE)*		
NON-ALTCS FUNDED SERVICE	**RESPONSIBLE PARTY/PAYER SOURCE**	**APPROXIMATE SERVICE FREQUENCY *(~~EXAMPLE~~E.G.,~~:~~ 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 member's ~~individual's~~ general health condition and quality of life.

EVERY ~~INDIVIDUAL~~ MEMBER 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)
- If risk is deemed to be EM, the **SUMMARY OF DISCUSSION** below shall be used to outline the information and sources utilized in making this determination.[38]
- If FA is needed, the **SUMMARY OF DISCUSSION** below shall be used to reflect next steps/how this will/was addressed. [39]
- Consider normal and unusual risks for the member ~~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.

SUMMARY OF DISCUSSION: _____

[38] Added to clarify the expectation for documenting risks identified as "Effectively Managed" including information and sources utilized in making this determination.
[39] Added to clarify the expectation for documenting risks identified as requiring "Further Assessment" including next steps and how the risk/s will be/were addressed.

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

HEALTH AND MEDICAL RISKS		SAFETY AND SELF-HELP RISKS		MENTAL HEALTH, BEHAVIORAL AND LIFESTYLE RISKS	
☐	Allergies:	☐	Access to body of water:	☐	Isolation/isolating behavior:
☐	Aspiration and/or pneumonia infection:	☐	Access to medication:	☐	Military Service/Veteran related illness or injury:
☐	Choking:	☐	Court involvement*:		
☐	Constipation:	☐	Does not or cannot evacuate a home or vehicle in an emergency:	☐	Other Mental Health, Behavioral or Lifestyle Risks: *(loss of loved one, feeling sad, angry, or otherwise "not yourself"?)*:
☐	Dehydration:				
☐	Diabetes:				
☐	Dietary:	☐	Exploitation:	☐	Past or potential police/ justice involvement:
☐	End Stage Renal Disease (ESRD) or on dialysis:	☐	Falls:		
☐	Feeding Tube:	☐	Household chemical safety:	☐	Physical aggression:
☐	Heart problems; high or low blood pressure:	☐	Lack of fire safety skills:	☐	Placing in mouth, or ingesting non-edible objects or PICA:
☐	Hepatitis C:	☐	Lack of judgement or difficulty understanding consequences:		
☐	Medical Restrictions:			☐	Property destruction:
☐	Oxygen use:			☐	Self-abusive behaviors:
☐	Pregnancy:				
☐	Refusing medical care:	**MENTAL HEALTH, BEHAVIORAL AND LIFESTYLE RISKS**		☐	Smoking/vaping:
☐	Seizures:			☐	Substance use: drug, alcohol or other:
☐	Serious or chronic health condition(s):		Attempted Suicide:		
☐	Skin breakdown:	☐	Court involvement*:	☐	Traumatic illness/injury:
☐	Unreported/reported illness:	☐	Expressed Suicidal Thoughts:	☐	Unsafe use of flammable materials:
☐	Unreported/reported pain:	☐	Extreme food or liquid seeking Behavior:	☐	Use of objects as weapons:
☐	Unsafe medication management:	☐	Harm to animals:	☐	Wandering or Exit seeking behavior:
☐	Ventilator/Trach dependent:	☐	High risk or illegal sexual behavior:	**FINANCIAL RISKS**	
☐	Other Health or Medical Risk:	☐	Illegal behavior:	☐	Financial exploitation or abuse:
		☐	Inappropriate sexual behavior:	☐	Lack of individual resources:
		☐	Invades personal space:	☐	Other Financial Risk:

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

IX. RISK ASSESSMENT*Can include court ordered protections, restrictions, and treatment*

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.~~[40] 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 member~~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:

[40] Language removed here and added/revised in the " IDENTIFICATION OF RISKS" section above. This also clarifies that the "RISK ASSESSMENT" section is only applicable if/when a member's rights/independence are restricted. *Not all identified risks require a risk assessment as defined by the HCBS Rules.*

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

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)?*

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/HCDM prior to being implemented. Modification made to this plan by the planning team cannot be made without the member/HCDM'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 (PCSP):

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

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:

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 member~~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 case manager has provided me with information about fraud, waste, and abuse, including how to report abuse, neglect, exploitation, and other critical incidents.

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 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. The letter will tell me how to appeal the decision that has been made about my services. The letter will also tell me how I can receive continued services.

My 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 the services I agree with today. I know that if I change my mind before the changes go into effect, I will get a letter that tells me the reason my services 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 and/or related to fraud, waste, and abuse.

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.
*By signing on behalf of the member I attest, I have prioritized the individual's needs, choices and preferences as part of the person centered service planning process and supported decision making in the best interest of the member including supporting their self-determination to the maximum extent possible.[41]

[41] Added statement regarding the focus of participation is in support of the best interest of the member

MEMBER NAME	DATE OF BIRTH	AHCCCS ID #

MEMBER~~/HEALTH CARE DECISION MAKER SIGNATURE~~	DATE
HEALTH CARE DECISION MAKER SIGNATURE*	DATE
INDIVIDUAL REPRESENTATION SIGNATURE (AGENCY WITH CHOICE ONLY)*	DATE
ALTCS CASE MANAGER/SUPPORT COORDINATOR SIGNATURE	DATE

Other Attendees Responsible for Plan Implementation:

I prioritized the individual's needs, choices and preferences as part of the personal centered service planning process and supported decision making in the best interest of the member including supporting their self-determination to the maximum extent possible.[42]

NAME	SIGNATURE	NAME OF AGENCY/RELATIONSHIP	DATE
NAME	SIGNATURE	NAME OF AGENCY/RELATIONSHIP	DATE
NAME	SIGNATURE	NAME OF AGENCY/RELATIONSHIP	DATE

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: *A copy of the PCSP shall be provided to the member/HCDM and providers. The member/HCDM, can give permission for the case manager to share the PCSP[43] ~~as well as~~ with other ~~all~~ parties involved in the member's care and/or in the development of the PCSP (as consented to by the member/HCDM below). The PCSP shall be signed by the member/HCDM, as well as all other attendees responsible for the implementation of this plan. Document when the PCSP was sent to the Member, and/or the HCDM, 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:

[42] Added statement regarding the focus of participation is in support of the best interest of the member
[43] Revised to clarify that case manager can share Person Centered Service Plan per member permission

MEMBER NAME	DATE OF BIRTH	AHCCCS ID #

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

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 NAME	*DATE OF BIRTH*	*AHCCCS ID #*

MEMBER / HEALTH CARE DECISION MAKER'S SIGNATURE _____ *DATE* _____

XIII. NEXT MEETING INFORMATION

NEXT REVIEW DATE (*CHECK ONE*):

☐ Not to exceed 90 days (HCBS)
☐ Not to exceed 180 days (Nursing Facility (NF), ICF-ID, or DDD Group Home)
☐ Annual (Acute Care Only)

Date of Next Meeting: _____
Time: _____
Meeting Location/Address: _____

FOR CASE MANAGER USE ONLY

Placement: ☐ D ☐ H ☐ Q ☐ Z

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

MAJOR DIAGNOSIS
(*MUST HAVE AT LEAST ONE BUT ALLOW UP TO THREE*)

CHRONIC DISEASE	INTELLECTUAL/DEVELOPMENTAL DISABILITY
☐ Dementia~~u~~/Alzheimer's	☐ Neurodevelopmental Disorder
☐ Other Neurological	☐ Intellectual/Cognitive Disability
☐ Head/Spinal Cord Injuries	☐ Autism Spectrum Disorder
☐ Metabolic	☐ Cerebral Palsy
☐ Cardiovascular	☐ Down Syndrome
☐ Musculoskeletal	☐ Fetal Alcohol Syndrome
☐ Respiratory	☐ Prader-Willi Syndrome
☐ Hematologic/Oncologic	☐ Spina Bifida
☐ Psychiatric	☐ Tourette Syndrome
☐ Gastrointestinal	☐ Epilepsy[44]
☐ Genitourinary	☐ Other; If other, specify:
☐ Skin Conditions	☐ _____
☐ Sensory	☐ _____
☐ Infectious diseases	
☐ Seizure Disorder/Epilepsy	
☐ Congenital anomalies/Developmental Conditions	
☐ Other; If other, specify:	
☐ _____	
☐ _____	
☐ _____	

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 ☐ N/A (*For DDD notation only*)

[44] Additional DDD qualifying diagnosis added.

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

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?

EPD MEMBERS ONLY:

☐ Class 1
☐ Class 2
☐ Class 3
☐ Wandering/Dementia
☐ Behavioral
☐ Sub-Acute Medical
☐ Respiratory/Vent
☐ Other: _____
☐ N/A (*DDD Member*)

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

DDD MEMBERS ONLY:

☐ MLOC 1
☐ MLOC 2
☐ MLOC 3
☐ MLOC 4
☐ MLOC 5
☐ MLOC 6
☐ MLOC 7
☐ N/A (*EPD Member*)

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

☐ Yes ☐ No

MEMBER'S ASSIGNED BEHAVIORAL HEALTH CODE: _____

SUMMARY OF DISCUSSION:	

BEHAVIORAL HEALTH TREATMENT PLAN:

☐ Yes ☐ No

DDD MEMBERS ONLY:

☐ QBHR Dates of Review: _____[45]

SUMMARY OF DISCUSSION:

COURT ORDERED TREATMENT (COT):

☐ Yes ☐ No

SUMMARY OF DISCUSSION:

[45] Added to align with NCQA LTSS 1 Element H 5

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

ORIENTATION/MEMORY[46]**:**

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

Check as many as apply:

☐ Appropriate

☐ Alert, able to focus and shift attention, comprehends and recalls direction independently

☐ Oriented to Person

☐ Oriented to Place

☐ Oriented to Time/Day

☐ ~~Forgetful~~Requires prompting (cuing, repetition, reminders) only under stressful situations or unfamiliar conditions

☐ ~~Lethargic~~ Requires assistance and some direction in specific situations (e.g. on all tasks involving shifting attention) or consistently requires low stimulus environment due to distractibility

☐ ~~Confused~~Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.

☐ ~~Unresponsive~~Totally dependent due to disturbance such as constant disorientation, coma, persistent vegetative state or delirium

~~☐ Incoherent~~

~~☐ Oriented to Person~~

~~☐ Oriented to Place~~

~~☐ Oriented to Time/Day~~

ORIENTED X:

☐ 1 ☐ 2 ☐ 3

[46]Revised section to align with NCQA LTSS- 1 Element F,H Factor 6

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

SOCIAL ISOLATION ASSESSMENT AND SCREENING:[47]

A member might be experiencing or at risk of social isolation if they do not have all four of the following:

- **Trusted Relationships** – People they can talk with, confide in, and depend upon
- **Social Connections** – People with common interests that they do activities with (in-person or online)
- **Community Engagement Activities** - Participation in activities in the community and/or groups the member participates in
- **Access to the Community** – Support for participating in activities and spending time with others (e.g., transportation, internet access, personal assistance).

Were any concerns expressed or identified with any of the above?

☐ Yes ☐ No

If Yes is marked in the question above and/or if the CM is unsure if the member is at risk of or experiencing social isolation, the CM should administer the *Social Isolation and Loneliness Assessment and Screening Tool in AMPM Exhibit 1620-11.* The completed screening shall be attached to the PSCP.

[47] Incorporated to align with the Whole Person Care priorities of social isolation for ALTCS members.