ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

ISP - ANNUAL REVIEW AND UPDATE PACKET
At Home Adult

Table of Contents

DDD-1623A FORFF (8-13)
(DDD-1472A packet)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

PLANNING MEETING ATTENDANCE SHEET

INDIVIDUAL'S NAME *(Last, First, M.I.)*	DATE
Learner, Ima	2/4/2019

LOCATION OF MEETING *(No., Street, City, State, ZIP Code)*

123 Study Street, Phoenix, az

REASON FOR TEAM MEETING:

ISP Planning Meeting

SIGNATURES

Signature indicates attendance at the meeting. Please indicate people in attendance who would not or could not sign.

Team Member's Name *(print)*	**Relationship to Person**	**Team Member's Signature**	**Date**
Ima Learner			
Mrs. Learner			
Helper			
Support Coordinator			

DDD-1512A FORFF (3-17)
(DDD-1472A packet)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

ACKNOWLEDGMENT OF PUBLICATIONS / INFORMATION

MEMBER / RESPONSIBLE PERSON'S NAME *(Print or type)*	LOCATION OF MEETING	DATE
Ima Learner	123 Study Street, Phoenix, az	2/4/19

The Member/Responsible Person will acknowledge receipt of the publication/information by placing his/her initials next to the applicable statements.

Required Annually for All Members

ML — I was informed of the opportunity to choose my Support Coordinator. I understand my choice will be honored to the best of the District's ability

ML — I understand the member eligible for the Division must be present at all meetings.

ML — I understand I can raise a concern to the Human Rights Committee (HRC) about a possible violation of the rights of an eligible member by calling 1-866-229-5553.

ML — I understand that the Human Rights Committee members and the Program Review Committee members will have access to my personal information in the performance of official duties.

ML — The Division gave me a Statement of Rights (PAD-195) and Notice of Privacy Practices (DES-1077A). I may also go to the Division's website[1] to obtain a copy.

ML — I understand the Division may disclose to providers any historical and behavioral information per A.R.S. 36-557 (N).

ML — I understand the Support Coordinator may assist me in developing a disaster/emergency plan.

Additional Requirements for Specific Groups

ML — I understand that the services offered through the ALTCS program are described in the ALTCS Member Handbook *(PAD-465 that is required annually for all ALTCS members)*. The Handbook was given or offered to me. I may also go to the Division's website[1] to obtain a copy.

ML — The pamphlet, Decisions About Your Healthcare (PAD-588), was given or offered to me. I may also go to the Division's website[1] to obtain a copy. *(Required annually for all members age 18 or older.)*

ML — The Voter Registration information was given or offered to me. I may also go to the Arizona Secretary of State's website[2] to obtain a copy. *(Required for members who do not have a legal guardian, and who are or will be 18 by the next general election.)*

ML — I was informed of my requirement to register with the Selective Service. *(Required for males at age 18.)*

[1] des.az.gov/services/disabilities/developmental-disabilities

[2] www.azsos.gov/election/VoterRegistration.htm

See Page 2 for EOE/ADA/LEP/GINA disclosures

Your signature indicates the information listed above has been reviewed.

Member's Signature *Date*

Responsible Person's Signature *Date*

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

TEAM ASSESSMENT SUMMARY

INDIVIDUAL'S NAME *(Last, First, M.I.)*	DATE
Learner, Ima	2/4/2019

Use as many pages as needed to describe the person's capacities, resources, challenges and supports needed. Areas to address must include, but are not limited to:

- **Daily routine** (What does a typical day look like? What are the best parts of the day? What are the most challenging?)
  - Communication
  - Health
  - Daily living skills (level of independence)
  - Places where the person spends time *(school, work, community)* or would like to spend time
- **Health**, including behavioral health and acute care services.
- Friends, family and other important people (unpaid) and amount of time spent together
- Paid supports (through Division or others, such as school) and amount of time spent together
- Things the person does that may gain respect/lose respect
- What things do other people do that cause loss of respect for the person?
- Accomplishments / Progress on outcomes
- How does the person make major life decisions? Who helps with major life decisions?
- Risks (As risks are discussed, complete a *Risk Assessment*, DDD-1309A)

Ima Learner is a 17 years old female with a diagnosis of eplipsy, moderate intellectual disability and communication delays. She has had speech delays since pre-school and uses an Augmentative Communication Device. Her verbal communication skills and use of the Augmentative Device have improved over the last few years which has improved her realtionships with family and friends.

Ima lives at home with her mother, younger brother and older sister who are very supportive of her. She is a responsible person who independently completes her self care routine and gets ready for school every day. Like her silblings, Ima has assigned chores to complete including putting away the dishes, cleaning her room and taking out the trash. She uses a picture chore chart to know what tasks to complete. Her Mother reports that Ima is helpful at home, often straightening up the house and helping her cook dinner. Ima states that she wants to be more independent and learn to take care of herself so that she can buy things and learn how to cook. Her mother noticed that Ima has challenges when not knowing what to do next and loud noises which cause her anxiety. Sometimes she has a loud inappropriate reaction.

Ima enjoys being with her family, playing with their dogs, watching YouTube videos, painting, coloring, using the computer and going on walks with her sister.She also enjoys being with her friends and having new experiences in the community.

The Planning Meeting was held at the family home with Mrs. Lerner and Ima who was very interested in participating in her the meeting.

Daily Routine:

Ima awakens to her alarm clock at 6:00am, completes her toiletry, grooming and gets dressed. She eats breakfast, takes her daily medication, gets lunch from the refrigerator and is picked up by her school bus in front of her house at 6:45am. At 3:30pm, Ima takes the school bus home. After school on Monday through Friday, Ima is with her Habilitation provider working on skills to increase her independence such as preparing meals, shopping for dinner and putting away groceries. Ima enjoys shopping and would like to earn money so she can buy things she likes.

When Ima's Mother returns home from work at 5:30, she participates in family activities such as playing with her siblings or enjoying down time. When her Mother begins preparing dinner, Ima often helps. She states she likes to cook. The family eats dinner together about 7:00pm, after which Ima watches TV or uses her computer. Ima completes her evening routine and is usually in bed around 9:00pm on school nights.

Currently, Ima receives Habilitation Services and Resite Care

Communication:

Ima faced speech delays during her pre-school developmental years and uses an Augmentative Communication Device. Ima's teacher has told her mother that in school, Ima is very curious, friendly, enjoys her friends and meeting new people. Ima works especially hard to please the adluts in her life.

INDIVIDUAL'S NAME *(Last, First, M.I.)*	DATE
Learner, Ima	2/4/2019

Ima mainly uses her Communication Device to talk with others but gets frustrated that it takes longer to respond. Ima tends not to use her device to ask for help or explanations. After discussing using the device to initiate conversations or request help, it was agreed that Ima will use the device consistently with her Habilitation provider when she is grocery shoppng or asking for assistance in following cooking recepies. She attends weekly Speech Therapy at school. Ima's mother had requested that Ima be evaluted for a newer device which the family is trying out at home with her.

Daily Living Skills:
Ima is self-sufficient in eating, bathing and grooming which she completes without prompts or assistance. Ima has assigned chores such as taking out the garbage and often offers to help her Mother. Currently, she is working on needed skills to become fully self-sufficient in order to live independently in the community. She wants to learn about how to handle money. Her Habilitation provider is teaching her cooking lessions using picture charts with sequential picture directions to cook a simple meal in the micowave. Ima's Habilitation provider is also helping her learn how to shop and pay for groceries on her own. In response to her question about getting to the grocery store, they discussed how habilitation services can help Ima learn how to use Dial-A-Ride or the city bus.

School/Work/Community:
Ima attends Best Years High School, where she participates in the TSW program. Ima likes school and the structure of the day. Her favorite class is art and she is doing well in her school work. Her mother noted the art teacher mentioned that Ima gets frustrated when she is unsure what to do next and sometimes yells and gets annoyed with her classmates. She has difficulties figuring out the prioritization and sequence of tasks. It was agreed that Ima will work on these tasks with her Habilitation Provider when figuring out the steps to grocery shop and make dinner.
Ima has a good group of school friends, one of whom recently got a job at Target. Ima said she wants to get a job, too. Knowing that she gets along well with others and likes to help people, after a discussion with her family and doing research including watching job videos at school, she said she would like to work in customer service as a job goal. In order to develop required skills, it was decided that Ima will participate in Transition to Employment (TTE) service during school breaks and in the summer in order to job shadow and participate in work exploration to expand her experiences

Guardianship/Major Life Decisions
Mrs. Learner makes all major life for Ima. Because Ima turns 18 soon, she has been asking if she will be able to make her own decisions. The Support Coordinator has provided information to Mrs. Learner to contact Raising Special Kids for support and orientation and classes about Guardianship.

Health:

Ima is in good health and her allergies have improved with only seasonal flare-ups. Her epilipsy is under better control during the day, but sometimes she has seizures at night and has difficulites communicating what has occurred. Her health status was good and all vaccinations are up to date.
Primary Care Physician: Dr. Wellness, MD 999-111-4444

The Behavioral Health Plan was recently implemented as Ima is showing some progress in expressing her anxitey and asking for help.
Dr. Calm Smith 888-222-444

The night time seizures were discuss with her neurologist. In order to better control the seizures, new medication was added to her current medication. Ima has a follow-up visit with the neurologist in three months. She has not had any ER or Urgent Care visits in the last 90 days.
Dr. No Seizures 777-333-4444

Ima has regular Dental Visits and good dental hygiene. Dr. Strong Teeth 666-555-444

DD-220-FF (10-14)
(DDD-1472A packet)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

ISP - SUPPORT INFORMATION

MEMBER'S NAME	DATE
Learner, Ima	2/4/2019

Skip questions A-D if member is under age 18.

A. Does the member have an Advance Directive? ..... ☒ No ☐ Yes ☐ N/A

B. If Yes, is there a copy in the file? ..... ☐ No ☐ Yes

C. Does the member have a burial plan? ..... ☒ Burial ☐ Cremation ☐ No preference ☐ No plan

D. Instructions regarding religious services *(if any)* ☐ None

ADAPTIVE EQUIPMENT

Equipment	Purpose for Use / Instructions	If not meeting needs is an action item needed?
Augmentative Communication Device	Facilitate Communication	Yes

BEHAVIORAL HEALTH

BEHAVIORAL HEALTH DIAGNOSIS
Anxiety Disorder

BEHAVIORAL HEALTH PRESENTING PROBLEMS
Verbal agression

Behavioral Health Treatment Plan ..... ☐ No ☒ Yes *If Yes, attach a copy to ISP.*

Is the member court ordered to receive Behavioral Health Treatment? ... ☒ No ☐ Yes

If Yes, per the qualified Behavioral Health Professional, has the member been compliant with treatment? ..... ☐ No ☐ Yes

MEMBER'S NAME	DATE
Learner, Ima	2/4/2019

MEDICATIONS

Assistance needed for medication self-administration: ☐ None ☐ Needs reminder ☐ Total assistance

Name of Medication	Dosage	Reason for Medication	Precautions/ Major Side Effects
Anti-Seizure Medication	Moderate Amount	Epilipsy	

SPECIAL INSTRUCTIONS

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

RISK ASSESSMENT

INDIVIDUAL'S NAME *(Last, First, M.I.)*	DATE
Learner, Ima	2/4/2019

CRITICAL DOCUMENTATION:

The Risk Assessment is used to identify risks that could compromise the individual's quality of life. It should identify what could be done differently to minimize or eliminate the risk. Any Risk Assessment document should be simple, straightforward, visible and readily available to the staff working directly with the individual. The third page may assist in determining whether Part II of the Risk Assessment is required.

- Every individual must be assessed for risk.
- If risks are determined, then Part II - Prevention of Risks must be developed.
- Consider normal and unusual risks for the individual in various areas of the person's life and discuss preventative measures.
- If additional risks are identified, use an additional form.

Is the person ALTCS eligible and receiving Attendant Care, Habilitation Independent (HAI), Nursing, Housekeeping or Respite in a Non-Licensed setting? ☐ Yes *(If yes, complete a Back-Up Plan, DDD-1309B)* ☐ No

The signature below indicates the team has assessed and determined that a Part II – Prevention of Risks is NOT necessary.

INDIVIDUAL/RESPONSIBLE PERSON'S SIGNATURE	DATE	SUPPORT COORDINATOR'S SIGNATURE	DATE

WHAT IS THE IDENTIFIED RISK?	DATE RISK IDENTIFIED
Verbal Agression	1/1/17

WHAT IS CURRENTLY WORKING TO PREVENT THE RISK?

A Behavioral Plan has been developed and put in place.

Action Item Needed? ☐ Yes ☒ No

WHAT IS THE IDENTIFIED RISK?	DATE RISK IDENTIFIED
Yelling at her family, teacher or classmates.	1/1/17

WHAT IS CURRENTLY WORKING TO PREVENT THE RISK?

Action Item Needed? ☐ Yes ☒ No

(DDD-1472A packet)

INDIVIDUAL'S NAME *(Last, First, M.I.)*	DATE
Learner, Ima	2/4/2019

WHAT IS THE IDENTIFIED RISK?	DATE RISK IDENTIFIED
Seizure disorder	1/2/10

WHAT IS CURRENTLY WORKING TO PREVENT THE RISK?

Ima is under the care of a neurologist and on anti-seizure medication

Action Item Needed? ☐ Yes ☒ No

WHAT IS THE IDENTIFIED RISK?	DATE RISK IDENTIFIED
Difficulty with communication	2/3/04

WHAT IS CURRENTLY WORKING TO PREVENT THE RISK?

Ima uses an Assistive Communication Device

Action Item Needed? ☐ Yes ☒ No

WHAT IS THE IDENTIFIED RISK?	DATE RISK IDENTIFIED
Community safety skills	

WHAT IS CURRENTLY WORKING TO PREVENT THE RISK?

Ima will learn how to sue Dial-A-Ride and city buses

Action Item Needed? ☒ Yes ☐ No

WHAT IS THE IDENTIFIED RISK?	DATE RISK IDENTIFIED
Help with Independence skills	

WHAT IS CURRENTLY WORKING TO PREVENT THE RISK?

Work with Habilitation provider to learn how to cook simple meals

Action Item Needed? ☒ Yes ☐ No

INDIVIDUAL'S NAME *(Last, First, M.I.)*: Learner, Ima

DATE: 2/4/2019

What is the Identified Risk?

☐ **None**

Life Threatening Behavior

- ☐ Alcohol Use/Abuse
- ☐ Illegal drug use
- ☐ Individual attempted suicide
- ☐ Person has ingested foreign objects
- ☐ Other _____

Medical Issues

Please list specific risks related to the diagnosis listed below

- ☐ Allergies *(Environmental, Food and/or Medications)*
- ☐ Asthma/Breathing Problems
- ☐ Bowel Problems
- ☐ Brittle Bones
- ☐ Bronchitis
- ☐ Catheter
- ☐ Cerebral Palsy
- ☐ Diabetes
- ☐ Dietary
- ☐ Feeding Tube
- ☐ Hearing/Vision Impairment
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ History of Aspiration and Pneumonia
- ☐ Infection
- ☐ Other Medical Equipment
- ☐ Respiratory/Lung Problems
- ☐ Seizures
- ☐ Skin Break Down
- ☐ Ventilator Dependent
- ☒ Other Seizures

Behavioral Issues

- ☐ Depression/Mood disorders or any mental illness
- ☐ Difficulty understanding consequences
- ☐ Invades personal space
- ☐ Pica
- ☐ Property destruction
- ☐ Runaway risk

(Continued in next column)

Behavioral Issues (continued)

- ☐ Self-Abusive
- ☐ Suicidal thoughts
- ☒ Verbal/Physical aggression
- ☐ Other _____

Safety/Self-Help

- ☐ Chokes easily
- ☐ History of ambulation concerns/falls
- ☐ Inability to evacuate home in an emergency situation
- ☐ Lack of judgment
- ☒ Lacks community safety
- ☐ Lacks fire safety skills
- ☐ Lacks Stranger Danger skills
- ☐ Memory loss
- ☐ Past or potential for police involvement
- ☐ Risk of exploitation
- ☐ Other _____

Risks associated when a provider does not show up

- ☐ Cannot self-medicate
- ☐ Cannot use the telephone
- ☒ Difficulty with communication
- ☐ Difficulty with reading comprehension
- ☐ Does not recognize signs of an illness
- ☐ Food handling and storage
- ☐ Managing own finances
- ☐ Relying on an untrained caregiver
- ☐ Unable to complete independently; dressing, cooking, feeding, bathing or using the bathroom
- ☐ Other _____

Life Events

- ☐ Aging
- ☐ Change in Household Composition
- ☐ Change of residence
- ☐ Does not adjust well to change
- ☐ Family member dies
- ☐ Family move or abandonment of support system
- ☐ New health diagnosis/disabling condition
- ☐ Other _____

DDD-1568A FORFF (8-13)
(DDD-1472A packet)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

VISION AND PRIORITIES

INDIVIDUAL'S NAME *(Last, First, M.I.)*	DATE
Learner, Ima	2/4/2019

What I want for my future *(short/long term goals)*:

To work in the community doing customer service such as a courtesy clerk at a grocery store.

What my family/guardian wants for my future:

To be more independent and get a job after graduating from High School.

Based on the above, identify the individual's priorities for the upcoming year.

What are the top priorities?	What is currently happening?	What else is needed to get there? What natural or community supports are available or what else is needed?	Check if support is needed beyond natural or community supports.*
Graduate from High School	Attending Best Years High School in the TSW Program	Family and School support	☐
Financial responsibility	Take basic money class at school	Family support	☐
Promote independence by learning cooking skills	Receiving Habilitation Services	Family support and continued Habilitation service	☒
Learn Basic job skills	Support Coordination Authorization for Transition to Employment Service	Authorize Transition to Employment Service	☒
Get a job in the community as a courtesy clerk		Family support and continued VR support	☐

* If checked, complete the *Service Evaluation,* DDD-1517A or B, as appropriate.

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

SERVICE CONSIDERATIONS – Adult

1. MEMBER'S NAME *(Last, First, M.I.)*		2. DATE OF BIRTH
Learner, Ima		
3. LIVING SITUATION	4. ASSIGNED SUPPORT COORDINATOR OR DESIGNEE	5. ASSESSMENT DATE
☐ Lives Alone ☒ Lives with Family ☐ Lives with Non-Family		2/4/2019

Discuss only the service considerations related to the identified priorities when a paid service is needed.

6. ATTENDANT CARE TASKS CONSIDERATIONS ..... ☐ N/A

- ☐ Unable to meet specific, basic personal care needs
- ☐ Temporarily unable to meet basic personal care needs due to a medical condition or illness
- ☐ Needs are not currently being met due to unavailability of another Division funded service
- ☐ Medical condition prevents attending a Division funded program
- ☐ Medical/physical need that with attendant care would allow the member return home from out-of-home placement

7. ATTENDANT CARE SUPERVISION REQUIREMENTS..... ☐ N/A

A. **Part I (Only need to meet criteria in one category in this section)**

1. **Wandering risk**
   - ☐ Documentation of the adult leaving without knowledge or permission, **AND**
   - ☐ Documentation of risk to self or others when alone in the community, or may be unable to return home safely
2. **Confused/disoriented**
   - ☐ Documentation of the presence of confusion or disorientation (prior to being diagnosed with dementia) **OR**
   - ☐ Documentation indicating a loss of skills (due to aging or injury) and the skills are unlikely to be regained
3. **Unable to call for help even with a lifeline**
   - ☐ Documentation of inability to use a telephone or press a button to alert the lifeline system
4. **Unsafe Behaviors**
   - ☐ Documentation that behaviors place the adult at risk of injury to self or others, **AND**
   - ☐ Documentation that the member is receiving or pursuing services through a behavioral health agency/professional

   OR
   - ☐ Documentation that behaviors place the adult at risk of injury to self or others, **AND**
   - ☐ Habilitation outcome to decrease unsafe behaviors has been unsuccessful in the past
5. **Medical**
   - ☐ Documentation from medical professional describing a severe medical need or physical condition that would put the member at risk if left alone

AND

B. **Part II**

- ☐ A Division funded employment/day program is not available or has been considered and not appropriate
- ☐ Receives enhanced staffing (self-contained) or assistance from an aide at school as documented on the IEP (if not yet graduated) (Year of graduation: ____) ..... ☐ N/A
- ☐ If a wandering risk or has unsafe behaviors, the member has received, is receiving, or will receive habilitation to minimize the need for supervision in the future ..... ☐ N/A

C. **Part III**

1. **Attendant Care Supervision Summary**
   - ☐ Meets the criteria for attendant care supervision
   - ☐ Cannot learn to be safe alone

8. HABILITATION CONSIDERATIONS ..... ☐ N/A

- A ☒ Priorities identified to learn a new skill
- B. ☒ The member can learn to become more independent

9. HOMEMAKER CONSIDERATIONS ..... ☐ N/A

A. **A member living with family:**

1. ☐ Does not receive attendant care.
2. ☐ Has medical/physical needs that precludes member from maintaining/ attaining a safe and sanitary environment (member's area only)
3. ☐ Documentation of the family members own medical/physical needs that prevent the family members from maintaining a safe and sanitary environment (shared space)
4. ☐ The family is experiencing a crisis that prevents them from maintaining a safe and sanitary environment

B. **A member living independently:**

1. ☐ Has medical/physical needs that preclude him/her from maintaining/ attaining a safe and sanitary environment
2. ☐ Has demonstrated that he/she cannot maintain a safe and sanitary environment (Habilitation should be considered before using homemaking so the member's abilities may be maximized)
3. ☐ Is experiencing a crisis that prevents them from maintaining a safe and sanitary environment

MEMBER'S NAME	ASSESSMENT DATE
Learner, Ima	2/4/2019

10. RESPITE CONSIDERATIONS (Must live with family) ..... ☐ N/A

- ☐ Living with family **AND**
- ☐ The amount of time the primary caregiver spends with the member in an unpaid capacity; **OR**

The primary unpaid caregiver:

- ☐ Needs time to recover from abnormally stressful situations in order to resume his/her unpaid care responsibilities; **OR**
- ☐ Is experiencing an emergency that temporarily prevents performance of normal unpaid care responsibilities; **OR**
- ☐ Requires more frequent or extended relief from unpaid care responsibilities due to advanced age or disability; **OR**
- ☐ Is experiencing unusual stressors such as unpaid care for more than one individual who has a developmental disability; **OR**
- ☐ Provides care to a member who presents intense behavioral challenges or needs a high degree of medical care

11. EMPLOYMENT CONSIDERATION..... ☐ N/A

- ☒ Member's age; **AND**
- ☒ Stated interest in employment

A. **Center Based Employment (CBE)**

- ☐ Able to work in a secure setting, part time or full time
- ☐ Needs supervision at all times
- ☐ Needs/wants to develop general work skills for future integrated employment
- ☐ No prior job skills training
- ☐ No prior work experience

B. **Group Supported Employment (GSE)**

- ☐ Needs supervision while in an integrated community setting; **OR**
- ☐ Needs assistance to maintain positive work skills; **AND**
- ☐ Wants paid employment in an integrated community setting
- ☐ No prior job skills training
- ☐ No prior work experience

C. **Individual Support Employment (ISE)**

- ☐ Able to work independently in the community; **OR**
- ☐ May need intermittent on-the-job supports while working; **AND**
- ☐ Has alone time; **AND**
- ☐ Wants paid employment in an independent community setting
- ☐ Has a job currently, but wants a new job

D. **Employment Support Aide (ESA)**

- ☐ Meets criteria to receive GSE or ISE
- ☐ Needs no more than an hour a day of personal care assistance to maintain employment when receiving GSE or ISE; **OR**
- ☐ Has a behavioral health diagnosis and needs assistance to manage challenging behaviors while receiving GSE or ISE; **AND**
- ☐ Needs no more than 3 hours a week of ongoing on-the-job supports to maintain independent community employment

12. DAY TREATMENT AND TRAINING ..... ☐ N/A

- ☐ Employment/job skill training has been considered and is not appropriate

13. THERAPIES ..... ☐ N/A

- ☐ Age; **AND**
- ☐ Developmental/functional skills; **AND**
- ☒ Medical condition; **AND**
- ☐ Network of support is unable to provide due to expertise needed; **AND**
- ☒ Therapies provided at school

Documentation may include the following:

A. Individual Support Plan
B. Individualized Education Program (IEP)
C. Multi-Disciplinary Education Team (MET)
D. Medical Documentation
E. Psychiatric/Psychological Evaluation
F. Clinical Notes
G. Incident Reports
H. Pre-Admission Screening (PAS)
I. Day Care Center Letter

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

SERVICE EVALUATION – Adult

1. MEMBER'S NAME *(Last, First, M.I.)*		2. DATE OF BIRTH
Learner, Ima		
3. LIVING SITUATION	4. ASSIGNED SUPPORT COORDINATOR OR DESIGNEE	5. ASSESSMENT DATE
☐ Lives Alone ☒ Lives with Family ☐ Lives with Non-Family		2/4/2019

The time range to complete a task as shown in the "Approx Time" column is only a guide. If the time it takes to complete the task exceeds the average range, enter the assessed time it takes to complete the task in "Minutes to do task 1 time" and explain why more time is needed by completing the comment section for the task or the Justification section on the *Justification and Additional Service Outcomes.*

Key:

- **Independent:** The member requires no assistance to complete the task the majority of the time.
- **Natural Support:** Natural Supports (NS), also known as Informal Supports, assist the member to complete the task.
- **Paid Provider and Natural Support:** A paid provider and natural support assist the member with the task. The paid time is listed below and all other times needed to assist with the task are provided by a natural support.
- **Paid Provider Only:** Member receives Attendant Care and a paid provider assists the member with the task.
- **Habilitation Outcome:** Member receives Habilitation related to this task.

Person Providing Natural Supports/Informal Supports: _____

6A. MEAL PREPARATION AND CLEAN UP

☐ Independent ☐ Natural Support ☐ Paid Provider and Natural Support ☐ Paid Provider Only ☒ Habilitation Outcome

Make only one choice indicating whether the member eats alone or with family. Includes meal planning, preparing the food, cooking or putting food together, storing foods left over, and cleaning the dishes involved in the preparation and presentation of the food. Alternative Meal Schedule is for a member who must eat more frequently, such as members with diabetes or others that eat multiple small meals throughout the day for medical reasons. Adjust time to the appropriate levels based the frequency of the meals/snacks.

LEVEL OF ASSISTANCE *(Based on the person's needs)*	**Approx Time**	**Minutes to *do* task 1 time**	**Number of Times Paid Support is Needed**							**TOTAL**
			MON	**TUE**	**WED**	**THU**	**FRI**	**SAT**	**SUN**	
Breakfast alone	1-15 min/day									
Breakfast with family	1-5 min/day									
Lunch alone	1-20 min/day									
Lunch with family	1-5 min/day									
Dinner alone	1-40 min/day	60	1	1	1	1	1			300
Dinner with family	1-5 min/day									
Alternative Meal Schedule Example: A member with diabetes eating multiple small meals/snack per day requiring preparation.	1-10 min/meal									

COMMENTS

Meal Prep and Clean Up Total 300

MEMBER'S NAME	ASSESSMENT DATE
Learner, Ima	2/4/2019

6B. EATING AND ASSISTANCE WITH EATING

☒ Independent ☐ Natural Support ☐ Paid Provider and Natural Support ☐ Paid Provider Only ☐ Habilitation Outcome

Eating is the process of getting nourishment. Time for the preparation of meals is calculated in section 6A, Meal Preparation and Clean Up. Use of mechanical aids such as modified utensils or plate guards does not disqualify the member from being independent.

LEVEL OF ASSISTANCE *(Based on the person's needs)*	Approx Time	Minutes to *do* task 1 time	Number of Times Paid Support is Needed							TOTAL
			MON	TUE	WED	THU	FRI	SAT	SUN	
Minimum: Meal set up, cutting food, cueing, or blending meal.	1-10 min/meal									
Moderate: As above plus hands-on assist, cueing, or supervision for 50-75% of meal.	1-15 min/meal									
Maximum: Hands-on assist with 75%+ of meal, bringing food to mouth or totally feeding member. Constant supervision and cueing.	1-30 min/meal									

COMMENTS

Eating and Assistance with Eating Total

6C. BATHING (Transfer included in bathing time)

☒ Independent ☐ Natural Support ☐ Paid Provider and Natural Support ☐ Paid Provider Only ☐ Habilitation Outcome

Washing, rinsing, drying, and transferring in/out of the tub or shower. This process includes getting the bath/shower prepared by adjusting the water, setting up the equipment, or bathing the member in the bed. Use of assistive devices such as tub/shower chair, pedal/knee controlled faucets, or long-handled brushes do not disqualify the member from being independent. Transfer time into the shower/bath is included in the bath time. If the member has a problem getting to and from the bathroom to bathe, this should be assessed in section 6F, Mobility, not as part of bathing. When a member is incontinent and requires assistance to be cleaned, include that time in 6E, Toileting.

LEVEL OF ASSISTANCE *(Based on the person's needs)*	Approx Time	Minutes to *do* task 1 time	Number of Times Paid Support is Needed							TOTAL
			MON	TUE	WED	THU	FRI	SAT	SUN	
Sponge bath	1-5 min/day									
Minimum: Some supervision, cueing, or set-up. Assist with getting in and out of tub. Help with back or lower body.	1-15 min/day									
Moderate: Step-by-step cueing or supervision. Hands-on assist with 50-75% of the bathing process.	1-30 min/day									
Maximum: 75%+ assist with bathing process. Two or more assist. Lift needed / bed-baths	1-45 min/day									

COMMENTS

Bathing Total

MEMBER'S NAME	ASSESSMENT DATE
Learner, Ima	2/4/2019

6D. DRESSING AND GROOMING

☒ Independent ☐ Natural Support ☐ Paid Provider and Natural Support ☐ Paid Provider Only ☐ Habilitation Outcome

Laying out, taking off, putting on, and fastening of body braces and splints, clothing, and footwear. Use of assistive devices such as reachers, sock pullers, shoe horns, and Velcro fasteners does not disqualify the member from being independent. Grooming includes oral hygiene, nail care, applying lotion, shaving, menses care, hair styling, and obtaining the water and supplies necessary to complete the task. If the member is physically able to do this activity then the person should be considered independent, unless the time it takes for the member to complete the task is so extraordinary as to impair the member's ability to retain employment or to conduct other activities of daily living.

LEVEL OF ASSISTANCE *(Based on the person's needs)*	Approx Time	Minutes to *do* task 1 time	Number of Times Paid Support is Needed							TOTAL
			MON	TUE	WED	THU	FRI	SAT	SUN	
Minimum: Some supervision, reminding, selecting clothes.	1-10 min/day									
Moderate: Supervision or hands-on with 50-75% of dressing activity. Regular assist with buttons, shoes & socks, fixing hair or brushing teeth.	1-15 min/day									
Maximum: Hands-on with 75%+ of dressing and grooming tasks. Complete assist with dressing includes transfer if needed.	1-20 min/day									

COMMENTS

Dressing and Grooming Total

6E. TOILETING (transfer time included in toileting)

☒ Independent ☐ Natural Support ☐ Paid Provider and Natural Support ☐ Paid Provider Only ☐ Habilitation Outcome

Reminders, following a toileting schedule, taking off and putting on of clothing and/or diapers, post-toilet hygiene, and cleaning of a catheter or ostomy bag.

LEVEL OF ASSISTANCE *(Based on the person's needs)*	Approx Time	Minutes to *do* task 1 time	Number of Times Paid Support is Needed							TOTAL
			MON	TUE	WED	THU	FRI	SAT	SUN	
Minimum: Stand-by assist, supervision, reminders.	1-5 min/event									
Moderate: 50-75% assist with clothing, diapers, post-toilet hygiene or equipment.	1-10 min/event									
Maximum: Total assist with clothing, briefs, entire toileting process. Includes episodes of incontinence.	1-15 min/event									
Catheter: Emptying and cleaning bag.	1-15 min/day									
Ostomy: Emptying and cleaning bag.	1-15 min/day									

COMMENTS

Toileting Total

MEMBER'S NAME	ASSESSMENT DATE
Learner, Ima	2/4/2019

6F. MOBILITY

☒ Independent ☐ Natural Support ☐ Paid Provider and Natural Support ☐ Paid Provider Only ☐ Habilitation Outcome

Assisting the member with using a wheelchair when the member is unable to maneuver independently, unable to safely use a walker or cane, or has a history of balance instability, vision difficulties, or frequent falls and requires physical guidance or support from another person. The use of assistive devices such as a wheelchair, walker, or cane does not disqualify the member from being independent. **Transfer time is counted in section 6G, Transferring.**

LEVEL OF ASSISTANCE *(Based on the person's needs)*	Approx Time	Minutes to *do* task 1 time	Number of Times Paid Support is Needed							TOTAL
			MON	TUE	WED	THU	FRI	SAT	SUN	
Minimum: Some supervision, stand-by, or reminders for safety. Adjusting devices or restraints.	1-10 min/day									
Moderate: Needs hands-on assist. One person assist with/without assistive devices.	1-15 min/day									
Maximum: One or more person assist, totally dependent.	1-30 min/day									

COMMENTS

Mobility Total

6G. TRANSFERRING (excludes bathing and toileting transfers)

☒ Independent ☐ Natural Support ☐ Paid Provider and Natural Support ☐ Paid Provider Only ☐ Habilitation Outcome

Addresses the ability to move between the bed, chair, wheelchair, commode, etc.

LEVEL OF ASSISTANCE *(Based on the person's needs)*	Approx Time	Minutes to *do* task per day	Number of Times Paid Support is Needed							TOTAL
			MON	TUE	WED	THU	FRI	SAT	SUN	
Minimum: Some supervision, stand-by, or reminders for safety. Adjusting devices.	1-10 min/day									
Moderate: Needs hands-on assist. One-person assist with/without assistive devices.	1-15 min/day									
Maximum: One or more person assist, totally dependent.	1-30 min/day									
Positioning: Frequent repositioning ☐ Outside caregiver 20-40 min/day. ☐ Live-in caregiver 60-90 min/day.	20-40 min/day 60-90 min/day									
Lift: If lift time assessed, no transfer time in other areas.	1-20 min/event									

COMMENTS

Transferring Total

MEMBER'S NAME	ASSESSMENT DATE
Learner, Ima	2/4/2019

6H. CLEANING

☐ Independent ☐ Natural Support ☐ Paid Provider and Natural Support ☐ Paid Provider Only ☐ Habilitation Outcome

Tasks necessary to attain and maintain sanitary living conditions, caring for service animal.

LEVEL OF ASSISTANCE *(Based on the person's needs)*	Approx Time	Minutes to *do* task 1 time	Number of Times Paid Support is Needed							TOTAL
			MON	TUE	WED	THU	FRI	SAT	SUN	
Lives with others: cleaning of member's area only.	1-60 min/week									
Without support. Member lives alone. Consider the size of the home.	1-120 min/week									

COMMENTS

Cleaning Total

6I. LAUNDRY

☐ Independent ☐ Natural Support ☐ Paid Provider and Natural Support ☐ Paid Provider Only ☐ Habilitation Outcome

Preparing and putting clothes in the washer, dryer, or on the line, and folding or putting away clothes with the goal of maintaining the member's clothing in a clean manner and neat appearance.

LEVEL OF ASSISTANCE *(Based on the person's needs)*	Approx Time	Minutes to *do* task 1 time	Number of Times Paid Support is Needed							TOTAL
			MON	TUE	WED	THU	FRI	SAT	SUN	
Washer and dryer on site (inside member's home, garage or yard).	1-30 min/week									
Washer is on site, clothes are line dried.	1-60 min/week									
Laundry is done in apartment laundry facility.	1-90 min/week									
Laundry facility is off site, such as a community laundromat facility.	1-120 min/week									
Incontinence episodes: soiled clothes and linens.	1-10 min/day									

COMMENTS

Laundry Total

MEMBER'S NAME	ASSESSMENT DATE
Learner, Ima	2/4/2019

6J. SHOPPING

☐ Independent ☐ Natural Support ☐ Paid Provider and Natural Support ☐ Paid Provider Only ☒ Habilitation Outcome

Grocery shopping, and obtaining medications or medical supplies and household items for the member. Assistance with paying bills. Travel time and time to put away the groceries is included.

LEVEL OF ASSISTANCE *(Based on the person's needs)*	**Approx Time**	**Minutes to *do* task 1 time**	**Number of Times Paid Support is Needed**							**TOTAL**
			MON	**TUE**	**WED**	**THU**	**FRI**	**SAT**	**SUN**	
Lives with others: shopping for member only.	1-5 min/week	60	1		1		1			180
Member lives alone.	1-90 min/week									

COMMENTS

Shopping Total 180

If Cleaning, Laundry, or Shopping are the only needs identified, authorize Homemaker (Housekeeping).

MEMBER'S NAME
Learner, Ima

ASSESSMENT DATE
2/4/2019

7. HABILITATION HOURLY OUTCOMES ..... ☐ N/A

OUTCOME	Minutes to *teach* task (HAH)	Number of Times Paid Support is Needed							TOTAL
		MON	TUE	WED	THU	FRI	SAT	SUN	
Grocery shop ingredients for a simple meal	60	1							60
Prepare a smiple dinner in the microwave	60	1					1		120
Ask for help using Augmentative communication device	60		1	1					120
Handle money	60	1			1	1			180
Follow multi-step picture directions	60	1		1	1				180

Additional Outcomes (Habilitation) Total 660

MEMBER'S NAME	ASSESSMENT DATE
Learner, Ima	2/4/2019

8. DAYS / HOURS PARENT / GUARDIAN IS OUT OF THE HOME

Complete this section only if the person meets the requirements for supervision as identified on page 1 of the *Service Considerations* (DDD-1617A).

9A. Activity	B. Comment	C. Time of Day Each Activity Occurs						
		MON	TUE	WED	THUR	FRI	SAT	SUN
School								
Employment								
Day Program								
Therapy								
Family/Friends/Free Time								
Sleep								
Respite								
Attendant Care								
Habilitation								
Nursing								
School Breaks								

10A. ATTENDANT CARE SUPERVISION

Supervision is based on need, and can be provided based on the member need identified on the *Service Considerations* (DDD-1617A).

B. Number of MINUTES Supervision is Required Each Day							C. Total
MON	TUES	WED	THU	FRI	SAT	SUN	

MEMBER'S NAME	ASSESSMENT DATE
Learner, Ima	2/4/2019

11A. WEEKLY TOTALS	
Meal Preparation and Clean Up	300
Eating and Assistance with Eating	
Bathing	
Dressing and Grooming	
Toileting	
Mobility	
Transferring (excludes toileting and bathing transfers)	
Cleaning*	
Laundry*	
Shopping*	180
Supervision	
Total minutes for tasks *(includes supervision)*	480
ROUNDED TOTAL HOURS *(Follow process for rounding)*	
ATTENDANT CARE *(includes Supervision)*	**8 Hours**
HABILITATION HOURLY OUTCOMES	**11 Hours**
***HOMEMAKER ONLY** *If Cleaning, Laundry and Shopping are the only needs identified, authorize Homemaker (Housekeeping), not ATC.*	

PROCESS FOR ROUNDING HOURS

- Add all of the minutes in the column.
- Convert "Total Minutes" to "decimal hours and minutes" by dividing total minutes by 60. (e.g., 850 minutes divided by 60 minutes = 14.17 hours.)
- Round up hours. **ANY** fraction of an hour must be rounded **UP** to the next hour (e.g., the weekly total of 14.17 hours will be rounded up to 15 hours for the assessment of weekly hours).
- Document the **weekly** total hours on the ALTCS Member Service Plan (DDD-1500A).

I have contacted the Natural Support/Informal Support named above (top of page 1) and s/he voluntarily agree/s to provide the services indicated, with no compensation.

SC Signature and Date of Review:

☐ _____ Date _____

☐ _____ Date _____

☐ _____ Date _____

☐ _____ Date _____

☐ _____ Date _____

DDD-1581A FORFF (1-18)
(DDD-1472A packet)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

JUSTIFICATION AND ADDITIONAL SERVICE OUTCOMES

A. MEMBER'S NAME *(Last, First, M.I.)*	B. ASSESSMENT DATE
Learner, Ima	2/4/2019

C. JUSTIFICATION FOR PAID SERVICES *(Include any changes in the individual's life)*

Ima Learner is a 17 year old female diagnosed with Epilipsy and Moderate Cognitive Impairment. She lives with her Mother and two siblings. Her Mother is her guardian and primary caregiver. Ima recieves RSP and HaH Services. Her mother needs time to recover from everyday stress realted to taking care of her daughter. Habilitation services are being provided to increase Ima's ability to become independent in the near future and be able to live on her own. Ima needs to learn basic work skills in order to get a job in the community .

D. ADDITIONAL SERVICE OUTCOMES *(Teaching / Learning)*	E. SERVICE
Ima will learn basic job skills	Transition to Employment

DDD-1500A FORFF (8-14)
(DDD-1472A packet)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

ALTCS MEMBER SERVICE PLAN

MEMBER'S NAME	AHCCCS ID NO.	DATE
Learner, Ima		2/4/2019

NEXT REVIEW DATE *(Check one)*

☒ Not to exceed 90 days *(HCBS)* ☐ Not to exceed 180 days *(Nursing facility or DD Group Home)*

☐ Annual *(Acute care only)*

I choose the following service model: *(Check "N/A" for members not receiving Attendant Care, Homemaker or Habilitation)*

☒ TRADITIONAL ☐ AGENCY WITH CHOICE ☐ INDEPENDENT PROVIDER ☐ N/A

☐ SELF DIRECTED ATTENDANT CARE

In accordance with their contract with the ALTCS Contractor and receipt of the service authorization, providers are notified and agree to their roles and responsibilities in implementing this service plan.

Service and Provider	Service Frequency In Place Prior to This Assessment	Service Frequency Currently Assessed	Service Change	Start / End Date	Member / Representative
Habilitation (HAH) My Care	5 hours per week	5 hours per week	☒ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend	5/4/19	☐ Agree ☐ Disagree
Respite	300 hours	300 hours	☒ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend	5/4/19	☐ Agree ☐ Disagree
TTE		TTE	☐ None ☒ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend	5/4/19	☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend		☐ Agree ☐ Disagree
			☐ None ☐ New ☐ Increase ☐ Reduce ☐ Terminate ☐ Suspend		☐ Agree ☐ Disagree

COMMENTS

Service Plan Acknowledgement: My service plan has been reviewed with me by my Support Coordinator. 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 Support Coordinator 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 Support Coordinator has told me how the appeal process works. I know how I can appeal service changes I do not agree with. I know that I can change my mind later about services I agree with today. I know that if I change my mind before the changes go into effect, I will get a letter that tells me the reason my services changed. The letter will also tell me about my appeal rights, including how to receive continued services.

MEMBER'S NAME	AHCCCS ID NO.	DATE
Learner, Ima		2/4/2019

Support Coordinator: Please list all non-ALTCS funded services provided by a 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 Service Evaluation (DDD-1517A - Adult, DDD-1517B - Child).

Non-ALTCS Funded Service (Indirect)	**Responsible Party / Payer Source**	**Approximate Service Frequency** *(example: daily, weekly, monthly)*
EXAMPLE:		
EXAMPLE:		
EXAMPLE:		
EXAMPLE:		
EXAMPLE:		
EXAMPLE:		

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 Support Coordinator, _____, at _____.
I also know that I can contact my Support Coordinator at any time to discuss questions, issues, and/or concerns that I may have regarding my services. My Support Coordinator will contact me within 3 working days. Once I have talked with my Support Coordinator, he/she will give me a decision about that request within 14 days. If the Support Coordinator is not able to make a decision about my request within 14 days, s/he will send me a letter to let me know more time is needed to make a decision.

MEMBER / LEGAL REPRESENTATIVE'S SIGNATURE	DATE
INDIVIDUAL REPRESENTATIVE'S SIGNATURE *(Agency with Choice only)*	DATE
SUPPORT COORDINATOR'S 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
NAME	SIGNATURE	NAME OF AGENCY/RELATIONSHIP	DATE
NAME	SIGNATURE	NAME OF AGENCY/RELATIONSHIP	DATE
NAME	SIGNATURE	NAME OF AGENCY/RELATIONSHIP	DATE

Support Coordinators: *Please document when the service plan was sent to the Member, Individual Representative and/or the Legal Representative.*

NAME	DATE	NAME	DATE
NAME	DATE	NAME	DATE

Routing: Original – File; Copy – Member/Individual Representative/Legal Representative

DDD-1309B FORFF (6-17)
(DDD-1472A packet)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

AHCCCS / ALTCS / DDD MEMBER CONTINGENCY / BACK-UP PLAN

DATE OF PLAN 2/4/2019

MEMBER'S NAME Learner, Ima AHCCCS ID NO. _____ ASSISTS ID NO. _____

1) Respite	2 x week 1 hour	My Care
2)		
3)		

MEMBER SERVICE PREFERENCE LEVEL – based on member's choice for how quickly a replacement caregiver will be needed if the scheduled caregiver becomes unavailable. Members must be informed that they have the right to a back up caregiver within 2 hours if they choose. *(Check member's choice)*

☒ Needs services within 2 hours ☐ Needs services today ☐ Needs services within 48 hours ☐ Can wait until next scheduled visit by provider

The member has been advised that he/she may change the Member Service Preference Level and also his/her back-up plan, as indicated below, at any time, including at the time of a gap.* Support Coordinator (Initials) (Date)

If my ALTCS / DDD caregiver does not show up to provide services as scheduled, my back-up plan is as follows: *(Check all that apply)*

☐ I WILL CONTACT AHCCCS		1-800-218-7509
☐ I will contact my provider agency		
☐ I will contact my support coordinator		
☒ **I prefer to have family or friends provide my care instead of another AHCCCS / ALTCS / DDD provider/caregiver.**	1 Sister Learner	623-222-3333
	2	
	3	
	4	
☐ I can wait until the next scheduled visit from my provider agency to receive authorized care.		
☐ **Other:**		

See next page for EOE/ADA/LEP/GINA disclosures

AHCCCS / ALTCS / DDD MEMBER CONTINGENCY / BACK-UP PLAN (continued)

MEMBER'S NAME Learner, Ima AHCCCS ID NO. _____ ASSISTS ID NO. _____

***A gap in critical services is defined as the difference between the number of hours of critical service scheduled in each member's care plan and the hours of the scheduled type of critical service that are actually delivered to the member. The following situations are NOT considered gaps:**

- The member is not available to receive the service when the caregiver arrives at the member's home as scheduled.
- The member refuses the caregiver when he/she arrives, unless the caregiver is not able to do the assigned duties.
- The member refuses services.
- The member's home is seen as unsafe by the agency/caregiver, so the caregiver refuses to go there.

I understand that I have the right to receive all the services in my care plan to help me with bathing, toileting, dressing, feeding, transferring to or from my bed and wheelchair and other similar daily activities as needed. These services (Attendant Care, Personal Care, Homemaker and Respite) are called "critical services." I understand that the Division must make sure that I receive these critical services without delays. I understand that if I do not receive my critical services on time I can call AHCCCS to report the problem so they can assist in replacing my caregiver as soon as possible. I may also call my provider agency or case manager for help. If there is a delay and I do not receive these services on time, the Division must provide a back-up caregiver within 2 hours of the time they are notified of the gap, unless I specify otherwise at the time of the gap. I understand I also have the right to file a written complaint about the failure to provide such services as scheduled.

I understand that in order to receive services I must be available and willing to accept the scheduled services. If I choose not to accept the services I understand I must tell my support coordinator. This plan has been reviewed with me and I agree with it. I will keep a copy of this plan.

Please have member/representative sign here at time of initial/annual plan development

MEMBER / REPRESENTATIVE'S SIGNATURE _____ RELATIONSHIP TO MEMBER _____ DATE _____

Quarterly Visit

This plan was reviewed with me by the support coordinator during my quarterly service review. My signature below indicates I still agree with this plan and no changes are needed. I understand that I may change my Member Service Preference Level at any time, including at the time a gap may occur. My support coordinator and I will fill out a new Contingency Plan form if I have changes to my plan, but at least once a year.

Please have member/representative sign here to indicate continued agreement with the plan at the time of each 90 day service assessment. If the member/representative wishes to make changes to the information in this plan, a new plan must be written. A new plan is required at least once a year.

DATE OF REVIEW _____ MEMBER / REPRESENTATIVE'S SIGNATURE _____

DATE OF REVIEW _____ MEMBER / REPRESENTATIVE'S SIGNATURE _____

DATE OF REVIEW _____ MEMBER / REPRESENTATIVE'S SIGNATURE _____

DATE OF REVIEW _____ MEMBER / REPRESENTATIVE'S SIGNATURE _____

Copy to: Member/Representative – Provider – Case file

IMPORTANT MEMBER RIGHTS NOTICE

As a result of the lawsuit *Ball v. Betlach* (also known as *Ball v. Biedess*), the AHCCCS Administration is sending you this notice about your rights to receive "critical" long term care services at home when you are enrolled in the ALTCS Program.

You have the right to receive all the services in your care plan to help you with bathing, toileting, dressing, feeding, transferring to or from your bed and wheelchair and other similar daily activities. These services are called "critical services." Your program contractor or tribal contractor must make sure that you receive these critical services without delays. If there is a delay and you do not receive these services on time, your program contractor or tribal contractor must provide them within 2 hours of the time they are notified of the gap. (A gap in critical services is defined as the difference between the number of hours of critical service scheduled in each individual's care plan and the hours of the scheduled type of critical service that are actually delivered to the individual.) Your other long term care services cannot be reduced to make up for the critical services that you did not receive on time.

If you do not receive your critical services on time, call your provider to report the issue. In addition, you may also call your program or tribal contractor or AHCCCS, at the telephone numbers listed below, to report the problem. Your case manager will also provide you with phone numbers to call if there are delays in getting your critical services. Your program contractor or tribal contractor will also give you a form that you can fill out and mail back if there is a gap in critical services. You will get an answer by phone or in writing. You will be told the reason for the delay and how it will be fixed now and in the future if it happens again.

AHCCCS will collect reports on gaps in critical services from each program contractor on a monthly basis. AHCCCS will also collect information to help determine how to set rates to pay workers who provide critical services. The program contractors will also give information to AHCCCS every 6 months about home care workers' current wages and benefits. This information will be made public once a year beginning August 15, 2005.

AHCCCS has hired experts to look at the amount of critical services available for AHCCCS members and the general population. This information will be available on October 15, 2005.

We will send you another Notice if a Court makes changes to this information. If you have any questions about this Notice, please call your program contractor or tribal contractor, your case manager or AHCCCS. Telephone numbers are listed below.

Arizona Health Care Cost Containment System (AHCCCS)
1 (800) 218-7509

AFTER HOURS CONTACT NUMBERS

District Central	(602) 375-1403	District South	(855) 375-1403
District North	(877) 739-3941 (520) 732-2600 Weekdays (602) 375-1403 Weekends	District East	(520) 723-2600 or (602) 375-1403
		District West	(602) 375-1403

DD-219-FF (6-12)
P/P Ch.800
(DDD-1472A packet)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

ISP – ACTION PLAN

INDIVIDUAL'S NAME *(Last, First, M.I.)*	DATE
Learner, Ima	2/4/2019

ACTION ITEMS

HCBS Provider Training - Document specific training needed (if any) in the section below.

If skin integrity is an issue, the team must identify a person responsible for monitoring and document any follow-up needed as an Action Item.

Action Items	Person Responsible	Due Date	Date Completed
Support Coordination provide a cipy of the ISP to all team members	Support Coordinator	2/18/19	
Support Coordinator refer guarding to Raising Special Kids for information and support	Support Coordinator	2/18/19	
Transition to Employment Services	Support Coordinator	2/18/19	

COMMENTS