Adult BH HCBS Plan of Care

Name of Individual:		*MCO:*	[Select MCO]
Medicaid CIN:		*Member ID:*	
Date of Birth:		*Lead Health Home:*	Not applicable
BH HCBS Eligibility:	Not Eligible	*HH CMA or RCA:*	

Plan of Care Development Date:

PART 1: CONTACT INFO & RESIDENTIAL SETTING

Provide setting and contact information for the individual. If the individual does not live in a community-based setting of their choice, the Care Manager/ Recovery Coordinator must support the individual with identifying a plan to move to the setting of their choice and document this in the Plan of Care.

Individual's Residential Address:
Individual's Phone Number:
Is the residential address provided above a community-based setting? ○ Yes ○ No
Does the individual want to live in this setting/ at this address? ○ Yes ○ No

PART 2: INDIVIDUAL NARRATIVE & GOALS

A. Individual Narrative

The individual narrative should include a brief formulation of the NYS Eligibility Assessment, including the individual's diagnosis. Describe the individual's characteristics, skills, strengths, preferences, and behavioral health barriers and needs. Also include the individual's living arrangements, cultural traditions, and social relationships. Clearly document the individual's valued life roles.

***Items marked with an asterisk (*) minimally required for a Level of Service Determination for BH HCBS**

B. Individual's Life Role Goal Statement(s)

The Individual's Life Role Goal is a personalized goal related to how the individual wants to live, work, learn, or socialize. An individual may have more than one life role goal. Write the goal statement using the individual's language. The "Desired Outcomes" should clearly state what will be achieved in the Individualized Service Environment, as documented in Part 3 of this Plan of Care.

Life Role Domain: ○ Living ◉ Working ○ Learning ○ Socializing

Goal:*

Desired Outcomes:

Target Date:

Life Role Domain: ○ Living ○ Working ○ Learning ○ Socializing

Goal:*

Desired Outcomes:

Target Date:

PART 3: THE INDIVIDUALIZED SERVICE ENVIRONMENT

A. Natural Supports & Community Resources

List the unpaid natural supports & community resources the individual will access in support of their life role goal. These may include family, friends, neighbors, mutual aid/ self-help groups, community centers, faith communities, etc.

Support Provided*	Name of Support or Resource	Contact Information (Address, Phone, and/or Email)

B. Physical & Behavioral Health Providers

This section should include all physical and behavioral health (mental health and substance use) providers which support the individual in pursuing and attaining their life role goal, with the exception of Adult BH HCBS. This includes primary care, psychiatry and any Article 16, 28, or 31 Clinic providers. Documenting the frequency and duration will support integration of care and treatment with other providers.

Service Type*	Name of Provider	Frequency (if known)	Duration (if known)

C. Other Services, Resources, and Supports

This section should include any additional non-HCBS services, resources, and supports that the individual receives which are not listed above. Only list the services and providers which support pursuit and attainment of the life role goal. Examples may include Social Security Disability Insurance (SSDI), Drop-In Centers, Psychosocial Clubs or Clubhouses, Ongoing and Integrated Support Employment (OISE), etc. It may also include services and supports paid for by other NYS agencies, including Department of Health, Department of Aging, ACCES-VR, Department of Labor, etc.

Service Type*	Name of Provider

D. Health Home Care Management / Recovery Coordination

This section should document information about the HH Care Management Agency or Recovery Coordination Agency. For individuals receiving Health Home services, this section must include all Care Coordination interventions. There should be at least one intervention listed for each applicable objective.

Type of Service:	Health Home Care Management
Provider Agency:	
Care Manager/ Recovery Coordinator Name:	
Contact Information:	

Care Coordination Objectives and Interventions should only be completed for individuals enrolled in Health Home Care Management. For individuals NOT enrolled in Health Home and receiving Recovery Coordination only, this section may be left blank.

Care Coordination Objectives	Care Coordination Interventions (Scope)
☐Physical Health Objective(s):	☐Physical Health Interventions:
☐Mental Health Objective(s):	☐Mental Health Interventions:
☐Substance Use Objective(s):	☐Substance Use Interventions:
☐HIV/AIDS Objective(s):	☐HIV/AIDS Interventions:
☐Other Care Management Objectives:	☐Other Care Management Objectives:

E. Adult Behavioral Health Home and Community Based Services (BH HCBS)

This section should include all adult BH HCBS providers selected by the individual from a choice of in-network providers. The frequency, duration, and effective date may be added after receiving additional information from the providers and Managed Care Organization. Each HCBS should have at least one corresponding intended outcome from Part 2(B) of this Plan.

Service Type*	Name of Provider	Frequency	Duration	Effective Date
Non-Medical Transportation				
Desired Outcome(s):				

Service Type*	Name of Provider	Frequency	Duration	Effective Date
Non-Medical Transportation				
Desired Outcome(s):				

Service Type*	Name of Provider	Frequency	Duration	Effective Date
Non-Medical Transportation				
Desired Outcome(s):				

PART 4: SAFEGUARDS & MODIFICATIONS

For individuals residing in a provider-owned or controlled setting: Have the individual's choices been limited or restricted in any way related to an identified risk?

☐ Yes ☐ No ■ N/A: The individual does not reside in a provider-owned or -controlled setting

If yes, a "Modifications Based on Risk Assessment" form must be attached.

PART 5: ATTESTATION, SIGNATURES, ATTACHMENTS, & DISTRIBUTION OF THE PLAN OF CARE

The Care Manager/ Recovery Coordinator and Managed Care Organization are responsible for monitoring the Plan of Care. Revisions may be initiated by contacting the Care Manager /Recovery Coordinator. The Plan of Care must be reviewed at least annually and whenever the individual experiences a significant life event.

A. Person-Centered Planning Attestation

My signature on this Plan of Care attests that I agree with the following:

- ☐ I have been informed of my eligibility status for Adult BH HCBS.
- ☐ I understand that I have the choice of any qualified providers in my MCO's network and I have been notified of the providers available.

B. Signatures

The Plan of Care (and/or accompanying ISP) must be signed by the individual receiving services, his or her legal guardian (if applicable), the Care Manager/Recovery Coordinator, and all Adult Behavioral Health HCBS Providers. Signatures provided in this section will indicate that the individual and all other providers participating in this Plan of Care are in agreement with the Plan of Care.

Name	Title/Role	Signature	Date
	Individual Receiving Services		
	Personal Representative, if applicable		
	Care Manager / Recovery Coordinator		

C. Attachments to Plan of Care

Indicate below which additional forms are attached to this Plan of Care.

- ☐ Crisis Prevention Plan (required)
- ☐ Back-Up Plan (required)
- ☐ BH HCBS Individualized Service Plan
- ☐ Modifications Based on Risk Assessment (required in answer to Part 4 is “yes”)
- ☐ Other (please specify):

D. Distribution of the Plan of Care

The Plan of Care must be distributed to the individual, his or her legal guardian (if applicable), and all Adult BH HCBS providers at least annually and upon any significant revisions made following a life event.

Name and Agency (if applicable)	Consent on File? (Y/N)	Date Sent	CC Signature or Initials

Plan of Care Attachment: Crisis Prevention Plan

Name of Individual:		*MCO:*	[Select MCO]
Medicaid CIN:		*Member ID:*	
Date of Birth:		*Lead Health Home:*	Not applicable
BH HCBS Eligibility:	Not Eligible	*HH CMA or RCA:*	

Instructions for Care Manager/ Recovery Coordinator: This form should be reviewed and updated at least annually, in coordination with the review of the Plan of Care. It should also be reviewed and revised following any significant life event. If the individual already has a Crisis Prevention Plan or Relapse Prevention Plan (WRAP), you may attach a copy of it, rather than completing this form. It is still important to review that plan with the individual at the same intervals.

The purpose of the crisis prevention plan is to help you figure out ways to prevent a behavioral health crisis. Preventing a crisis helps to keep you moving towards your personal life goals. It is important that the plan is based on your personal preferences and needs and takes into account cultural, religious or ethnic factors. The plan is something you and your Care Manager/ Recovery Coordinator work on together. This plan may be shared with others in accordance with your preferences. You may want to consider designating someone in your life to be a health care agent or creating some other form of advance directive.

1. **What triggers or problems should you be watching out for?**
   These are the triggers and symptoms that cause you the most upset, make it difficult to manage day to day activities and work towards your personal goals. Examples may include specific symptoms, conflict with family or friends, financial pressures, housing instability, changes in medication, etc.

2. **What are the early warning signs that your behavioral health symptoms are increasing?**
   These are the earliest changes you notice when your behavioral health problems are getting worse. Examples may include: cravings, trouble sleeping, feeling uncomfortable or nervous around people, difficulty concentrating, others express concern about your mental health, and feelings of sadness or worry.

3. **What are some steps you can take to cope with stress or triggers?**
   Consider what has worked for you and/or others in the past. What coping or problem-solving skills are most effective for you? Examples may include: reading, watching TV, journaling, attending a self-help group, deep breathing and muscle relaxation, getting out of the house, calling a friend, etc.

4. Who can you call if you begin experiencing the early warning signs?

Identify the people who can help you before and during a crisis. Include their name(s) and contact info below. This may include natural supports (friends and family) and paid supports (Care Manager, Therapist, etc.).

Plan of Care Attachment: Back-Up Plan

Name of Individual:
Medicaid CIN:
Date of Birth:
BH HCBS Eligibility: Not Eligible

MCO: [Select MCO]
Member ID:
Lead Health Home: Not applicable
HH CMA or RCA:

Instructions for Care Manager/ Recovery Coordinator: This form should be reviewed and updated at least annually, in conjunction with the review of the Plan of Care. It should also be reviewed and revised following any significant life event.

The purpose of this Back-Up Plan is to help you in the event of an emergency situation or if a regularly scheduled support/service is unavailable.

In the event of an emergency, call 911 right away.

It is important to talk to your service providers, including your HCBS providers, about their availability and scheduling. Having a back-up plan means you'll know what to do and who to call if your provider can't meet with you.

Service Provider	**Who can I call?** *(For example, agency on-call or supervisor, friend or family member, sponsor, Care Manager)*	**Phone Number**

Plan of Care Attachment: BH HCBS Individualized Service Plan

Name of Individual:		*MCO:*	[Select MCO]
Medicaid CIN:		*Member ID:*	
Date of Birth:		*Lead Health Home:*	Not applicable
BH HCBS Eligibility:	Not Eligible	*HH CMA or RCA:*	

This document is completed by each Adult Behavioral Health Home & Community Services provider. Attaching it to the Plan of Care supports integration and coordination of services and is important for meeting CMS requirements.

Date of ISP Development:

Service Specific Information

Service Type:	N/A
Provider:	
Provider Agency Contact:	wdfsdf
Alternate Contact:	asdgsadg
Provider Address:	adgasdg
Frequency & Duration:	asdgasdf

Individualized Life Role Goal & Intended Outcomes

The information below should come from the Plan of Care document. The Individual's Life Role Goal is a personalized goal related to how the individual wants to live, work, learn, or socialize. An individual may have more than one life role goal. Write the goal statement using the individual's language.

Life Role Domain: ◯ Living ◉ Working ◯ Learning ◉ Socializing

Goal:*

Strengths, Talents, Resources, & Abilities

Using information from the Plan of Care, service-specific intake evaluation, and feedback from the individual and family members, describe the individual's strengths, talents, resources, and abilities, as they relate to attainment of the goal.

Behavioral Health Barriers & Level of Support

Using information from the Plan of Care, service-specific intake evaluation, and feedback from the individual and family members, describe the behavioral health barriers and needs related to attainment of the individualized goals. Describe the level of support that will be required in order to achieve intended outcomes (e.g. staff modeling, role play, supervision, instruction, etc.).

HCBS Objectives & Scope

Document measurable objectives for HCBS that will support the individual in moving toward his or her goal and intended outcomes. Describe the scope of services (interventions and staff activities) that will support attainment of the objectives.

HCBS Objectives	Scope of HCBS (Service Components/ Interventions/ Modality)

Signatures

Signature of Individual Receiving Services: Date:

Signature of Adult BH HCBS Service Provider: Date:

Signature, Credentials (if applicable), & Title

Plan of Care Attachment: Modifications Based on Risk Assessment

Name of Individual:	*MCO:* [Select MCO]
Medicaid CIN:	*Member ID:*
Date of Birth:	*Lead Health Home:* Not applicable
BH HCBS Eligibility: Not Eligible	*HH CMA or RCA:*

This document is completed by the Care Manager/ Recovery Coordinator if and when an individual's choice has been limited or restricted in any way due to an assessed risk.

For some individuals, home and community based settings may present an increased risk of harm to themselves or others. This tool will help the Care Manager/ Recovery Coordinator support individuals with complex needs to live in the least restricted setting. Examples of limitations or restrictions on an individual's choice may include, but are not limited to: restrictions on access to food, residential visiting hours, inability to come and go freely, etc.

1. **Describe in detail the modification(s) based on risk.**

   [Attach additional pages as necessary.]

2. **Document the specific and individualized assessed need.**

   [Attach additional pages as necessary.]

3. **Document the positive supports and interventions previously used that were unsuccessful to address the need.**

   [Attach additional pages as necessary.]

4. **Document less intrusive methods that have been previously used that were unsuccessful.**

   [Attach additional pages as necessary.]

5. **Describe the condition that is connected to the specific need or risk.**

   [Attach additional pages as necessary.]

6. **Describe the data collection method to be used to monitor the effectiveness of the modification.**

   [Attach additional pages as necessary.]

7. **Document the established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.**

[Attach additional pages as necessary.]

8. **Will the interventions and supports cause harm to the individual? (The Care Manager or Recovery Coordinator must provide assurance that the interventions and supports will cause no harm to the individual.)**
   ☐ Yes ☐ No

My signature below affirms that the individual has been given the opportunity to make an informed choice regarding the limitations and restrictions described above, and that the individual is in agreement with the modifications and supports required to address his or her assessed risk(s) and needs.

Signature of the Individual Receiving Services: **Date:**

Signature of Personal Representative (if applicable): **Date:**

Signature of the Care Manager/ Recovery Coordinator: **Date:**