SECTION
APPENDIX

SUBJECT
Person-Centered Recovery Plan (DPHHS-AMDD-135) Instructions

PURPOSE

To provide an assessment of an individual's physical and social needs for Home and Community Based Services (HCBS) and to develop a Person-Centered Recovery Plan (PCRP) with the individual to meet his or her needs. The case management team (CMT) completes Form DPHHS-AMDD-135 upon initial assessment and for annual update of the individual's need for HCBS.

The Person-Centered Recovery Plan is an agreement between the individual and the CMT for the provision of HCBS. A discussion of mental health recovery and the individual's discharge potential must take place during the initial assessment and at the annual review.

DISTRIBUTION

The CMT retains the suspense (pink) copy in its files while obtaining appropriate signatures on the original and yellow copies. Once these signatures are obtained, the CMT retains the white copy and sends the yellow copy to the recipient. A copy of the completed PCRP will be sent to the individual's health care professional.

INSTRUCTIONS

PAGE 1
Admit Date--Enter the date of initial admittance.

Update--Enter the date of HCBS reevaluation.

Level I Date-- Enter the date the Level I was approved by Mountain-Pacific Quality Health Foundation. (Reminder: This date must be the same or before the admission date.)

Level II--Check "No" if a Level II was not required. Check "Yes" if a Level II was completed. Check "MR" for a Mental Retardation evaluation and "MI" for a Mental Illness evaluation. If both evaluations were completed, check both boxes.

Level II Date--Enter date(s) of completed evaluation(s). (Reminder: These date(s) must be the same or before to the admission date.)

Care Category--Enter appropriate level of care. Care Category 3 (CC3) plans requires prior authorization.

Discharges/Readmits--Enter dates of discharge and readmits.

Recipient Name--Enter the individual's name, address and telephone number.

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Medicaid Number (SSN)--Enter the individual's Medicaid identification number.

Date of Birth--Enter the individual's date of birth.

Height--Enter the individual's height.

Weight--Enter the individual's weight.

Sex--Enter M for Male or F for female.

Marital Status--Enter the individual's marital status. (Single, married, divorced, widowed, or separated.)

Responsible Party--Enter the name, address and telephone number of the person responsible for the individual. This could be a spouse, relative, legal guardian, etc. Indicate the relationship to the individual.

Significant Other--Enter the name, relationship to the individual, address and telephone number of individual's significant other.

Attending Health Care Professional--Enter the name, address and telephone number of the individual's attending health care professional. The health care professional may be a M.D, nurse practitioner or physician assistant.

Hospital Preference--Enter the hospital the individual prefers to use.

Eligibility Category--Enter elderly or disabled and if individual is under 21.

Residential Status--Enter the individual's residential status under HCBS. If none of the three choices applies, write in the residential status.

Medicare--Enter 'Yes" if Medicare eligible and Medicare number. Enter "No" if not Medicare eligible.

Other Insurance--Enter name, address, and phone number of any other insurance.

Veteran--Enter "Yes" if eligible for veteran benefits. Enter "No" if not.

Date of Referral--Enter the date individual was referred for services. This is completed only on initial assessments.

Referral Source--Enter the name and telephone number of the individual or agency who referred the individual. This is completed only on initial assessments.

Interview Date--Enter the date the individual was interviewed. This is completed only on initial assessment.

Allergies--Enter any known allergies of the individual.

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Medical Diagnoses--Enter all current and pertinent medical diagnoses and the date(s) of diagnoses, if possible. Enter the primary diagnosis first.

ICD-9 Code--Enter the ICD-9 code for the diagnosis(es) of the recipient.

Medications--Enter all current medications prescribed, dosages and frequency.

Comments--Enter any other pertinent comments relating to the individual's overall medical condition.

PAGE 2
Recipient Name--Enter individual's name and date.

Mental Status/Psychosocial Status--Briefly describe the individual's mental and psychosocial status (lucid, alert, confused, combative). Enter any problems with orientation, judgment, memory, energy, motivation, sleep patterns, behavior, delusions, depression, grief, isolation, fear, low self-esteem, agitation, sexuality, etc.

Diet--Enter any special diet requirements such as diabetic, low salt, etc.

Safety Measures--Enter pertinent instructions regarding safety or precautionary measures required or used; e.g., stand by assistance for bathing and mobility.

Assistive Devices Used--List any appliances/ prosthetic devices/assistive technology that the individual uses such as walker, wheelchair, dentures, glasses, braces, etc.

Psychological Crisis Intervention Plan—Include the following:

- Description of what a crisis looks like for the individual
- Description of what wellness looks like for the individual
- Description of signs of relapse and triggers for the individual
- Description of interventions that have worked in the past
- Description of what the CMT needs to know about the individual to be effective during crisis
- Description of what the individual feels is not helpful at the time of crisis
- Description of actions to be taken to address the individual's needs

Medical Crisis Intervention Plan-- Describe how medical crises or emergencies will be handled.

Functional Overview--Enter for each task whether the individual is independent, needs assistance or is dependent. Indicate whether the tasks are done by someone other than the individual; e.g., spouse. Compare these to the assessments on the Level of Care Determination form (DPHHS-SDMI-86). If there is a significant difference, contact your CPO or the Foundation.

Other Treatment/Therapies/Social Services and Informal Support Systems--Enter all other treatments, therapies or services provided to the individual. Enter the problem, need, provider and frequency of service. This section would include all services to the individual that are not paid for

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through HCBS; e.g., State Plan Medicaid services, meals-on-wheels, adult protective services, home health, volunteer services, etc.

PAGE 3
Recipient Name—Enter individual's name and date.

Service Delivery Plan--Enter for each HCBS service the identified support required, the type and/or name of the service provider and frequency of service. Service provider and frequency must be specific. For example, provider name--2 hours per day, 3 times a week (Monday, Wednesday, and Friday).

PAGE 4
Recipient Name--Enter individual's name and date.

Plan Assessment Summary--Summarize the individual plan of care, including individual's short-term objectives and long-term goals. Be specific in stating goals and objectives. Attach additional pages if required. RN should complete the physical summary and SW should complete social summary.

Discharge Potential--The CMT must address the individual's discharge potential and plan from Home and Community Based Services.

Signatures--Signatures of all individuals who participated in development of the Person-Centered Recovery Plan. All signatures must be dated.

This includes dated signatures of the following:

- Recipient - The individual must sign the plan unless unable to do so. An "X" is acceptable but must be co-signed by another person. The signature page of the care plan should contain a note explaining that the individual was unable to sin. No one should sign the individual's name on their behalf. If the individual has a legal representative, the representative must sign.

- Community Program Officer (CPO): The Community Program Officer must sign the initial and annual Person-Centered Recovery Plan.

- Health Care Professional - A health care professional (HCP) may be a physician, physician assistant certified, or a nurse practitioner. The signature of a health care professional is not mandatory, but can be requested at the team's discretion. In all instances, a copy of the completed Person-Centered Recovery Plan will be sent to the health care professional.

- Case Management Team Nurse and Social Worker - Both members of the CMT must sign the Person-Centered Recovery Plan. The plan may be initially approved with only one signature if one team member is not available, but the other member must review, sign and date the plan upon their return.