Living Choices Person-Centered Service Plan

Please notify the PCSP/CC RN within **3 working days** of **starting services**. If the provider does not return the **AAS-9510** within 1**0 working days from the date** the PCSP/CC RN mailed this form to the provider, action may be taken to secure another provider. If there have been any changes in services or if services have been discontinued, the PCSP/CC RN **must be notified by form AAS-9511 immediately**.

Last Name, First Name, MI	Last 4 digits of SS#	Date Mailed

☐ **Provisional PCSP Expiration Date: (valid 60 days)**

☐ **Comprehensive PCSP**

Client Information

Client Name		**Phone**
Medicaid Number	**Date of Birth**	**County**
Physical Address		
Mailing Address		

☐ I have confirmed with the Client and/or representative, during the visit, that the above is the correct physical, and mailing address and phone number. ***Nurse Signature***

Does the Client have a significant other?	☐	**Yes**	☐ **No**
Name		**Relationship**	
Client Physician Name			
Address			
Telephone Number			

Backup Plan

Primary Contact Person (Cannot be paid caregiver)	☐	Check if: POA
Relationship to Client	☐	Check if: legal guardian
Phone	☐	Check if this person is available for backup care
Secondary Contact Person (Cannot be paid caregiver)	☐	Check if: POA
Relationship to Client	☐	Check if: legal guardian
Phone	☐	Check if this person is available for backup care
List any additional informal (unpaid) support for the Client:		
Name:	☐	Check if available for backup care
Phone:		

Power of Attorney/Legal Guardian Representative Information (if applicable Obtain Copy for Records) ☐ **N/A**

Name	
Relationship	
Address	

Client Name		Last 4 digits of SS#	

Diagnosis (In order of significance as related to need for nursing care)

Diagnosis provided by name/relationship	

Requested Change Information

To request a change in your service(s), provider(s), and/or conflict resolution, please contact your DHS PCSP/CC RN.

DHS PCSP/CC RN	
Phone	
Regional Supervisor	
Phone	

Verification of Current Services Listed on the Person-Centered Service Plan

☐ Initial Person-Centered Service Plan

☐ Continuation of services with client and/or family member as provided according to the current Person-Centered Service Plan.

Client satisfied with services, and the Client's needs are met at this time. Yes ☐ No ☐

If no, explain.

Justification of Assisted Living Services

Assisted Living Services	☐ Yes	☐ No

Comments / Justification of Assisted Living Services

Client Name		Last 4 digits of SS#	

Overview of the Last Year

List any improvements/declines/change of condition that wasn't noted in your most recent check in:

Goals – **What would you like to accomplish for the next year?**

Risks

Strengths

Challenges – **What challenges have you experienced in the last year that you may need to address in helping to meet your needs?**

Client Education

Client Name		Last 4 digits of SS#	
☐ Provisional		☐	Comprehensive

	Waiver Services	Provider	Amount / Frequency	Comments, N/A or Refused (if appropriate)
☐	Assisted Living Service			
☐	Attendant Care			
☐	Bathing/Skin Care		Minimum Days/Wk	
☐	Shampoo/Shave		Minimum Days/Wk	
☐	Grooming		Minimum Days/Wk	
☐	Dressing		Minimum Days/Wk	
☐	Mobility/Transfer		Minimum Days/Wk	
☐	Toileting		Minimum Days/Wk	
☐	Catheter/Ostomy		Minimum Days/Wk	
☐	ROM		Minimum Days/Wk	
☐	Eating/Fluids		Minimum Days/Wk	
☐	Meal Preparation		Minimum Days/Wk	
☐	Housework		Minimum Days/Wk	
☐	Laundry		Minimum Days/Wk	
☐	Shopping/Errands		PRN	
☐	Therapeutic, Social * Recreational Activities		PRN	
☐	Med. Oversight		PRN	
☐	Med. Administration		PRN	
☐	Periodic Nursing Evaluation		PRN	
☐	Limited Nursing		PRN	
☐	Non-Medical Transportation		PRN	

	Non-Waiver Services (Circle all that apply)	Provider	Amount/Frequency	Comments, N/A or Refused (if appropriate)
☐	Home Health			
☐	DME			
☐	Incontinence Supplies	Client's Choice	Not to exceed med. Max/Mth; PRN	
☐	Hospice	Client's Choice		
☐	Therapy			
☐	Other	Client's Choice		

***TO THE EXTENT PERMITTED UNDER STATE LAW**

The Living Choices Person-Centered Service Plan is recommended for 12 months and is designed specifically for each Client to assist in reaching individual goals enabling them to remain in the community.

Client Name		Last 4 digits of SS#	

Living Choices Waiver Agreement

☐	**I understand that I will receive services based upon my own preferences and on my level of needs, which is within the scope of services and supports available according to the state plan HCBS benefit. The PCSP/CC and the ALF Provider are responsible for monitoring the person-centered service plan.**

☐	**Yes**	☐	**No**	**Is the use of restrictive device(s)/intervention(s)/seclusion being utilized?**

If yes, must include documentation of investigation concerning restrictive device(s)/intervention(s):

Home Condition:

Condition of Client:

Who lives in the home with the Client? Name/relationship

Health and Welfare

☐	**APS Brochure Provided**	☐	**RN read information to Client**	☐	**Information provided to Client in alternate format**

☐	**HCBS Magnet and DHS RN contact information left in the Client's home.**

Abuse or Critical Incident reports within the last year? **If yes, document occurrence and all follow-ups in nurse note.**	☐ **Yes**	☐	**No**

Date followed up on reports to APS/Critical Incidents: **Note: Document all follow-ups in nurse note.**	

Client Name		Last 4 digits of SS#	

Living Choices Person-Centered Service Plan Signature Page

For the purpose of providing me with waiver services, I hereby authorize the Department of Human Services to release any medical and/or social information to the appropriate Medicaid provider. I also authorize the review of my files or records by personnel of the Department of Human Services and/or their authorized agent(s) for the purpose of assessing and monitoring provider program compliance. I understand that the information will be used only for the purpose of providing services to me and/or to monitor and assess these services and will not be released in any way that would disclose my personal identification to any other agency or agents without my prior written consent. I understand that I may revoke this authorization at any time.

If I am found eligible for intermediate level of care by the DHS reviewer, I may choose to be provided services in either an institutional setting or through home and community-based services.

I have reviewed the current provider listing for my area, and the providers listed on the service plan were chosen, according to policy, by:

☐	Client	☐	Client's Family	☐	Legal Guardian / POA

If chosen by the Client's family, list the name and relationship of family member(s) who chose providers.

Please read each statement Below and then mark each box beside it.

☐ **I choose and agree with my involvement in the development of the Person-Centered Service Plan.**

☐ **I understand that I have a choice of service providers and may change service providers by contacting the person responsible for the Person-Centered Service Plan.**

I choose to be cared for:

☐ **In an institutional setting**

☐ **In a community setting**

Signature of Client or Legal Representative (if applicable, relationship to Client)	**Date**
Signature of DHS RN	**Date**

Requested Change Information

To request a change in your service(s), provider(s), and/or conflict resolution, please contact your DHS RN.

Revision of PCSP

Date Revised/Sent	RN

Your Right to a Hearing

If you disagree with any revision to this person-centered service plan, including removal or decrease of services, you may request a hearing. A request for an appeal must be received by the DHS Appeals and Hearings section no later than 30 days from the business day following the postmark on the envelope with the person-centered service plan that contains a revision which you wish to appeal.

If you are currently receiving Medicaid assistance and request a hearing no later than 30 days from the business day following the postmark on the envelope with the person-centered service plan that contains a revision which you wish to appeal, your assistance may continue at its present level pending a decision on your appeal. If assistance is continued at its present level until a decision is reached, you may be required to repay the additional benefits if the hearing decision is not in your favor.

If you wish to discuss your case before deciding whether to file a hearing, contact the DHS RN who signed this person-centered service plan.

How to File for a Hearing

If you are not satisfied with the decision to revise your person-centered service plan, you may request a hearing in writing at the **Arkansas Department of Human Services, Appeals and Hearings Section, PO Box 1437, Slot N401, Little Rock, Arkansas, 72203-1437**. Official requests for a hearing must be made in writing.

Your Right to Representation

If you request a hearing, you have the right to appear in person and to be represented by a lawyer or other person you select. If you wish to have a lawyer, you may ask the DHS county office to help you arrange for one. If free legal services are available in your area, you may ask your county office for contact information for this service.

Prior to the hearing, you and/or your representative have the right to review your record and any other evidence which will be presented at the hearing. You have the right to present evidence on your own behalf, bring witnesses, and question any person who is presented as a witness against you.