|  |  |
| --- | --- |
| Date of Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Member’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Care Coordinator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | CMA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Staff Completing Plan: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | MCO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section 1: Member Information**

|  |  |
| --- | --- |
| **Demographic Information** | |
| Member CIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Gender:  Male  Female  Transgender |
| Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Alternate Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is the Member linked with any type of housing supports?  No  Yes, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Note: Members in Supported and Enhanced Housing are eligible for HCBS with some restrictions*  *Members in Community Residences are not eligible for HCBS* | |
| Diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section 2: BH HCBS Eligibility and Services**

Results of HCBS Eligibility Screen:

Eligible for Tier 1 HCBS Services  Eligible for Tier 2 HCBS Services

**Section 3: Member Goals and Related HCBS Services**

In the table below, please specify the specific goals of the Member and the related HCBS service type. Goals should be written in the Member’s words. Write in first person using “I” statements to reflect the Member’s participation in the goals statements.

|  |  |
| --- | --- |
| **Goal** | **HCBS Service** |
|
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|  |  |

**Section 4: Current Services**

Please provide a list of the services or supports the Member is currently receiving. ***If PROS involved, please note that specifically in the grid.***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service Type or Support**  *(Counseling, Substance abuse groups, family support, etc.)* | **Agency** | **Provider Name** | **Start Date** | **Frequency** *(daily, weekly, etc.)* | **Paid or Unpaid Service/Support?** | |
| **Paid** | **Unpaid** |
|  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |
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**Section 5: Preferences Regarding your HCBS Services and Goals**

Please note the Member’s preferences for services (i.e. things the Member may want HCBS provider to know about them before intake).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member Signature Date

*Obtain signature if possible*