Adult BH HCBS Plan of Care

Name of Individual:	______________	*MCO:*	______________
Medicaid CIN:	______________	*Member ID:*	______________
Date of Birth:	______________	*Lead Health Home:*	______________
BH HCBS Eligibility:	______________	*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.

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: O Living O Working O Learning O Socializing

Goal:*

Desired Outcomes:

Target Date:

Life Role Domain: O Living O Working O Learning O 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:	
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
Desired Outcome(s):				

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

Service Type*	Name of Provider	Frequency	Duration	Effective Date
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?

O Yes *If yes, a "Modifications Based on Risk Assessment" form must be attached.*
O No
O N/A: The individual does not reside in a provider-owned or -controlled setting

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:*	____________
Medicaid CIN:	____________	*Member ID:*	____________
Date of Birth:	____________	*Lead Health Home:*	____________
BH HCBS Eligibility:	____________	*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:	______________	*MCO:*	______________
Medicaid CIN:	______________	*Member ID:*	______________
Date of Birth:	______________	*Lead Health Home:*	______________
BH HCBS Eligibility:	______________	*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**