BH HCBS Plan of Care (POC)

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Section 1: Behavioral Health Home and Community Based Services (BH HCBS) Eligibility

Person Completing POC:	**Organization:**
Phone #:	**Email:**
Lead Health Home:	
Eligibility Assessment Completion Date:	Results of BH HCBS screen: ☐ Eligible for Tier 1 BH HCBS only ☐ Eligible for Tier 2 BH HCBS (Full array) ☐ Not Eligible
Next Assessment Due:	

Section 2: Demographic information

Individual Name		MCO, Member ID, & Medicaid #/CIN	
Date of Birth		Gender	
Address		Home Phone #	
Cell Phone #		Email	
Language		Religion	

Is the address listed above a setting chosen by the individual? (Does the individual want to live in the above setting?)	☐ Yes ☐ No
The address listed above is not: (1) a nursing home; (2) an institution for mental diseases; (3) an intermediate care facility for individuals with developmental disabilities; (4) a hospital; (5) an OMH licensed Congregate Treatment Site (Community Residence); or, (6) any other location that has the qualities of an institution, as determined by New York State.	☐ Yes ☐ No

****** If the individual does not wish to live in his or her current setting, the CM should assist in developing a plan to facilitate a move. The Housing Questionnaire may be used as a tool to assist with this process.***

Section 3: Approved/Denied BH HCBS Services

Service 1:

MCO Approval Status ☐ Approved ☐ Denied ☐ Pending	**MCO Representative Name:**	**Reason:**

Date service started: _____ **Provider Specialty:** _____ **Provider Name:** _____

Organization: _____ **Address:** _____ **Work Phone:** _____ **Email:** _____

Service Diagnosis Code: **Description:** **Prescription Unit:** **Frequency:**

Service 2:

MCO Approval Status ☐ Approved ☐ Denied ☐ Pending	**MCO Representative Name:**	**Reason:**

Date service started: _____ **Provider Specialty:** _____ **Provider Name:** _____

Organization: _____ **Address:** _____ **Work Phone:** _____ **Email:** _____

Service Diagnosis Code: **Description:** **Prescription Unit:** **Frequency:**

Service 3:		
MCO Approval Status ☐ Approved ☐ Denied ☐ Pending	**MCO Representative Name:**	**Reason:**

Date service started: _____ **Provider Specialty:** _____ **Provider Name:** _____

Organization: _____ **Address:** _____ **Work Phone:** _____ **Email:** _____

Service Diagnosis Code: **Description:** **Prescription Unit:** **Frequency:**

Service 4:		
MCO Approval Status ☐ Approved ☐ Denied ☐ Pending	**MCO Representative Name:**	**Reason:**

Date service started: _____ **Provider Specialty:** _____ **Provider Name:** _____

Organization: _____ **Address:** _____ **Work Phone:** _____ **Email:** _____

Service Diagnosis Code: **Description:** **Prescription Unit:** **Frequency:**

Complete the following two items, only if an education or employment support service (Pre-Vocational Services, Transitional Employment, Intensive Supported Employment, Ongoing Supported Employment, and/or Education Support Services) is included in the Plan of Care.

The Health Home Care Manager (HHCM) is responsible for facilitating the Member's informed choice in education and/or employment support services. The following selection should be made by the Member, based on an informed choice.

Based on the information provided to me by my Care Manager, I have chosen to (please select only one option):

☐ Receive services through the Home and Community Based Services (HCBS) Waiver designated agency;

☐ Pursue support from ACCES-VR; or,

☐ Receive services through the BH HCBS Waiver *and* pursue separate and non-duplicative services through ACCES-VR.

If BH HCBS education and/or employment support services are chosen by the Member, the HHCM must affirm the following:

☐ The Behavioral Health Home and Community Based Services identified in this Plan of Care are not available to this individual under Section 110 of the Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq.) (i.e. ACCES-VR).

Section 4: Clinical and Non Clinical Services at the Time of Assessment

Behavioral and Medical Health Needs (e.g., Mental Health Treatment, Addiction Treatment, and PCP Information)											
Service	**Provider Specialty**	**Provider name**	**Organization**	**Address**	**Work Phone**	**Email**	**Service / Diagnosis code**	**Description**	**Prescription/ unit**	**Frequency**	**Last visit date**

Section 5: Health Home Care Management/Recovery Coordination Agency

Status	Tests/ Treatment/ Service/ Referral	Service Description	Provider Name	Provider Specialty	Organization	Phone	Email	Address

Section 6: My Goals, Preferences, Desired Outcomes, and Strengths

Goal # 1	
Category	**Target Date**
Past Efforts (Things that I have tried in the past to reach my goal)	
Objectives (The outcomes I want to achieve)	
Preferences (I would prefer that when I receive services the following is taken into account by the provider)	
Strengths (My strengths are)	
Potential Barriers (Things that make it hard for me to achieve these outcomes)	
Strategies (Things that I will do to address the barriers and achieve my desired outcomes)	
Support(s) Needed (Who will help me reach my goal) ***Indicate if supports are to be provided by paid or unpaid provider and the frequency needed***	
Goal # 2	
Category	**Target Date**
Past Efforts (Things that I have tried in the past to reach my goal)	
Objectives (The outcomes I want to achieve)	
Preferences (I would prefer that when I receive services the following is taken into account by the provider)	
Strengths (My strengths are)	
Potential Barriers (Things that make it hard for me to achieve these outcomes)	
Strategies (Things that I will do to address the barriers and achieve my desired outcomes)	
Support(s) Needed (Who will help me reach my goal) ***Indicate if supports are to be provided by paid or unpaid provider and the frequency needed***	

Goal # 3	
Category	**Target Date**
Past Efforts (Things that I have tried in the past to reach my goal)	
Objectives (The outcomes I want to achieve)	
Preferences (I would prefer that when I receive services the following is taken into account by the provider)	
Strengths (My strengths are)	
Potential Barriers (Things that make it hard for me to achieve these outcomes)	
Strategies (Things that I will do to address the barriers and achieve my desired outcomes)	
Support(s) Needed (Who will help me reach my goal) ***Indicate if supports are to be provided by paid or unpaid provider and the frequency needed***	

Section 7: Risk Assessment and Mitigation Strategies

Crisis Prevention Plan

It is often helpful to be aware of events, feelings, thoughts and sensations that are early warning signals for an emotional crisis. If I begin to experience them, I can use the following plan.

What are my triggers (what people, places, or things upset me); how do I know when I am upset?

What activities can I do to feel better (for example, take a walk, listen to music, or watch TV)?

Who can I call for support?

Name	Relation	Contact Info

Emergency Plan (In the event of an emergency, natural disaster, etc.)

If there is an emergency, call 911. *An emergency plan assists in locating help in an emergency situation or if regularly scheduled worker(s) cannot provide you care, services, or supports. The back- up plan will indicate: whom I will call, including service needs, and phone numbers, plans for service animals or pets, and plans for preparing for a disaster.*

I will talk with back-up workers about their availability and my care needs before an emergency comes up. I understand that I may only get my most serious needs met in an emergency.

I will call/contact one of the individuals listed below if my regularly scheduled worker(s) does not report for his/her scheduled time. (Examples: provider, friends, family, previous workers, church members, other volunteers).

Service	Contact	Phone	Availability

Risk Assessment to Justify an Intervention / Support to Address an Identified Risk

If a risk is identified address items A – H below:

If risk is identified, complete the following:

A. Identify the specific and individualized assessed need.
B. Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
C. Document less intrusive methods of meeting the need that have been tried, but did not work.
D. Include a clear description of the condition that is directly proportionate to the specific assessed need.
E. Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
F. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
G. Include informed consent of the individual or legal representative or guardian.
H. Assure that interventions and supports will cause no harm to the individual.

Include a narrative addressing all items A-F and H if an intervention is utilized:

A.	
B.	
C.	
D	
E.	
F.	
G	
H	

By signing below, I agree with the use of this intervention or support to address the identified risk. I will watch and make sure that the interventions and support do not harm me in any way.

Recipient:		Date:	
Legal Representative/Guardian:		Date:	
Care Manager:		Date:	
Care Manager Supervisor:		Date:	

Section 8: Person-Centered Plan of Care Affirmation / Attestation

The Care Manager and MCO are responsible for monitoring, on a regular basis, whether the services in the Plan of Care are being delivered as outlined in the Plan of Care and whether those delivered services meet the needs of the individual. The Care Manager will contact the Recipient routinely to ensure that the Recipient's goals, preferences, and needs are being met. The Recipient may call the Care Manager at any time to initiate changes or discuss the quality of care of the services listed in the Plan of Care. If at any time a provider or the Recipient becomes aware of unnecessary or inappropriate services and supports being delivered, he/she is obligated to contact the Care Manager and discuss a change in the Plan of Care.

Commitment to Confidentiality and Support:
By signing this form, I agree to maintain Recipient confidentiality; I affirm that I participated in the development of this Plan of Care and the Recipient was given choices in selecting providers; I support the goals of the Recipient below; I acknowledge that I understand and approve the content of this Plan of Care; and I have a copy of this Plan of Care.

Release of Information: I consent to the release of information under the BH HCBS program, so I may receive services. I understand that the information included on the Plan of Care will be released to _____ and service providers listed below to enable the delivery of services and program monitoring. I understand that my Care Manager shall not release my record in the absence of written authorization from me or my representative.

I affirm to share my PLAN OF CARE with following individuals:

Name	Phone	Address	Relationship (relative, doctor, Care Manager, other)

Documentation of Informed Choice: My signature below affirms that I have been informed by my Care Manager of the benefits of receiving supported education and employment services through the Behavioral Health Home & Community Based Services (BH HCBS) Waiver and ACCES-VR, as documented in Section 3 of this Plan of Care.

Signature	*Date*	*Print Name*
Individual		
Legal Representative/Guardian		
Care Manager		
Provider:		
Provider:		
Provider		

Recipient Rights for Individuals Receiving Behavioral Health Home and Community Based Services (BH HCBS)

I qualify for BH HCBS which are essential to my health and welfare and may be provided to me within the program limits. My signature below indicates that I agree with the following:

☐ I have been informed that I am eligible to receive services.

☐ I understand that I may choose to remain in the community and receive the services, as designated in my Plan of Care.

☐ I understand that I have the choice of any qualified providers in my plan's network and I have been notified of the providers available.

☐ I understand that I have the right to be free of abuse, neglect, and exploitation and to report of these abuses at any time.

☐ I understand I may grieve and appeal at any time and have received information on how to do this.

☐ I have been offered a choice of settings in which I can receive BH HCBS.

Please ensure that your Care Manager has reviewed the Plan of Care with you and has provided a copy of this Plan of Care to you before signing.

My choice is to (check one):

☐ Receive BH HCBS as indicated on the attached Plan of Care.

☐ Refuse the recommended services

Recipient Signature	**Date**
Representative Signature	**Date**
Care Manager Signature	**Date**

Abuse, Neglect, Exploitation

Physical Abuse: Non-accidental contact which causes or potentially causes physical pain or harm

Psychological Abuse: Includes any verbal or nonverbal conduct that is intended to cause emotional distress

Sexual Abuse: Any unwanted sexual contact

Neglect: Any action, inaction or lack of attention that results in or is likely to result in physical injury; serious or protracted impairment of the physical, mental or emotional condition of an individual

Exploitation: The illegal or improper use of an individual's funds, property, or assets by another individual. Examples include, but are not limited to, cashing an individual's checks without authorization or permission; forging an individual's signature; misusing or stealing an individuals' money or possessions; coercing or deceiving an individual into signing any document (e.g. contracts or will); and the improper use of guardianship, conservatorship or power of attorney

I understand what abuse, neglect and exploitation mean.

If I believe I am at risk of harm from or experience abuse, neglect, or exploitation, I know that I should contact:

Name	Phone	Location
		if at home
		if in the community