APPENDIX H

SPECIALIZED SERVICES PLAN

RESIDENT INFORMATION

RESIDENT/PARTICIPANT'S NAME: _____

SS # _____-_____-_____ DATE OF BIRTH ____/____/_____

GENDER: _____ LIMITED ENGLISH PROFICIENCY? YES___ NO ___

DATE OF INITIAL CONTACT: _____

PROVIDER INFORMATION

SPECIALIZED SERVICES PROVIDER: _____

NAME OF PROVIDER'S REPRESENTATIVE: _____

PROVIDER TELEPHONE NUMBER: _____

NURSING FACILITY INFORMATION

NURSING FACILITY: _____

NURSING FACILTY ADMINISTRATOR: _____

DATE OF INITIAL CONTACT OF ADMINISTRATOR: _____DATE OF INITIAL SPECIALIZED SERVICES PLAN MEETING: _____

SPECIALIZED SERVICES PLAN FOR
RESIDENTS WITH OTHER RELATED CONDITIONS

Have the eligibility letter and description of the specialized services available under the Office of Long-Term Living (OLTL) been explained to the resident?

YES_____ NO _____

_____ Resident / participant wants Specialized Services.

_____ Resident / participant does <u>not</u> want specialized services.

IF THE RESIDIENT/PARTICIPANT DOES NOT WANT SPECIALIZED SERVICES STOP HERE

NOTE: This document must remain on the resident's clinical record.
Copy of most recent plan must be on file at the Provider's office.

SPECIALIZED SERVICES PLAN

1. The Specialized Services Provider will provide the Specialized Services listed below as determined at the Specialized Services Plan Meeting.

SPECIALIZED SERVICES	***FREQUENCY AND/OR DATE DELIVERED***	***SERVICES DELIVERED BY***
SUPPORTS COORDINATION		
PEER SUPPORT		
COMMUNITY INTEGRATION		
ACADEMIC AND EDUCATIONAL SERVICES (PRE-APPROVED BY OLTL)		
NON-MEDICAL TRANSPORTATION		
TRAINING IN:		
--Self-Empowerment		
--Household Management		
--Community Mobility		
--Decision Making		
--Rights and Responsibilities of Persons with Disabilities		
--Leadership		
--Sexuality		
--Time Management		
--Self-Defense and Victim Assistance		

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SPECIALIZED SERVICES PLAN

--Interpersonal Relationships		
ASSISTIVE TECHNOLOGY EVALUATION AND SPECIALIZED MEDICAL EQUIPMENT (ONLY FOR THOSE WHO PLAN TO RELOCATE TO COMMUNITY SETTINGS)		

2. The Nursing Facility as needed and appropriate will provide basic nursing facility services along with the Specialized Rehabilitative Services listed below:

SPECIALIZED REHABILITATIVE SERVICES	***FREQUENCY AND/OR DATE DELIVERED***	***DELIVERED BY***
PHYSICAL THERAPY		
OCCUPATIONAL THERAPY		
SPEECH LANGUAGE PATHOLOGY		
EQUIPMENT (SUCH AS ADAPTIVE APPLIANCES FOR EATING, WHEELCHAIRS, ETC)		
PLANS TO CHANGE INAPPROPRIATE BEHAVIOR		
DRUG THERAPY AND MONITORING		

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SPECIALIZED SERVICES PLAN

SPECIALIZED REHABILITATION SERVICES	**FREQUENCY and/or DATE DELIVERED**	**DELIVERED BY**
STRUCTURED ENVIRONMENT TO DIMINISH ISOLATION AND WITHDRAWAL		
IMPLEMENTATION OF PROGRAMS TO TEACH DAILY LIVING SKILLS, PERSONAL HYGIENE, MOBILITY, ETC.		
CRISIS INTERVENTION SERVICES		
INDIVIDUAL GROUP AND FAMILY THERAPY		
PERSONAL SUPPORT NETWORKS		
FORMAL BEHAVIOR MODIFICATION		

3. Briefly describe the services, goals and outcomes that the Provider of Specialized Services, nursing facility representative and the resident//participant hope to achieve.

SERVICE/ DETAILS	**OUTCOME / GOALS**

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SPECIALIZED SERVICES PLAN

4. This Specialized Services Plan was prepared on _____with the participation of:

_____ _____
Resident/Participant's Signature Date

_____ _____
Specialized Services Provider Signature Date

_____ _____
Nursing Facility Representative Signature Date

_____ _____
Legal Guardian or Representative if applicable Date

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SPECIALIZED SERVICES PLAN

5. The frequency with which the Specialized Services Provider will meet with the resident and his/her nursing facility representative to develop, monitor and maintain the Specialized Services Plan is at the Specialized Services Provider's discretion so long as the minimum number of meetings are held as follows:

a. One meeting a year must be held for a resident who intends to remain in the nursing facility.

b. Two meetings a year must be held for a resident who is undecided about leaving the nursing facility.

c. Three meetings a year must be held for a resident who has decided to relocate to a community setting.

Frequency _____

NOTE: A new specialized services plan must be completed if residents experience a significant change in condition or if a new service provider is involved in the delivery of specialized services. If a resident/participant declines any of the above meetings it should be documented in section # 6 of the plan under changes/updates however this would not change the frequency above.

6. Indicate below all updates, meetings, and changes to this Specialized Services Plan. Consumer, or their representative if appropriate, and the Provider representative should initial all changes/updates.

DATE	DESCRIPTION OF CHANGES / UPDATES

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SPECIALIZED SERVICES PLAN

7. Copy of Plan and/or Plan Updates given to participant/representative on:

Date: _____ Date: _____

Date: _____ Date: _____

Date: _____ Date: _____

Date: _____ Date: _____

Date: _____ Date: _____

Date: _____ Date: _____

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