

HCBS-AMH
Individual Recovery Plan
* Required Field

*IRP Population Served	
Population: <input type="checkbox"/> Long Term Hospitalization <input type="checkbox"/> Jail Diversion <input type="checkbox"/> Emergency Department Diversion	
*IRP Type	
<input type="checkbox"/> Initial <input type="checkbox"/> Update <input type="checkbox"/> Transfer <input type="checkbox"/> Discharge	Completion Date:
*Demographics	
<u>Direct Services Provider Name:</u>	<u>DOB:</u>
<u>Recovery Management Entity and RM Name:</u>	<u>Preferred Language:</u>
<u>Participant Name (First Name, MI, Last Name):</u>	Does Individual Need a Translator or Interpreter? <input type="checkbox"/> Yes <input type="checkbox"/> No
CARE ID#:	Medicaid Number:
<u>Current Address:</u>	
<u>Current Setting:</u>	
<input type="checkbox"/> Assisted Living	<input type="checkbox"/> Jail/Prison
<input type="checkbox"/> Group Home	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family Home	<input type="checkbox"/> Nursing Home
<input type="checkbox"/> Apartment	<input type="checkbox"/> Other Non-HCBS-AMH Setting
<input type="checkbox"/> State Hospital	<input type="checkbox"/> Unknown
Setting Verification	
Recovery Manager has reviewed individual's current setting and attests that the setting meets HCBS-AMH requirements. <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, complete the following:	
<ul style="list-style-type: none"> Reason setting does not meet HCBS-setting requirements: Action steps to address settings requirements: Time frame in which action steps will be taken: 	
<input type="checkbox"/> Individual agrees that they have chosen their current setting	
Diagnoses, Current Medications, and Physical Examination	
<u>Diagnoses (Both Behavioral and Physical, and ICD-10):</u>	
<u>Current Medications:</u>	

Date of Individual's Annual Physical Examination: _____

Change in Services (If Applicable)

- Discharge
 Transfer
 Suspension
 Extension of Services
 Reduction in Services
 End of Transitional Services
 End of Conversion Services
 Reinstatement of Services

Summary:

***Life Narrative**

Life Narrative:

***Strengths, Barriers, Immediate Needs, and Personal Interests**

Strengths:

Barriers:

Immediate Needs:

Personal Interests:

***Goals/Objectives**

(This section may be duplicated if additional goals/objectives/interventions are identified)

Life Domain Area of need: Family Functioning Social Functioning Involvement in Recovery
 Transportation Employment Recreational Intellectual/Development Sexuality
 Residential Stability Legal Sleep Self-care Daily Living Physical/Medical Health
 Decision Making

Goal Statement

Next Review Date:

Status of Goal:

- In Process
 Achieved
 Reconsidered
 Discontinued

Progress on Goal:

Objectives: 1.

2.

3.

1. Intervention:

Type of Service:

- Transition Assistance Services HCBS-AMH Psychosocial Rehabilitation Services
 Adaptive Aids/Medical Supplies Employment Assistance Supported Employment Transportation
 Community Psychiatric Supports and Treatment Peer Support Assisted Living Supervised Living Services
 Supportive Home Living Host Home Companion Respite Care Home Delivered Meals Minor Home
Modifications Nursing-RN Nursing-LVN Substance Use Disorder Services Flexible Funds RM Services
 RM Transitional Services RM Conversion Services

Frequency:

Duration:

Objective Intervention is Addressing: 1 2 3

Number of Anticipated Units Utilized/30 days

Signature of Provider, Credentials, and Date: _____



Responsibility of the Recovery Manager: IRP Development Assisting with Informed Choices
 Coordinating/Monitoring Service Provision Resource Development Advocating

Role Statement in Service Provision:

Frequency: **Duration:**

Number of Anticipated Units Utilized/30 days

2. Intervention:

Type of Service:
 Transition Assistance Services HCBS-AMH Psychosocial Rehabilitation Services
 Adaptive Aids/Medical Supplies Employment Assistance Supported Employment Transportation
 Community Psychiatric Supports and Treatment Peer Support Assisted Living Supervised Living Services
 Supportive Home Living Host Home Companion Respite Care Home Delivered Meals Minor Home Modifications Nursing-RN Nursing-LVN Substance Use Disorder Services Flexible Funds RM Services
 RM Transitional Services RM Conversion Services

Frequency: **Duration:**

Objective Intervention is Addressing: 1 2 3

Number of Anticipated Units Utilized/30 days

Signature of Provider, Credentials, and Date: _____

Responsibility of the Recovery Manager: IRP Development Assisting with Informed Choices
 Coordinating/Monitoring Service Provision Resource Development Advocating

Role Statement in Service Provision:

Frequency: **Duration:**

Number of Anticipated Units Utilized/30 days

3. Intervention:



Type of Service:

Transition Assistance Services HCBS-AMH Psychosocial Rehabilitation Services
 Adaptive Aids/Medical Supplies Employment Assistance Supported Employment Transportation
 Community Psychiatric Supports and Treatment Peer Support Assisted Living Supervised Living Services
 Supportive Home Living Host Home Companion Respite Care Home Delivered Meals Minor Home Modifications
 Nursing-RN Nursing-LVN Substance Use Disorder Services Flexible Funds RM Services
 RM Transitional Services RM Conversion Services

Frequency: _____ **Duration:** _____

Objective Intervention is Addressing: 1 2 3

Number of Anticipated Units Utilized/30 days

Signature of Provider, Credentials, and Date: _____

Responsibility of the Recovery Manager: IRP Development Assisting with Informed Choices
 Coordinating/Monitoring Service Provision Resource Development Advocating

Role Statement in Service Provision:

Frequency: _____ **Duration:** _____

Number of Anticipated Units Utilized/30 days

***Goals/Objectives**
 (This section may be duplicated if additional goals/objectives/interventions are identified)

Life Domain Area of need: Family Functioning Social Functioning Involvement in Recovery
 Transportation Employment Recreational Intellectual/Development Sexuality
 Residential Stability Legal Sleep Self-care Daily Living Physical/Medical Health
 Decision Making

Goal Statement		Next Review Date:
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Type of Service:

- Transition Assistance Services HCBS-AMH Psychosocial Rehabilitation Services
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- Nursing-RN Nursing-LVN Substance Use Disorder Services Flexible Funds RM Services
- RM Transitional Services RM Conversion Services

Frequency:

Duration:

Objective Intervention is Addressing: 1 2 3

Number of Anticipated Units Utilized/30 days

Signature of Provider, Credentials, and Date: _____

Responsibility of the Recovery Manager: IRP Development Assisting with Informed Choices
 Coordinating/Monitoring Service Provision Resource Development Advocating

Role Statement in Service Provision:

Frequency:

Duration:

Number of Anticipated Units Utilized/30 days

6. Intervention:

Type of Service:

- Transition Assistance Services HCBS-AMH Psychosocial Rehabilitation Services
- Adaptive Aids/Medical Supplies Employment Assistance Supported Employment Transportation
- Community Psychiatric Supports and Treatment Peer Support Assisted Living Supervised Living Services
- Supportive Home Living Host Home Companion Respite Care Home Delivered Meals Minor Home Modifications
- Nursing-RN Nursing-LVN Substance Use Disorder Services Flexible Funds RM Services
- RM Transitional Services RM Conversion Services

Frequency:

Duration:

Objective Intervention is Addressing: 1 2 3

Number of Anticipated Units Utilized/30 days

Signature of Provider, Credentials, and Date: _____



Responsibility of the Recovery Manager: IRP Development Assisting with Informed Choices
 Coordinating/Monitoring Service Provision Resource Development Advocating

Role Statement in Service Provision:

Frequency:

Duration:

Number of Anticipated Units Utilized/30 days

***Goals/Objectives**

(This section may be duplicated if additional goals/objectives/interventions are identified)

Life Domain Area of need: Family Functioning Social Functioning Involvement in Recovery
 Transportation Employment Recreational Intellectual/Development Sexuality
 Residential Stability Legal Sleep Self-care Daily Living Physical/Medical Health
 Decision Making

Goal Statement

Next Review Date:

Status of Goal:

- In Process
- Achieved
- Reconsidered
- Discontinued

Progress on Goal:

Objectives: 1.

2.

3.

7. Intervention:



Type of Service:

- Transition Assistance Services HCBS-AMH Psychosocial Rehabilitation Services
- Adaptive Aids/Medical Supplies Employment Assistance Supported Employment Transportation
- Community Psychiatric Supports and Treatment Peer Support Assisted Living Supervised Living Services
- Supportive Home Living Host Home Companion Respite Care Home Delivered Meals Minor Home Modifications
- Nursing-RN Nursing-LVN Substance Use Disorder Services Flexible Funds RM Services
- RM Transitional Services RM Conversion Services

Frequency:

Duration:

Objective Intervention is Addressing: 1 2 3

Number of Anticipated Units Utilized/30 days

Signature of Provider, Credentials, and Date: _____

Responsibility of the Recovery Manager: IRP Development Assisting with Informed Choices
 Coordinating/Monitoring Service Provision Resource Development Advocating

Role Statement in Service Provision:

Frequency:

Duration:

Number of Anticipated Units Utilized/30 days

8. Intervention:

Type of Service:

- Transition Assistance Services HCBS-AMH Psychosocial Rehabilitation Services
- Adaptive Aids/Medical Supplies Employment Assistance Supported Employment Transportation
- Community Psychiatric Supports and Treatment Peer Support Assisted Living Supervised Living Services
- Supportive Home Living Host Home Companion Respite Care Home Delivered Meals Minor Home Modifications
- Nursing-RN Nursing-LVN Substance Use Disorder Services Flexible Funds RM Services
- RM Transitional Services RM Conversion Services

Frequency:

Duration:

Objective Intervention is Addressing: 1 2 3

Number of Anticipated Units Utilized/30 days

Signature of Provider, Credentials, and Date: _____

Responsibility of the Recovery Manager: IRP Development Assisting with Informed Choices
 Coordinating/Monitoring Service Provision Resource Development Advocating

Role Statement in Service Provision:

Frequency:

Duration:

Number of Anticipated Units Utilized/30 days

9. Intervention:

Type of Service:

- Transition Assistance Services HCBS-AMH Psychosocial Rehabilitation Services
- Adaptive Aids/Medical Supplies Employment Assistance Supported Employment Transportation
- Community Psychiatric Supports and Treatment Peer Support Assisted Living Supervised Living Services
- Supportive Home Living Host Home Companion Respite Care Home Delivered Meals Minor Home Modifications
- Nursing-RN Nursing-LVN Substance Use Disorder Services Flexible Funds RM Services
- RM Transitional Services RM Conversion Services

Frequency:

Duration:

Objective Intervention is Addressing: 1 2 3

Number of Anticipated Units Utilized/30 days

Signature of Provider, Credentials, and Date: _____

Responsibility of the Recovery Manager: IRP Development Assisting with Informed Choices
 Coordinating/Monitoring Service Provision Resource Development Advocating

Role Statement in Service Provision:

Frequency:

Duration:

Number of Anticipated Units Utilized/30 days

Modifications of HCBS-AMH Requirements (If Applicable)
(This section may be duplicated if additional Modifications are identified)

Type of Modification:

- Setting Requirements Medication Safety and Management Personal Restraint
 Individual Autonomy

Next Review Date of Modification:

- Interventions and supports will cause no harm

Assessed Need for Modification:

Specific Modification (a clear description of the condition that is directly proportionate to the specific assessed need):

Less Intrusive Methods Previously Utilized:

Effectiveness of Modification (based on review):

Person(s) Involved in Modifications:

By signing below, I am providing informed consent to this modification and have been informed of how to report incidences of abuse, neglect, or exploitation.

Signature of individual and/or LAR: _____



*HCBS-AMH Interdisciplinary Team Contacts		
Support Name/Role	Organization	Contact Information

*Contact Information of Alternate Recovery Manager
Name:
Phone:
Address:

By signing below, I agree that I created my own Individual Recovery Plan. I believe that everything listed on my Individual Recovery Plan will benefit me. I can request to review my Individual Recovery Plan at any time.

*Individual’s Signature:	Date:
*Legally Authorized Representative’s Signature (If Applicable):	Date:
*Recovery Manager’s Signature:	Date:
*Interdisciplinary Team Member, Name and Title:	Date:
*Interdisciplinary Team Member, Name and Title:	Date:
*Interdisciplinary Team Member, Name and Title:	Date:

Was the individual and/or LAR given a copy of the Individual Recovery Plan?

Yes No Declined

If declined, please indicate reason:

DSHS Internal Use Only	
Approval Date of IRP:	DSHS Representative Reviewing IRP: