	Focus	Goal	Intervention
1	I have been given an categorical exemption (Specify the exact type of categorical exemption that I have been given as found in my individualized PASRR summary of findings) from PASRR for (Specify) days. If not discharged by the identified date, the NF must submit a new PASRR at least one week prior to expiration of authorization.	Categorical exemptions are time limited, so I will need the NF to work with me to ensure that my rehabilitative and/or recovery goals are met during this time, and submit a new PARR prior to the expiration of the exemption if I am not ready for discharge by that time.	I will return to the community (specify location of lower level of care, if known) as soon as I am able.
		I want to focus on rehabilitation and plan to return to the community.	(Specify: list any/all rehabilitative services) will be provided by (Specify: Service/Therapy Providers) (Specify: Date). If my rehabilitative stay is expected to exceed the categorical exemption from PASRR, please resubmit a new Level I screen 1 week prior to the expiration date (Specify: Expiration Date).
2	I have been given a short-term nursing facility approval in PASRR which expires (Specify: date). As a result, all PASRR identified Community Placement Supports need to be addressed as part of my care plan in addition to any Specialized and Rehabilitative Services.	I want to focus on rehabilitation and plan to move or return to the community (specify the location of lower level of care, if known).	NF and other providers will help me arrange needed Environmental Management Services: (Specify each exact Service: Cleaning Service, Lawn Service, Assistive Devices or Technology, Home evaluation for modifications or other needs, referral for Iowa Program for Assistive Technology, Home Health Aide, Home Health Nurse, Outpatient or In-Home OT/PT/ST, Medical Alert systems or devices, Hospice Services, assessment for payee or other financial assistance, a guardian/conservator or Power of Attorney for Health care for assistance with decision making, health, and safety, referral to Office of Substitute Decision Maker, Development of a Healthcare Advanced Directive, Referral for a Medical Home, Referral for Medicaid eligibility determination, other, etc.) prior to discharge through (Specify: Agency).

	Focus	Goal	Intervention
			NF and other providers will help me arrange needed Services to address my Access to Community Resources: (Specify the exact Service: Public Transportation/Bus Pass, Supported Public Transportation, Arranged public transportation, respite services for caregivers, Family, Friends, or others, Assistive Devices or Technology, Referral for Options Counseling, etc.) prior to discharge through (Specify: Agency).
			NF and other providers will help me arrange needed Shopping or Meal Preparation Supports: (Specify the exact Support: Home Care Aide, Family, Friends or others, Assistive Devices or Technology, meals on wheels, etc.) prior to discharge through (Specify: Agency).
3			NF and other providers will help me arrange needed Behavioral Health Supports: (Specify each exact Service: Case Management for Frail Elders, Other case management, Individual Therapy/Mobile Therapy by a licensed behavioral health professional, Psychiatric services by a Psychiatrist to evaluate response to psychotropic medications, modify medication orders and to evaluate ongoing need for add'l behavioral health services, Partial Hospitalization/Day Treatment, Group Therapy by a licensed behavioral health professional, Peer Support Services delivered by a Certified Mental Health PSS, Referral for Integrated Health Home (IHH), Referral to a Community Based Recovery Center, Referral for Outpatient Substance use Treatment, Initial Substance use Evaluation to determine diagnosis and develop a plan of care, Support Group for Recovery from Substance Use (AA, NA, etc.), Other Support Groups, etc.) prior to discharge through (Specify: Agency).

	Focus	Goal	Intervention
4	PASRR has identified that I am in need of Specialized Services due to (Specify: MI; ID; MI and ID, or Related Conditions). Specialized Services will assist me to achieve optimal functioning and recovery.	Initial Psychiatric evaluation, by a Psychiatrist, (who has been provided required assessments) to determine diagnosis and develop plan of care. Findings from this evaluation shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider.	[Specify the exact name of Psychiatrist] of [Specify the name of the Agency] will conduct a psychiatric evaluation on [Exact date of appointment] in order to determine a diagnosis and plan of care that will support my recovery goals and help me maintain an optimal level of stability. I will attend the psychiatric evaluation [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter]. The report of psychiatric evaluation shall demonstrate that this service was delivered.
5	PASRR has identified that I am in need of Specialized Services due to (Specify: MI; ID; MI and ID, or Related Conditions). Specialized Services will assist me to achieve optimal functioning and recovery.	Ongoing Psychiatric Services by a Psychiatrist to evaluate response to psychotropic medications, modify medication orders and to evaluate response to, or need for, other services. Any changes to my treatment plan, as a result of ongoing psychiatric services, shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider.	[Specify the exact name of Psychiatrist] of [Specify the name of the Agency] will provide ongoing psychiatric services starting on [Exact date of appointment] in order to help me reach my recovery goals and maintain an optimal level of stability and recovery. I will attend ongoing psychiatric services [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter]. Progress notes from the provider of psychiatric services shall demonstrate that this service was delivered.

	Focus	Goal	Intervention
7	PASRR has identified that I am in need of Specialized Services due to (Specify: MI; ID; MI and ID, or Related Conditions). Specialized Services will assist me to achieve optimal functioning and recovery.	Individual Therapy Services by a licensed therapist to address [Specify: issues identified by PASRR that will specifically be addressed by therapy]. My progress in individual therapy goals will be communicated to my Primary Care Provider and to my Psychiatrist. Staff will encourage communication from the therapist to my care team by facilitating releases of information. Any changes to my treatment plan, as a result of individual therapy services, shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider and Psychiatrist.	[Specify the exact name and credentials of therapist] of [Specify the name of the Agency] will provide individual therapy starting on [Exact date of appointment] in order to help me reach my recovery goals and maintain an optimal level of stability and recovery. I will attend individual therapy [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter]. A letter from the therapist, to include the dates of treatment, a general statement of therapy goals and progress towards those goals shall demonstrate that this service was delivered.
	PASRR has identified that I am in need of Specialized Services due to (Specify: MI; ID; MI and ID, or Related Conditions). Specialized Services will assist me to achieve optimal functioning and recovery.	Group Therapy Services by a licensed therapist to address [Specify: issues identified by PASRR that will specifically be addressed by therapy]. My progress in group therapy goals will be communicated to my Primary Care Provider and to my Psychiatrist. Staff will encourage communication from the therapist to my care team by facilitating releases of information. Any changes to my treatment plan, as a result of group therapy services, shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider and Psychiatrist.	[Specify the exact name and credentials of therapist] of [Specify the name of the Agency] will provide group therapy starting on [Exact date of appointment] in order to help me reach my recovery goals and maintain an optimal level of stability and recovery. I will attend group therapy [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter]. A letter from the therapist, to include the dates of treatment, a general statement of therapy goals and progress towards those goals shall demonstrate that this service was delivered

	Focus	Goal	Intervention
		NF staff must Obtain archived psychiatric records to clarify history and to provide to behavioral health service providers	This activity is not a specialized service, but is an important component in the delivery of effective behavioral health services and must be implemented in order to see that my mental health treatment records are complete and comprehensive and they follow me to my various providers in order to facilitate most effective delivery of services
	PASRR has identified that I am in need of Specialized Services due to (Specify: MI; ID; MI and ID, or Related Conditions). Specialized Services will assist me to achieve optimal functioning and recovery.	I am in need of a Neuropsychiatric evaluation by a Neurological and Behavioral Health professional in order to evaluate [Specify need for evaluation as identified in PASRR]. Any changes to my treatment plan, as a result of the Neuropsychiatric Evaluation, shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider and Psychiatrist.	[Specify the exact name and credentials of Neurological and Behavioral Health Professional] of [Specify the name of the Agency] will provide a Neuropsychiatric evaluation on [Exact date of appointment] in order to help me reach my recovery goals and maintain an optimal level of stability and recovery. I will attend the Neuropsychiatric evaluation [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter]. The report of Neuropsychiatric evaluation shall demonstrate that this service was delivered.
	PASRR has identified that I am in need of Specialized Services due to (Specify: MI; ID; MI and ID, or Related Conditions). Specialized Services will assist me to achieve optimal functioning and recovery.	I am in need of Psychological testing by a Psychologist for differential diagnosis, resulting in appropriate treatment plan revisions and services. Any changes to my treatment plan, as a result of the Psychological Testing, shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider and Psychiatrist.	[Specify the exact name of Psychologist] of [Specify the name of the Agency] will provide Psychological testing on [Exact date of appointment] in order to help me reach my recovery goals and maintain an optimal level of stability and recovery. I will attend Psychological testing [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter]. The report of Psychological testing shall demonstrate that this service was delivered.

	Focus	Goal	Intervention
9	PASRR has identified that I am in need of Specialized Services due to (Specify: MI; ID; MI and ID, or Related Conditions). Specialized Services will assist me to achieve optimal functioning and recovery.	I will receive a functional assessment of my behaviors, which are interfering with my values, goals, or that jeopardize my own or others' safety, by a certified or licensed behavior analyst or qualified behavioral health professional with equivalent experience and/or training. Any changes to my treatment plan, as a result of the Functional analysis, shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider and Psychiatrist.	[Specify: Certified or Licensed Behavior Analyst or qualified behavioral health professional with equivalent experience and/or training] of [Specify the name of the Agency] will 1) complete a comprehensive Functional Analysis, and 2) work with staff to train them in the how to develop strategies for addressing the identified behavior. This analysis will occur on [Exact date of appointment] and will help me reach my recovery goals and maintain an optimal level of stability and recovery. I will participate in the Functional analysis [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter]. The report of Functional analysis and documentation of a staff-wide strategy for addressing identified behaviors shall demonstrate that this service was delivered.
	PASRR has identified that I am in need of Specialized Services due to (Specify: MI; ID; MI and ID, or Related Conditions). Specialized Services will assist me to achieve optimal functioning and recovery.	I will receive assistance with the development and implementation of a Behaviorally Based Treatment Plan, to include both routine and crisis related behavioral supports, and to be developed with assistance from a certified or licensed behavior analyst or qualified behavioral health professional with equivalent experience and/or training. Any changes to my treatment plan, as a result of the development and implementation of the Behavior Support Plan, shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider and Psychiatrist.	[Specify: Certified or Licensed Behavior Analyst or qualified behavioral health professional with equivalent experience and/or training] of [Specify the name of the Agency] will work with staff to develop a behavior support/treatment/management plan which will be implemented by all staff who work with me. The development and implementation of a Behaviorally Based Treatment Plan will start on [Exact date of appointment] and will help me reach my recovery goals and maintain an optimal level of stability and recovery. I will participate in the development of a Behavior Support Plan, based on a Functional Analysis, [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter]. The report of Functional Analysis and documentation of a staff-wide strategy for addressing identified behaviors shall demonstrate that this service was delivered.

	Focus	Goal	Intervention
11	PASRR has identified that I am in need of Specialized Services due to (Specify: MI; ID; MI and ID, or Related Conditions). Specialized Services will assist me to achieve optimal functioning and recovery.	I will develop a Behavioral Health Advanced Directive (e.g. as a component of a Wellness Recovery Action Plan (WRAP)), with support and assistance from a Certified Mental Health Peer Support Specialist or other appropriately trained behavioral health professional. Advance instructions for my psychiatric care shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider and Psychiatrist.	[Specify name and credentials of the Certified Mental Health Peer Support Specialist or other appropriately trained behavioral health professionI will participate in the development of the Behavioral Health Advance Directive [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter]. A signed and witnessed (or notarized) Iowa Durable Power of Attorney form, to include advance instructions for psychiatric care, shall demonstrate that this service was delivered. Resources: Iowa Statute: http://www.nrc-pad.org/images/stories/PDFs/iowa_lwstatute.pdf Iowa DPOA Form: http://www.nrc-pad.org/images/stories/PDFs/iowa_hcpaform.pdf Behavioral Health Advance Directives Template: http://mentalhealthrecovery.com/wp-content/uploads/2015/07/CrisisPlan2012Manual.pdf al] of [Specify the name of the Agency] will assist me in developing a Behavioral Health Advanced Directive. This will occur on [Exact date of appointment]. Such assistance can be obtained through a certified Peer Support Specialist. If none available or accessible, another qualified behavioral health professional with knowledge and experience in this area will be sought.
12	PASRR has identified that I am in need of Specialized Services due to (Specify: MI; ID; MI and ID, or Related Conditions). Specialized Services will assist me to achieve optimal functioning and recovery.	NF staff will make appropriate referrals for me to a local behavioral health service provider order to determine the most appropriate services and work with me to enhance my success in developing/retaining my Community Living Skills. Any changes to my treatment plan, as a result of the delivery of Community Living Skills Training shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider and Psychiatrist.	[Specify Exact name and credentials of professional] AND/OR[Local Behavioral Health Services Provider] will deliver Community Living Skills Training and/or Supported Community Living Services on [Exact date of appointment]. I will participate in Community Living Skills Training [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter]. Progress notes documenting that the individual met with a professional from the Local Behavioral Health Service Provider shall demonstrate that this service was delivered.

	Focus	Goal	Intervention
			Supportive Community Living Services may include habilitation, community support services, supported community living (SCL), or a range of other non-Medicaid services. Assessment for appropriate services can begin by contacting the Area Agency on Aging (AAA)/Aging and Disability Resource Center (ADRC), and/or prior community service providers. [Specify Exact name and credentials of professional] of Local Behavioral Health Services Provider] will deliver Supported Community Living Services on [Exact date of appointment]. I will participate in Supportive Community Living Services [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter]. Progress notes documenting that the individual met with a professional from the Local Behavioral Health Service Provider shall demonstrate that this service was delivered.
	PASRR has identified that I am in need of Specialized Services due to (Specify: MI; ID; MI and ID, or Related Conditions). Specialized Services will assist me to achieve optimal functioning and recovery.	I am in need of Peer Support Services, delivered by a Certified Mental Health Peer Support Specialist. Any changes to my treatment plan, as a result of the delivery of Peer Support Services shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider and Psychiatrist.	[Specify Name of Certified Mental Health Peer Support Specialist] of [Specify the name of the Agency] will provide Peer Support Services starting on [Exact Date of Appointment]. Peer Support Services may be available through Integrated Health Homes or other local behavioral health agencies that offer them as a stand-alone service. Peer Support Specialists are trained to support me and my recovery and to assist me with self-advocacy and other areas that will enhance my mental health, my Whole Health, and wellness. I will participate in Peer Support Services [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter]. Progress notes documenting that the individual met with the Certified Mental Health Peer Support Specialist shall demonstrate that this service was delivered.

	Focus	Goal	Intervention
13	PASRR has identified that I am in need of Specialized Services due to (Specify: MI; ID; MI and ID, or Related Conditions). Specialized Services will assist me to achieve optimal functioning and recovery.	Other Disability Specific Specialized Service(s) (specify)	Please use this space for the creation of care planning line items for any additional Specialized Services that are identified for me. I will participate in [Specify the Specialized Service] [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
14	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I want to focus on rehabilitation and returning to optimal functioning and/or a prior or lower level of care in the community.	I will return to the community (specify location of lower level of care, if known) as soon as I am able.
15	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I will receive ADL training from NF staff and or other identified individuals as part of my rehabilitative efforts. These skills and supports may be useful in preparation for discharge to the community or simply for maintenance or restoration of skills for optimal functioning.	NF staff will assist in the identification of needed ADL assistance/skills, indicate who/how ADL skills training and support will be implemented and any specific issues that the training will focus upon: (Specify: self cares, bathing, dressing, dental care, eating, social skills, personal care skills, communication, self-advocacy skills or others). [Specify Name of NF Staff or other identified individuals] of [Specify the name of the Agency] will provide ADL Training starting on [Exact Date of Appointment]. I will participate in ADL Training [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].

	Focus	Goal	Intervention
16	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I will receive Community Living Skills Training from designated NF staff and/or other identified individuals. These services may be useful in preparation for discharge to the community.	Once identified, indicate who/how community living skills training will be implemented and any specific issues that the training will focus upon: (Specify: adaptive behavior skills, communication skills, social skills, personal care skills, self-advocacy skills or others). [Specify Name of NF Staff or other identified individuals and their credentials] of [Specify the name of the Agency] will provide Community Living Skills Training starting on [Exact Date of Appointment]. I will participate in Community Living Skills Training [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
17	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	Please assist me with services to pursue Supported Community Living. These services could begin with ADL training from NF staff and may evolve to a point where community referrals are needed in order to pursue any goals I identify as progress is made and needs change.	Specify how this training will be implemented with me, and any preferences I have expressed about the delivery of this training, as well as how my progress will be documented. [Specify Name of NF Staff or other identified individuals and their credentials] of [Specify the name of the Agency] will provide services to pursue Supported Community Living starting on [Exact Date of Appointment]. I will participate in services to pursue Supported Community Living [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].

	Focus	Goal	Intervention
18	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I am in need of self-health care management training. Please offer such training to me in order to enhance my ability to manage and be actively involved in my own care. Self health care management training may be offered by NF staff, by an Integrated Health Home team, by health care providers, family, and supportive friends, or a range of other service providers. Assessment for appropriate services can begin by contacting a local Integrated Health Home (IHH) program, Area Agency on Aging (AAA)/Aging and Disability Resource Center (ADRC), or prior community service providers.	[Specify Name of NF Staff or other identified individuals and their credentials] of [Specify the name of the Agency] will provide self-health care management training starting on [Exact Date of Appointment]. I will participate in self-health care management training [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
19	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	Please educate me regarding medicine compliance and/or side effects so that I can be well informed regarding all medications. Assist me to learn and benefit from discussions of my medications, why compliance may be important, how to comply with the medication regimen, and any potential side effects or consequences of their use or misuse.	[Specify Name of NF Staff or other identified individuals and their credentials] of [Specify the name of the Agency] will provide education regarding medication compliance starting on [Exact Date of Appointment]. I will participate in education regarding medication compliance [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].

	Focus	Goal	Intervention
20	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	Please arrange for an occupational therapy evaluation. Findings from this evaluation shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider, any behavioral health providers, and any others to whom I have authorized release.	[Specify Name of Occupational Therapist] of [Specify the name of the Agency] will provide an occupational therapy evaluation starting on [Exact Date of Appointment]. I will participate in an occupational therapy evaluation [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
21	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I am in need of occupational therapy, please arrange.	[Specify Name of Occupational Therapist] of [Specify the name of the Agency] will provide occupational therapy starting on [Exact Date of Appointment]. I will participate in occupational therapy [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].

	Focus	Goal	Intervention
22	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	Please arrange for a physical therapy evaluation. Findings from this evaluation shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider, any behavioral health providers, and any others to whom I have authorized release.	[Specify Name of Physical Therapist] of [Specify the name of the Agency] will provide a physical therapy evaluation starting on [Exact Date of Appointment]. I will participate in a physical therapy evaluation [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
23	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I am in need of physical therapy, please arrange.	[Specify Name of Physical Therapist] of [Specify the name of the Agency] will provide physical therapy starting on [Exact Date of Appointment]. I will participate in physical therapy [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].

	Focus	Goal	Intervention
24	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	Please arrange an Audiological evaluation. Findings from this evaluation shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider, any behavioral health providers, and any others to whom I have authorized release.	[Specify Name of Audiologist] of [Specify the name of the Agency] will provide physical therapy starting on [Exact Date of Appointment]. I will participate in an audiological evaluation [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
27	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	Please assist me in exploring and arranging services for individuals with hearing impairments	[Specify Name of Audiologist or other hearing specialist] of [Specify the name of the Agency] will provide services for hearing impairments starting on [Exact Date of Appointment]. I will participate in services for hearing impairments [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].

	Focus	Goal	Intervention
25	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I am in need to a vision examination, please arrange. Findings from this evaluation shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider, any behavioral health providers, and any others to whom I have authorized release.	[Specify Name of Optometrist, Ophthalmologist, or other vision specialist] of [Specify the name of the Agency] will provide a vision examination starting on [Exact Date of Appointment]. I will participate in a vision examination [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
26	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	Please assist me in exploring and arranging services for individuals with vision impairments.	[Specify Name of Optometrist, Ophthalmologist, or other vision specialist] of [Specify the name of the Agency] will provide services related to vision impairments starting on [Exact Date of Appointment]. I will participate in services related to vision impairments [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].

	Focus	Goal	Intervention
28	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I am in need of speech/language therapy, please arrange.	[Specify Name of Speech Language Pathologist, Speech Therapist or other speech specialist] of [Specify the name of the Agency] will provide speech/language therapy starting on [Exact Date of Appointment]. I will participate in speech/language therapy [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
29	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	Please arrange for a dental evaluation. Findings from this evaluation shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider, any behavioral health providers, and any others to whom I have authorized release.	[Specify Name of Dentist, Orthodontist or other dental specialist] of [Specify the name of the Agency] will provide a dental evaluation starting on [Exact Date of Appointment]. I will participate in a dental evaluation [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
30	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I am in need of dental services. Please arrange and set up a regular schedule for delivery of dental services.	[Specify Name of Dentist, Orthodontist or other dental specialist] of [Specify the name of the Agency] will provide dental services starting on [Exact Date of Appointment]. I will participate in dental services [Anticipated Frequency, e.g. annually, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].

	Focus	Goal	Intervention
31	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I am in need of assistive devices or technology to accommodate my health conditions and/or disabilities.	I am in need of the following Assistive Devices or Technology (Specify types: cane, walker, wheel chair, adaptive products, communication equipment, etc.) [Specify nursing facility staff or identified qualified professional] of [Specify the name of the Agency] will provide assistive devices or technology starting on [Exact Date of Appointment]. I will participate in the provision of assistive devices or technology [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I am in need of a referral for assistance with Assistive Devices or Technology and may need assistance determining what is needed or will be most useful to me. NF staff will make a referral to Iowa Program for Assistive Technology (IPAT), will arrange for an evaluation and support as any identified technologies or devices are delivered and implemented. Findings from this evaluation shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider, any behavioral health providers, and any others to whom I have authorized release.	[Specify the qualified professional] of [Specify the name of the Agency, e.g. Iowa Program for Assistive Technology] will provide an evaluation for the provision of assistive devices or technology starting on [Exact Date of Appointment]. I will participate in an evaluation for the provision of assistive devices or technology [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
32	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	A Neurological evaluation will be conducted and any recommendations made as a result will be implemented in my care planning. Findings from this evaluation shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider, any behavioral health providers, and any others to whom I have authorized release.	[Specify the Neurologist] of [Specify the name of the Agency] will provide a neurological evaluation starting on [Exact Date of Appointment]. I will participate a neurological evaluation [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].

	Focus	Goal	Intervention
34	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	An Interpreter/foreign language services have been recommended and will be utilized to assist me in communicating with the NF and any service provider staff at the intervals and at the events that are consistent with my choices and the resources available.	[Specify the Interpreter] of [Specify the name of the Agency] will provide communication assistance starting on [Exact Date of Appointment]. I will participate in communication assistance by a interpreter/foreign language service [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
35	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	Please remind me and encourage me to become involved in socialization/recreation/leisure activities while I am here. Please identify opportunities to get me involved in activities and to interact with the other residents. Assist me to learn and benefit from these opportunities and support me in my efforts to maximize the benefits of socialization and recreation.	[Specify the nursing facility staff] of [Specify the name of the Agency] will remind me and encourage me to participate in activities starting on [Exact Date of Appointment]. I will be reminded and encouraged by nursing facility staff to participate in activities [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].

	Focus	Goal	Intervention
36	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	My family is important to me and I'd like to have them actively involved in my life and my care. Please encourage and provide specific opportunities for my family to be involved in my care.	(Specify: specific key family members and names) (if a family member has POA, guardian, conservator; name them) Please invite them to my care conferences and assist in creating other opportunities for them to visit and actively support me and my life in the NF and/or the community. [Specify the nursing facility staff] of [Specify the name of the Agency] will provide specific opportunities for my family to be involved in my care starting on [Exact Date of Appointment]. Staff will identify opportunities for my family to be involved in my care [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
37	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I will receive regular supportive counseling from NF staff on a variety of topics that PASRR may have identified, my family and I may identify and NF staff or other providers within the NF may identify. NF staff will employ a team approach to understand my values and to engage in strategies that support progress on my goals.	[Specify the nursing facility staff] of [Specify the name of the Agency] will provide supportive counseling starting on [Exact Date of Start/Appointment]. I will participate in supportive counseling [Anticipated Frequency, e.g. daily, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	NF staff must obtain archived psychiatric records to clarify history and disseminate copies of these records to treating behavioral health clinicians and physicians, pursuant to signed releases.	This activity is an important component in the delivery of effective behavioral health and overall health care services and must be implemented in order to see that my mental health treatment records are complete and comprehensive and that they follow me to my various behavioral health, primary and as appropriate, other health care providers in order to facilitate most effective and coordinated delivery of health services.

	Focus	Goal	Intervention
39	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	An evaluation will be conducted for a diagnosis of (Specify: Dementia, Alzheimer's disease, or other Organic Mental Disorder) to enhance my quality of life and my care needs. This evaluation will determine whether dementia diagnosis is appropriate, progression of dementia, and appropriate treatment and any behavioral intervention to be conducted Findings from this evaluation shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider, any behavioral health providers, and any others to whom I have authorized release.	[Specify Physician/Dementia Specialist] of [Specify Agency] will conduct an evaluation for a diagnosis of dementia on [Exact date of the appointment]. I will participate in this evaluation [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
41	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	Development and Implementation of a Behaviorally Based Treatment Plan is needed to help me and others manage my day to day behavior management concerns. This plan will include both routine and crisis related behavioral supports, which when implemented, may be useful in reducing the risk of high stress, decompensation, and/or hospitalization. My family or other members of my support network, as appropriate, may play a role in working toward my optimal functioning and reduction of risk, decompensation, challenging behaviors, or hospitalization. Any changes to my treatment plan, as a result of the development and implementation of the Behavior Support Plan, shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider and Psychiatrist.	[Specify: nursing facility staff or identified individual with experience developing behavior support plans] of [Specify the name of the Agency] will develop a behavior support/treatment/management plan which will be implemented by all staff who work with me. The development and implementation of a Behaviorally Based Treatment Plan will start on [Exact date of appointment] and will help me reach my recovery goals and maintain an optimal level of stability and recovery. I will participate in the development of a Behavior Support Plan [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].

	Focus	Goal	Intervention
42	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I will develop and maintain a Crisis Intervention/Safety Plan in order to reduce risk of harm to myself or others and to enhance my recovery. The elements of this plan shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider, any behavioral health providers, and any others to whom I have authorized release.	My crisis intervention/safety plan will be developed with me and (Specify: NF staff and/or Mental Health or other Service provider) who will also coordinate care with me, NF staff, and any others involved in helping me address how crises and safety issues are to be addressed. [Specify NF Staff or Behavioral Health Professional] of [Specify Agency] will develop, with me, a crisis intervention/safety plan on [Exact date of the appointment]. I will participate in the development, ongoing evaluation, and modification of this plan [Anticipated Frequency, e.g. quarterly, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter]. I will utilize my crisis intervention/safety plan when (Specify: I am expressing suicidal ideation, attempting to harm myself, threating/attempting to harm others, or any other specific at risk behaviors that we may have identified for me). Safety Planning Resources: http://www.namihelps.org/NAMIAdultMHCrisisPlanningMay2013Y.pdf http://www.sprc.org/library_resources/items/patient-safety-plan-template Crisis Plan Resource: http://mentalhealthrecovery.com/wp-content/uploads/2015/07/CrisisPlan2012Manual.pdf
	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I am in need of a referral for outpatient substance use treatment	[Specify the name of identified substance use professional] of [Specify the name of the Agency] will arrange for an appointment to engage in outpatient substance use treatment starting on [Exact Date of Appointment]. I will participate in the referral process for outpatient substance use treatment [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].

	Focus	Goal	Intervention
	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I am in need of an initial substance use evaluation to determine diagnosis and develop a plan of care. Findings from this evaluation shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider, any behavioral health providers, and any others to whom I have authorized release.	[Specify the name of identified substance use professional] of [Specify the name of the Agency] will arrange for a substance use evaluation starting on [Exact Date of Referral]. I will participate in the substance use evaluation [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
43	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I will attend (Specify: Alcoholic's Anonymous, Narcotic's Anonymous, or other substance abuse/ recovery groups) to facilitate my recovery related to substance use. NF staff will assist me in making contact with a local substance use support group and they will assist me to arrange appointments, transportation, and facilitate my active participation in these support group meetings	[Specify the name of meeting facilitator] of [Specify the name of the Agency] will facilitate a recovery-oriented meeting for substance use starting on [Exact Date of meeting]. I will participate in these meetings [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
44	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I will attend (Specify: Other Support Group(s) as identified by me, PASRR, NF staff, or others) to facilitate my recovery related to (identify the issue(s) to be addressed in these groups, e.g. grief/loss, trauma, anger management, etc.). NF staff will assist me in making contact with NF based or local support group and they will assist me to arrange appointments, transportation, and facilitate my active participation in these support group meetings	[Specify the name of meeting facilitator] of [Specify the name of the Agency] will facilitate a support group starting on [Exact Date of meeting]. I will participate in these meetings [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].

	Focus	Goal	Intervention
45	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I am in need of a guardian, conservator, and/or Power of Attorney for Healthcare. Please help me explore how to receive assistance in the designation of such a person to help me for purposes of support with decisions about my care needs, my health and safety. NF will assist in determining if there is an appropriate family member, friend, or support person who is well qualified to serve as PoA, conservator or guardian. If none available, a referral may be made to the Office of Substitute Decision Marker, Iowa Department on Aging.	[Specify the name of NF Staff] of [Specify the name of the Agency] will facilitate the identification and designation of a guardian, conservator and/or Power of Attorney for Healthcare on [Exact Date of meeting]. I will participate in these meetings [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I am in need of a referral to the Office of Substitute Decision Maker, within the Iowa Department of Aging, for assistance in finding some support for healthcare and other decisions about my care. Findings from this evaluation shall be (1) incorporated into my care plan and (2) communicated to my Primary Care Provider, any behavioral health providers, and any others to whom I have authorized release.	[Specify the name of professional at the Office of Substitute Decision Maker] of [Specify the name of the Agency, i.e. Iowa Department of Aging] will conduct an evaluation to determine if I am in need of a guardian, conservator and/or Power of Attorney for Healthcare on [Exact Date of meeting]. I will participate in this evaluation [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].

	Focus	Goal	Intervention
46	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I will develop and maintain a Behavioral Health Advanced Directive, such as a Wellness Recovery Action Plan (WRAP) which will identify triggers, appropriate interventions, self management strategies, and recovery tools for use when appropriate. Development of Behavioral Health Advanced Directives or WRAP plans are among the primary functions of Peer Support Specialists, so the services of a Certified Mental Health Peer Support Specialist will be useful in helping me to develop such a plan. If Peer Support Services are unavailable to me, then a behavioral health professional may be able to help in development of the Behavioral Health Advanced Directive	[Specify the name of NF Staff, behavioral health professional or Peer Support Specialist] of [Specify the name of the Agency] will assist me in developing a behavioral health advance directive on [Exact Date of initial meeting]. I will participate in the development of my behavioral health advance directive [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter]. Behavioral Health Advance Directive Resource: http://mentalhealthrecovery.com/wp-content/uploads/2015/07/CrisisPlan2012Manual.pdf
47	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	I am in need of a referral for an Integrated Health Home (IHH) which involves healthcare coordination for individuals with serious mental illness (SMI). Involvement in an IHH will permit access to a Certified Peer Support Specialist, a care manager and care coordination. Managed Care Organizations that will be managing Medicaid beginning in April 2016 can assist the NF in locating any nearby Integrated Health Home providers so that choices can be identified and arrangements can be made to begin receiving services. You may contact IME Member Services or your MCO for information on how to facilitate a referral for Iowa Medicaid members.	[Specify the name of NF staff or other identified professional] of [Specify the name of the Agency] will arrange for delivery of Integrated Health Home services to begin on [Exact Date of referral appointment]. I will participate in the referral process [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].

	Focus	Goal	Intervention
48	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	Please refer me for determination of eligibility for Medicaid Coverage, including coverage under any of the waiver programs	[Specify the name of NF staff or other identified professional] of [Specify the name of the Agency] will arrange for a referral to determine Medicaid eligibility on [Exact Date of referral appointment]. I will participate in the referral process [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
49	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	Please refer me for Options Counseling through Lifelong Links, Iowa's Aging and Disability Resource Center, www.lifelonglinks.org. NF staff will facilitate referral to the Aging and Disability Resource Center (ADRC) through telephone or web contact with LifeLong Links, so that I may meet with an Options Counselor and explore options including those for services to move toward community placement. LifeLong Links: 1-866-468-7887, or via the web: www.lifelonglinks.org	[Specify the name of NF staff or other identified professional] of [Specify the name of the Agency] will arrange for an initial appointment for Options Counseling through Lifelong Links to take place on [Exact Date of referral appointment]. I will participate in Options Counseling [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].

	Focus	Goal	Intervention
50	PASRR has identified the following rehabilitative services and other supports that must be implemented to address my rehabilitation.	The following additional rehabilitative services were identified for me by PASRR, (Specify anything that was listed as "other" in PASRR assessment and/or any other services the NF and individual have determined to be appropriate and needed. A variety of services are available to individuals who are Medicaid members, including: Home and Community Based Services (HCBS) Waivers, Habilitation, Peer Support Services, Mobile Therapy, Integrated Heath Homes, and others.	[Specify the name of NF staff or other identified professional] of [Specify the name of the Agency] will provide this rehabilitative service on [Exact Date of referral appointment]. I will participate in this service [Anticipated Frequency, e.g. one-time, weekly, monthly] for [Expected Duration] at [Location, e.g. nursing facility, outside agency] through [Modality, e.g. telehealth, face-to-face encounter].
51	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	The following environmental management services have been identified for exploration in any planned return to a lower level of care:	
52	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	I will need Cleaning Services. Please help me to locate appropriate services and arrange.	
53	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and	I will need Lawn Services. Please help me to locate appropriate services and arrange.	

	Focus	Goal	Intervention
54	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care	Assistive Technology (assessment for needs, or specify type)	
55	PASRR has identified the following community placement supports, which I may wish to explore as part of preparation for movement to the community, if and when I determine that I'd like to return to my home or another kind of living arrangement outside of the NF; specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Home evaluation for modifications or other needs	
56	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Refer for possible need for and access to Assistive Technology: Iowa Program for Assistive Technology: http://www.uihealthcare.org/ucedd/inclusive-community-living/ipat/	
57	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level	I will need the services of one or more Home Health Aide. Please help me to locate an appropriate agency and arrange.	
58	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level	I will need the services of one or more Home Health Nurses. Please help me to locate an appropriate agency and arrange.	
59	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level	I will need (Specify: Outpatient Occupational Therapy, Physical Therapy and/or Speech Therapy). Please help me to locate an appropriate agency and arrange.	

	Focus	Goal	Intervention
60	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level	I will need (Specify: In Home Occupational Therapy, Physical Therapy and/or Speech Therapy). Please help me to locate an appropriate agency and arrange.	
61	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	I will need to consider the use of a Medical Alert system or devices. Please help me to explore options and arrange.	
62	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level	I will need to consider the use of Hospice Services. Please help me to explore options and arrange.	
63	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	I am in need of an assessment for possible payee or other assistance with finances or financial management. Please help me explore options and arrange.	
64	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	I am in need of a guardian, conservator, and/or Power of Attorney for Healthcare. Please help me explore how to receive assistance in the designation of such a person to help me for purposes of support with decisions about my care needs, my health and safety.	

	Focus	Goal	Intervention
	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Please refer me for assistance to the Office of Substitute Decision Maker within the Iowa Department on Aging	
65	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level	Development of healthcare advanced directive	
	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	I am in need of a referral for a Medical Home. This is a care coordination service for individuals in need of assistance with care management, possibly related to complex of multiple health care needs.	
66	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Refer for eligibility determination for Medicaid coverage, including HCBS Waivers	NF will assist in determining if there is an appropriate family member, friend, or support person who is well qualified to serve as PoA, conservator or guardian. If none available, a referral may be made to the Office of Substitute Decision Marker, Iowa Department on Aging.
67	PASRR has identified the following community placement supports, which I will	Other (specify)	
68	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	The following community resources and transportation needs have been identified for exploration in any planned return to a lower level of care:	NF will assist me and arrange, if needed, the application process for Medicaid, and will help me to monitor all aspects of the application process in order to see that the process moves as quickly and as well as possible.

	Focus	Goal	Intervention
69	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level	Public Transportation/Bus Pass	
70	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Supported Public Transportation	NF staff (specify who) will assist me with appropriate referrals and options within my community. If case management is an option, referrals will be made and NF will assist in coordination of any and all services.
71	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Arranged public transportation (taxi, car service)	
72	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Respite services for caregivers	
73	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	In returning to the home, or community, I will need support of my Family, Friends or others. Please help me explore the exact nature of the support needs I will have and help me to meet with and plan for appropriate support from my family, friends, or others in advance of my discharge.	

	Focus	Goal	Intervention
74	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Assistive Devices or Technology (assessment for needs, or specify type)	NF staff (specify who) will assist me and my family caregivers with appropriate referrals and respite options within my community. Referrals will be made and NF will assist in coordination of any and all services.
75	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Referral for Options Counseling through Lifelong Links, Iowa's Aging and Disability Resource Center, www.lifelonglinks.org	NF staff will work with me and my supports (specify: family, children, friends, peer support specialist, case manager, etc.) and will invite all appropriate individuals to care plan meetings so that my discharge can be well coordinated and potential for success can be maximized.
76	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Other (specify)	NF staff will assist me, as needed, with referrals to the Iowa Program for Assistive Technology (IPAT), http://www.iowaat.org/, or other appropriate referrals for assessment of my needs, followed by arrangement for assistive technology by (Specify: date)
77	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	The following shopping related community resource needs have been identified for exploration in any planned return to a lower level of care:	NF staff will assist me as needed, with referral to LifeLong Links, on the web or at: 1-866-468-7887, to arrange an appointment for Options Counseling by (Specify: date), and will assist me in implementing any and all next steps that are identified as a result of that contact.
78	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level	If I move to a lower level of care, I will need assistance from a Home Health or Care Aide	

	Focus	Goal	Intervention
79	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Assistance from Family, Friends, or Others to be identified	NF staff will work with me and my supports (specify: family, children, friends, peer support specialist, case manager, etc.) and will invite all appropriate individuals to care plan meetings so that my discharge can be well coordinated and potential for success can be maximized.
80	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Assessment for assistive technology needs that might make it possible for me to maximize my meal preparation abilities	
81	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Other (specify)	
82	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	The following meal preparation related community resource needs have been identified for exploration in any planned return to a lower level of care:	
83	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level	When I return to home, or community, I may need assistance from Meals on Wheels. Please help me explore the availability of such services in my community in advance of my discharge.	

	Focus	Goal	Intervention
84	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be	Assessment for assistive technology needs that might make it possible for me to maximize my meal preparation abilities	
85	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Assistance from Family, Friends, or Others to be identified	NF staff will assist me as needed, with referral to LifeLong Links, on the web or at: 1-866-468-7887, to arrange an appointment for Options Counseling by (Specify: date), and will assist me in implementing any and all next steps that are identified as a result of that contact.
86	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Other (specify)	
87	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	The following behavioral health supports have been identified as community resource needs for implementation in any planned return to a lower level of care:	
88	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	I will need to explore Case Management services. Please help me explore my options in advance of my discharge and arrange.	

	Focus	Goal	Intervention
89	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and	I will need Individual Therapy (and may wish to explore the possibility of Mobile Therapy) by a licensed behavioral health professional.	
90	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Psychiatric services by a psychiatrist to evaluate response to psychotropic medications, modify medication orders and to evaluate ongoing need for additional behavioral health services	As a Medicaid member, I may be eligible for case management and/or waiver services. NF staff and/or Options Counselors may assist me in determining how to apply, whether I am eligible, and how to arrange for and connect with appropriate support services.
91	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	I will need access to a Partial Hospitalization/Day Treatment program in order to support my recovery in the community. Please help me explore the availability for these services in advance of my discharge.	
92	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	I will receive Group Therapy by a licensed behavioral health agency to address (Specify: treatment and mental health recovery and/or any issues identified by PASRR and/or the individual that will specifically be addressed) Please help me explore the options for group therapy in my community in advance of my discharge.	
93	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Peer Support Services, delivered by a Certified Mental Health Peer Support Specialist	NF staff will assist in helping me identify available services in my community. It will be useful to consider having a behavioral health advanced directive in place prior to discharge in order to help me maintain my recovery in the community.

	Focus	Goal	Intervention
94	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be	I will need a referral for Integrated Health Home, which involves healthcare coordination for individuals with serious mental illness	
95	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level	I will need a referral to a Recovery Center. Please help me explore the availability of a recovery center in the local community where I will reside (not available in all Iowa Communities)	Development of Behavioral Health Advanced Directives or WRAP plans are among the primary functions of Peer Support Specialists, so the services of a Certified Mental Health Peer Support Specialist will be useful in helping me to develop such a plan. If Peer Support Services are unavailable to me, then a behavioral health professional may be able to help in development of the Behavioral Health Advanced Directive
96	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	Other (specify)	
2	PASRR has identified the following community placement supports, which I will need to explore as part of preparation for movement to the community, specify type of lower level of care and that must be implemented to address my recovery and enhance success upon return to a lower level of care.	I want to focus on rehabilitation and plan to move or return to the community (specify the location of lower level of care, if known).	NF and other providers will help me arrange needed Environmental Management Services: (Specify each exact Service: Cleaning Service, Lawn Service, Assistive Devices or Technology, Home evaluation for modifications or other needs, referral for Iowa Program for Assistive Technology, Home Health Aide, Home Health Nurse, Outpatient or In-Home OT/PT/ST, Medical Alert systems or devices, Hospice Services, assessment for payee or other financial assistance, a guardian/conservator or Power of Attorney for Health care for assistance with decision making, health, and safety, referral to Office of Substitute Decision Maker, Development of a Healthcare Advanced Directive, Referral for a Medical Home, Referral for Medicaid eligibility determination, other, etc.) prior to discharge through (Specify: Agency).

Person/position Responsible
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate (Specify: Start Date, anticipated frequency, and duration of each service).
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate (Specify: Start Date, anticipated frequency, and duration of each service).
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate (Specify: Start Date, anticipated frequency, and duration of each service).

Person/position Responsible
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate (Specify: Start Date, anticipated frequency, and duration of each service).

Person/position Responsible
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate. Staff member responsible for making appointment:
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate. Staff member responsible for making appointment:

Person/position Responsible
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate. Staff member responsible for making appointment:
Indicate responsibilities related to delivery including who will copy and transmit the records to the psychiatrist, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff. Staff member responsible for making appointment:

Person/position Responsible
Indicate responsibilities related to delivery including who will copy and transmit the records to the psychiatrist and any other behavioral health service providers, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff
Indicate responsibilities related to delivery including who will copy and transmit the records to the psychiatrist and any other behavioral health service providers, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff Staff member responsible for making appointment: Staff member responsible for ensuring the evaluation report and recommendations reach the treating behavioral health professional:
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate. Staff member responsible for making appointment: Staff member responsible for ensuring the evaluation report and recommendations reach the treating behavioral health professional:

Person/position Responsible
Treatment plan will be implemented as newly developed or modified, (list any specific responsibilities of staff or individual or others here). Treatment plan revisions or additions will be written by [Specify service provider or staff member responsible]. Staff member responsible for ensuring the evaluation report and recommendations reach the treating behavioral health professional:
Treatment plan will be implemented as newly developed or modified, (list any specific responsibilities of staff or individual or others here). Treatment plan revisions or additions will be written by [Specify service provider or staff member responsible]. Staff member responsible for ensuring the evaluation report and recommendations reach the treating behavioral health professional:

Person/position Responsible
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate. Staff member responsible for making appointment: Staff member responsible for ensuring the advance instructions reach the treating behavioral health professional:
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate. Staff member responsible for making appointment:

Person/position Responsible
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate. Staff member responsible for making appointment:
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Person/position Responsible
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate. Staff member responsible for making appointment:
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate (Specify: Name of Provider and profession (Psychiatrist, Psychologist, Licensed Mental Health Professional, LISW, etc.) Start Date, anticipated frequency, and expected duration of each service).
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate. Staff member responsible for making appointment, implementing training, monitoring progress toward my goals, and updating my progress to the care team:

Person/position Responsible
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate. Staff member responsible for making appointment, implementing training, monitoring progress toward my goals, and updating my progress to the care team:
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Person/position Responsible
Indicate responsibilities related to delivery including who will copy and transmit the records to the specialist, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff. Staff member responsible for making appointment, implementing training, monitoring progress toward my goals, and updating my progress to the care team: Staff member who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care:
Indicate responsibilities related to delivery including who will copy and transmit the records to the specialist, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff. Staff member responsible for making appointment, implementing training, monitoring progress toward my goals, and updating my progress to the care team: Staff member who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care:

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Person/position Responsible
Indicate responsibilities related to delivery including who will copy and transmit the records to the specialist, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff. Staff member responsible for making appointment, making sure records are obtained and relayed to any other health care providers who may need it, monitoring progress toward my goals, and updating my progress to the care team: Staff member who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care:
Indicate responsibilities related to delivery including who will copy and transmit the records to the specialist, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff. Staff member responsible for making appointment, making sure records are obtained and relayed to any other health care providers who may need it, monitoring progress toward my goals, and updating my progress to the care team: Staff member who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care:

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Person/position Responsible
Indicate responsibilities related to delivery including who will copy and transmit the records to the specialist, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff. Staff member responsible for making appointment, implementing training, monitoring progress toward my goals, and updating my progress to the care team: Staff member who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care:
Indicate responsibilities related to delivery including who will copy and transmit the records to the specialist, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff. Staff member responsible for making appointment, implementing training, monitoring progress toward my goals, and updating my progress to the care team: Staff member who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care:
Indicate responsibilities related to delivery including who will copy and transmit the records to the specialist, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff. Staff member responsible for making appointment, implementing training, monitoring progress toward my goals, and updating my progress to the care team: Staff member who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care:

Person/position Responsible
Indicate responsibilities related to delivery including who will copy and transmit the records to the specialist, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff. Staff member responsible for making appointment, implementing training, monitoring progress toward my goals, and updating my progress to the care team: Staff member who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care:
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Person/position Responsible
Indicate responsibilities related to delivery including who will copy and transmit the records to the specialist, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff. Staff member responsible for making appointment, implementing training, monitoring progress toward my goals, and updating my progress to the care team: Staff member who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care:
Indicate responsibilities related to delivery including who will copy and transmit the records to the specialist, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff. Staff member responsible for making appointment, implementing training, monitoring progress toward my goals, and updating my progress to the care team: Staff member who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care:
Indicate responsibilities related to delivery including who will copy and transmit the records to the behavioral health care providers, primary care physician and any other health service providers, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff.

Person/position Responsible
Indicate responsibilities related to delivery including who will copy and transmit the records to the specialist, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff. Staff member responsible for making appointment, implementing training, monitoring progress toward my goals, and updating my progress to the care team: Staff member who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care:
Specify responsibilities of specific staff for having knowledge of my behavior management plan, helping me be accountable to commitments made within the plan, where the plan is located, strategies for implementing the plan, discussions that will happen when things are not working well with regard to the plan, etc. Treatment plan will be implemented as newly developed or modified, (list any specific responsibilities of staff or individual or others here). Treatment plan revisions or additions will be written by [Specify service provider or staff member responsible]. Staff member responsible for ensuring the evaluation report and recommendations reach the treating behavioral health professional:

Person/position Responsible
Specify responsibilities of specific staff for having knowledge of my Crisis/Safety plan, helping me be accountable to commitments made within the plan, where the plan is located, strategies for implementing the plan, discussions that will happen when things are not working well with regard to the plan, etc. Crisis/Safety plan will be implemented as newly developed or modified, (list any specific responsibilities of staff or individual or others here). Crisis/Safety plan revisions or additions will be written by [Specify service provider or staff member responsible].
Indicate responsibilities related to delivery including who will copy and transmit the records to the specialist, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff. Staff member responsible for making appointment, implementing training, monitoring progress toward my goals, and updating my progress to the care team: Staff member who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care:

Person/position Responsible
Indicate responsibilities related to delivery including who will copy and transmit the records to the specialist, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff. Staff member responsible for making appointment, implementing training, monitoring progress toward my goals, and updating my progress to the care team: Staff member who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care:
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Person/position Responsible
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Indicate responsibilities related to delivery including who will copy and transmit the records to the specialist, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff. Staff member responsible for making appointment, implementing training, monitoring progress toward my goals, and updating my progress to the care team: Staff member who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care:

Person/position Responsible
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Indicate responsibilities related to delivery including who will copy and transmit the PASRR, care plan, and any other appropriate records to the Options Counselor, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff. Staff member responsible for making appointment, implementing training, monitoring progress toward my goals, and updating my progress to the care team: Staff member who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care:

Person/position Responsible
Indicate responsibilities related to delivery including who will copy and transmit the records to the specialist, who will arrange, transport, deliver, and participate in the services, and share any relevant information as may be needed and appropriate with staff. Staff member responsible for making appointment, implementing training, monitoring progress toward my goals, and updating my progress to the care team: Staff member who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care:
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate (Specify: Start Date, anticipated frequency, and duration of each service).
Indicate responsibilities related to delivery including who will make referrals, arrange the needed services, and facilitate any necessary steps for implementation. Specify NF staff who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care.
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate (Specify: Start Date, anticipated frequency, and duration of each service).

Person/position Responsible
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Indicate responsibilities related to delivery including who will make referrals, arrange the needed services, and facilitate any necessary steps for implementation. Specify NF staff who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care and insure that my discharge plans are on track and appropriate.
Specify responsibilities of specific staff, specific providers, the individual and family, or any other designated individuals as appropriate (Specify: Start Date, anticipated frequency, and duration of each service).
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Person/position Responsible
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Indicate responsibilities related to delivery including who will make referrals, arrange the needed services, and facilitate any necessary steps for implementation. Specify NF staff who will make certain that all parties involved in my care are sharing information appropriately to coordinate my care and insure that my discharge plans are on track and appropriate.

Person/position Responsible
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