Comprehensive Class Member Transition Program
Comprehensive Service Plan

* Indicates a required field

Section Name: Service Plan Details

Decree	Prime	Class Member's Name	Medicaid RIN	DOB
Guardian	Current Address:	Phone:	Agency:	Case ID
Plan Phase	Planner*	Plan Type*	Facility's Name	Plan Date*

Updating due to quality review from a previous Non-Proficient outcome* ☐ Yes ☐ No

Update due to post-reportable incident* ☐ Yes ☐ No

No Income Service Plan* ☐ Yes ☐ No

If the Class Member declines engagement or is no longer proceeding in the program, select reason SP is not complete and corresponding no longer proceeding rational on the Member page.

Section Name: Background and Demographics

Payor/Insurance Sources

What type of health insurance does the member have? *Select all that apply*

☐ Medicaid ☐ Medicare ☐ Private Insurance ☐ Self-pay
☐ Medicaid-MCO health plan ☐ VA hospital benefits ☐ CHAMPUS/Military branch

☐ Check to apply the changes above to Member's level as well

Advance Directives

☐ Living will ☐ Do Not Resuscitate (DNR) ☐ Mental health treatment

Power of Attorney

☐ Healthcare [*If yes, provide:* Name: Phone #:]
☐ Finances [*If yes, provide:* Name: Phone #:]

Income

What type of income does the member receive or plan to receive? *Select all that apply*

☐ Social Security (SSA)
Complete if SSA is checked SSA Status* ☐ eligible ☐ receiving, eligible ☐ not receiving, eligible ☐ pending, unknown

☐ Social Security Supplemental Income (SSI):
Complete if SSI is checked SSI Status* ☐ eligible ☐ receiving, eligible ☐ not receiving, eligible ☐ pending, unknown

☐ Social Security Disability Income (SSDI)
Complete if SSDI is checked SSDI Status* ☐ eligible ☐ receiving, eligible ☐ not receiving, eligible ☐ pending, unknown
Reason for SSDI:*

Monthly amount $
SSA (must complete if checked above):*
SSI (must complete if checked above):*
SSDI (must complete if checked above):*
Veterans benefits:
Regular retirement:
Private trust:
Employment:
Other income:

1. Approximate monthly income the member is currently receiving: $

2. Due to income level, is spend-down expected to be an issue:* ☐ Yes ☐ No

3. Does member anticipate income withholding after transition (for example, for outstanding debt)?* ☐ Yes ☐ No
   If yes, describe:

4. Has the member had a representative payee in the past or does the member anticipate representative payee services after transition?* ☐ Yes ☐ No
   If yes, describe:*

Describe any concerns the member has regarding income:

Court Involvement *Do not include minor traffic violations or other tickets.*

1. Does the Class Member have any *current* court involvement?* ☐ Yes ☐ No If yes, describe:*

2. Does the Class Member have a history of criminal involvement with any of the following? *Select all that apply*

☐ Use of a weapon ☐ Sex crime ☐ Stalking ☐ Murder ☐ Manslaughter ☐ Arson
☐ Inflicting bodily harm ☐ Selling, possession, or manufacturing of illegal substances

3. If the Class Member is currently on probation or parole, provide the contact information for the probation/parole/court officer:
   Name: Title: Phone number: - - ext.

Other Legal Involvement *Select all that apply and describe if the Class Member currently has or had:*

☐ Court-ordered treatment. If yes, provide the following information:
Treatment start date: End date:
Court-ordered treatment: Describe

☐ Restraining order
Restraining order: Describe:

☐ History of forensic services.
Forensic services: Describe

☐ Other.
Other: Describe

Comments:

Justice Involvement

In addition to reviewing the Class Member's records and discussing history with the Class Member, the following websites may be utilized to gather legal information:

- *For sexual offenses,*
  - *Check the Illinois registered sex offender website at http://www.isp.state.il.us/sor, and*
  - *The National sex offender registry at https://www.nsopw.gov/*
- *For Class Members currently incarcerated or currently on probation or parole, consult http://www.idoc.state.il.us/. (Counties may vary, the reviewer should identify and access the appropriate circuit court website, if applicable.) Please report information on felonies and/or serious/violent misdemeanors.*

If the Class Member has current or previous arrests, charges, or incarcerations, complete the table below. Report information on felonies and serious or violent misdemeanors.

Type/Description	Approximate Date of Event	Current Status

		Description:
		Description:
		Description:

Section Name: Housing Preference

Current/Planned Community Housing

Projected Transition Date* Locator: Agency:

For the first move for this case, did the Class Member, or is the Class Member planned to transition to PSH or private residence?*

☐ Yes ☐ No

If yes, indicate type: ☐ Permanent Supportive Housing ☐ PSH- Senior housing ☐ Private Home

If no, complete the following*

☐ Severe cognitive impairment
☐ Serious medical needs requiring intensive nursing care
☐ Class Member presents an imminent risk of danger to themselves or others

Open text field:

Indicate recommended setting(s)* *Select all that apply*

☐ Supportive living program ☐ Supervised residential ☐ Assisted living

Indicate service basis for recommended setting(s):*

☐ Member preference ☐ Daily wellness check ☐ In-house medical support ☐ In-house mental health
☐ Medication management services throughout the day ☐ Availability of functional support ☐ Ongoing social support available ☐ Meals are provided
☐ Skill development: ☐ Other

Is a future move to PSH planned?* ☐ Yes ☐ No

If yes, what is the projected timeline for secondary transition to PSH?

Housing Location* *Select all that apply*

Central Collar				
☐ DeKalb	☐ DuPage	☐ Kane		
Cook Central				
☐ Andersonville	☐ Archer Heights	☐ Armour Square	☐ Austin	☐ Belmont Craigin
☐ Berwyn	☐ Bridgeport	☐ Brighton Park	☐ Chicago Lawn	☐ Cicero

☐ Clearing	☐ Douglas	☐ East Garfield Park	☐ Englewood	☐ Fuller Park
☐ Gage Park	☐ Garfield Ridge	☐ Grand Boulevard	☐ Humboldt Park	☐ Hyde Park
☐ Lincoln Square	☐ Lower West Side	☐ Lyons	☐ McKinley Park	☐ Near South Side
☐ Near West Side	☐ New City	☐ North Lawndale	☐ North Park	☐ Oak Park
☐ Oakdale	☐ Proviso	☐ Ravenswood	☐ River Forest	☐ Riverside
☐ Roscoe Village	☐ South Lawndale	☐ Stickney	☐ Washington Park	☐ West Englewood
☐ West Garfield Park	☐ West Lawn	☐ West Town	☐ Woodlawn	
Cook North				
☐ Albany Park	☐ Avondale	☐ Barrington	☐ Dunning	☐ Edgewater
☐ Edison Park	☐ Elk Grove	☐ Evanston	☐ Forest Glen	☐ Hanover
☐ Hermosa	☐ Irving Park	☐ Lakeview	☐ Leyden	☐ Lincoln Park
☐ Logan Square	☐ Loop	☐ Maine	☐ Montclare	☐ Near North Side
☐ New Trier	☐ Niles	☐ North Center	☐ Northfield	☐ Norwood Park
☐ O'Hare	☐ Palatine	☐ Portage Park	☐ Rogers Park	☐ Rosemont
Cook South				
☐ Ashburn	☐ Auburn Gresham	☐ Avalon Park	☐ Beverly	☐ Bloom
☐ Bremen	☐ Burnside	☐ Calumet	☐ Calumet Heights	☐ Chatham
☐ East Side	☐ Greater Grand Crossing	☐ Hegewisch	☐ Lemont	☐ Morgan Park
☐ Mount Greenwood	☐ Oak Lawn	☐ Orland	☐ Palos	☐ Pullman
☐ Rich	☐ Riverdale	☐ Roseland	☐ South Chicago	☐ South Deering
☐ South Shore	☐ Thornton	☐ Washington Heights	☐ West Pullman	☐ Worth
North Collar				
☐ Boone	☐ Lake	☐ McHenry		
Other				
☐ Champaign	☐ Decatur	☐ N/A	☐ Peoria	
Others: Must specify if checked				

South Collar				
☐ Grundy	☐ Kankakee	☐ Kendall	☐ LaSalle	☐ Will
☐ **No Zone Preference**				

Section Name: Condition Status

Physical Health Diagnosis

Diagnosis* *Select all that apply*
☐ Acute myocardial infarction
☐ AIDS
☐ Alzheimer's disease
☐ Amputation
☐ Anemia
☐ Angina
☐ Arthritis
☐ Aspiration
☐ Asthma
☐ Atrial fibrillation
☐ Benign prostatic hyperplasia (BPH)
☐
☐ Cancer
☐ Cancer (active treatment)
☐ Cancer (advanced stage)
☐ Cancer (medical monitoring)
☐ Cerebrovascular accident (CVA) or transient ischemic attack (TIA)
☐ Chronic pain
☐ Chronic pain (with narcotic medication)
☐ Cirrhosis
☐ Congestive heart failure (CHF)
☐ Constipation
☐ COPD (emphysema, chronic bronchitis)

Diagnosis* *Select all that apply*
☐ Coronary artery disease
☐ Diabetes mellitus
☐ Diabetes mellitus HgA1C over 7
☐ Diabetes mellitus with insulin
☐ Edema
☐ Falls
☐ Falls (frequent)
☐ Falls (less than 30 days)
☐ Fracture
☐ Fracture <30 days
☐ Gastroesophageal reflux disease (GERD) or esophagitis
☐ Hemiplegia/para-plegia/ quadriplegia
☐ Hepatitis
☐ HIV
☐ Hyperlipidemia/ high cholesterol
☐ Hypertension
☐ Hyperthyroid
☐ Hypothyroid
☐ Kidney disease
☐ Kidney disease (with dialysis)
☐ Lack of coordination
☐ Multiple sclerosis
☐ Muscle weakness
☐ Neuropathy
☐ Obesity
☐ Osteoporosis

Diagnosis* *Select all that apply*	
☐ Parkinson's disease	
☐ Peripheral vascular disease	
☐ Seizure or convulsion disorder	
☐ Seizure or convulsion disorder (frequent/uncontrolled)	
☐ Shortness of breath	
☐ Sleep apnea	
☐ Traumatic brain injury (TBI)	
☐ Unsteady gait	
☐ Urinary incontinence	
☐ Urinary tract infections (UTIs)	
☐ Wounds	
☐ Wounds (chronic)	
☐ Wounds (current)	
☐ Other	Specify if "Other"
☐ Other dementia	Specify if "Other"

Behavioral Health Diagnosis

Diagnosis* *Select all that apply*
☐ Anorexia nervosa
☐ Anxiety disorder
☐ Bipolar disorder
☐ Brief psychotic disorder
☐ Bulimia nervosa
☐ Delusional disorder
☐ Depression NOS

Diagnosis* *Select all that apply*	
☐ Generalized anxiety disorder	
☐ Major depressive disorder	
☐ Obsessive-compulsive disorder	
☐ Panic disorder	
☐ Post-traumatic stress disorder (PTSD)	
☐ Psychotic disorder NOS	
☐ Schizoaffective disorder	
☐ Schizophrenia	
☐ Schizophreniform disorder	
☐ Shared psychotic disorder	
☐ Alcohol use disorder	
☐ Other substance use disorder	
☐ Aggression	
☐ Fire setting/arson	
☐ Hoarding	
☐ Impulsive behavior	
☐ Property damage	
☐ Self-neglect	
☐ Sleep disturbance	
☐ Social isolation	
☐ Wandering / elopement	
☐ Other substance use disorder	Specify if "Other"
☐ Other	Specify if "Other"

Functional Status

Discuss the Class Member's functional abilities with the Class Member and collateral sources. Complete the following chart to identify the Class Member's functional capacity and needed support. Identify the Class Member's functional level in each category by selecting the appropriate Level of Capacity for each task. Provide details concerning the Class Member's functional abilities for each task. If the Class Member needs assistance in any task, describe the care needed and how often this assistance is needed. Elaborate in the comment sections as needed.

Activities of Daily Living (ADLs)
Level of Capacity

Grooming*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Dressing*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Bathing/showering*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Toileting*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Feeding self*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Transferring*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Walking*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Additional Comments**:**

Instrumental Activities of Daily Living (IADLs)
Level of Capacity

Using the phone*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Cooking and preparing meals*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Light household chores*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Laundry*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Managing money*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Managing medications*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Shopping*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Transportation*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Routine Health*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Special Health*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Being Alone*
(dropdown): ☐ Independent ☐ Independent Limited Assistance ☐ Some Assistance ☐ Substantial Assistance ☐ Completely Dependent

Additional Comments**:**

Section Name: Employment & Income Support

Employment History
Employment Details

Integration Support
Discuss integration needs with the Member and identify stage of need, incorporate related services and supports in plan below.

Employment
Select all that apply

SOAR	Current employment	Future employment	Employment Support
Does the Class Member need SOAR services?* ☐Yes ☐No **Class Member Preference** ☐ CM accepts referral ☐ CM declines referral **Referral Status** ☐ Referral not yet submitted ☐ Referral submitted ☐ Receiving services	**Is the Class Member currently employed?*** ☐Yes ☐No If Yes, check all that apply ☐ part time ☐ full time ☐ supported ☐ day laborer	**Is the Class Member interested in future employment?*** ☐Yes ☐No If Yes, check all that apply ☐ part time ☐ full time ☐ supported ☐ considering ☐ day laborer	**Is the Class Member interested in employment support services?*** ☐Yes ☐No ☐ ACT Vocational Support ☐ DRS Services ☐ IPS Services ☐ Other If "Other" Employment Support is selected, you must provide a description. **Referral Status** ☐ Referral not yet submitted ☐ Referral submitted ☐ Receiving services

Education
Select all that apply

Education in last 6 months	Current education	Future Education
☐ GED ☐ college ☐ vocational/trade	☐ GED ☐ college ☐ vocational/trade	☐ part time ☐ full time ☐ considering

Section name: Medical Equipment and Supplies

Medical Equipment/Supply	Has and Meets Needs	Needs	Comment
Air mattress:	☐	☐	
Automated blood pressure cuff:	☐	☐	
Bathtub seat:	☐	☐	
Bedpan:	☐	☐	
Bedside rails:	☐	☐	
Bedside commode:	☐	☐	
Cane:	☐	☐	
Diabetic shoes and inserts:	☐	☐	
Catheters:	☐	☐	
Compression stockings:	☐	☐	
Continuous Positive Airway Pressure (CPAP) Machine:	☐	☐	
Emergency home response system:	☐	☐	
Feeding tube:	☐	☐	
Glucose monitor:	☐	☐	
Glucose lancets:	☐	☐	
Glucose strips:	☐	☐	
Grab bars:	☐	☐	
Hospital bed:	☐	☐	
Incontinence pads:	☐	☐	
Incontinence undergarments:	☐	☐	
Lift chair:	☐	☐	
Nebulizer machine:	☐	☐	
Ostomy supplies	☐	☐	
Oxygen regulator:	☐	☐	
Prosthesis:	☐	☐	
Raised toilet seat:	☐	☐	
Reach and grab tool:	☐	☐	
Rolling walker:	☐	☐	
Scale:	☐	☐	
Sitz bath:	☐	☐	
Suction machine:	☐	☐	
Syringes:	☐	☐	

Medical Equipment/Supply	Has and Meets Needs	Needs	Comment
TED hose:	☐	☐	
Walker:	☐	☐	
Wheelchair (manual):	☐	☐	
Wheelchair (motorized):	☐	☐	
Other: Describe if "Other"	☐	☐	

Section name: Transition Services

Documentation Needs

☐ Identification
☐ Birth certificate
☐ Social Security Card
☐ Insurance Card
☐ Proof of Benefits
☐ Other

Waivers

Select the waiver the Class Member needs or is receiving

☐ Check if not applicable

Waiver

☐ Aging Waiver (60 and over)
☐ HIV/AIDS waiver
☐ Physical disability wavier (under 60)
☐ Supportive living program
☐ Traumatic Brain Injury

Waiver Status

☐ Determination pending
☐ Services declined by Member
☐ Services initiated
☐ Waiver applied and denied

DON Score

Waiver Services

☐ Adult day center
☐In-home service
☐ Emergency home response service (EHRS)
☐ Adult daycare
☐ Assistive equipment
☐ Environmental/accessibility modification
☐ Homemaker
☐ Personal assistant
☐ Home healthcare
☐ Respite
☐ Home delivered meals
☐ Personal emergency response system (PERS)
☐ Individual/agency-based home health services

Mental Health Services

☐ ACT/CSI/CST Community Health Services
☐ Individual Therapy
☐ Intensive outpatient (IOP)
☐ Support groups
☐ Peer support
☐ Supervised/Supportive residential
☐ Psychosocial rehabilitation (PSR)
☐ Drop-in center
☐ Other:

Class Member Preference

☐ CM accepts referral
☐ CM declines referral

Substance Use Services

☐ Medication assisted treatment (MAT)
☐ Outpatient Treatment
☐ Inpatient Treatment

☐ Other:

Class Member Preference
☐ CM accepts referral
☐ CM declines referral

Specialty Providers

☐ Cardiologist	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Dentist	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Dietician/nutritionist	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Endocrinologist	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ GI specialist	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Neurologist	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Nephrologist	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Oncologist	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Optometrist	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Orthopedist	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Pain management	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Podiatrist	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Psychiatrist	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Pulmonologist	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Other:	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable

Other Specialty Services

☐ Dialysis center	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Home health	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Infectious disease specialist/clinic	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Physical therapy (PT)	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Occupational therapy (OT)	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Wound clinic	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Speech therapy	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable
☐ Other:	Status (dropdown): ☐ Planned ☐ Current ☐ Declined ☐ Unavailable

Medication
☐ Bubble packs
☐ Refill support
☐ Laboratory monitoring required

☐ Medication packing support
☐ Prescribed controlled substances
☐ Prescribed high risk medication
☐ Other:

Transportation

☐ Free ride card
☐ Paratransit
☐ MCO transportation
☐ Other:

Class Member Preference

☐ CM accepts referral
☐ CM declines referral

Other Recommended Services

☐ UIC ATU referral

Class Member Preference

☐ CM accepts referral
☐ CM declines referral

Section Name: Individualized Plan

Section	Member-specific goal	Intervention/ Mitigation Strategy	Accountability	Accountability Other	Status	Start Date	Complete	Projection Completion Date
			☐ CMHC ☐ Community provider ☐ Facility Staff/provider ☐ Family/Social Support ☐ Health Plan ☐ Housing Locator ☐ Member ☐ Prime ☐ UIC ATU		☐ Completed ☐ Ongoing ☐ Pending		☐	

Section	Member-specific goal	Intervention/ Mitigation Strategy	Accountability	Accountability Other	Status	Start Date	Complete	Projection Completion Date
			☐ CMHC ☐ Community provider ☐ Facility Staff/provider ☐ Family/Social Support ☐ Health Plan ☐ Housing Locator ☐ Member ☐ Prime ☐ UIC ATU		☐ Completed ☐ Ongoing ☐ Pending		☐	
			☐ CMHC ☐ Community provider ☐ Facility Staff/provider ☐ Family/Social Support ☐ Health Plan ☐ Housing Locator ☐ Member ☐ Prime ☐ UIC ATU		☐ Completed ☐ Ongoing ☐ Pending		☐	
			☐ CMHC ☐ Community provider ☐ Facility Staff/provider ☐ Family/Social Support ☐ Health Plan ☐ Housing Locator ☐ Member ☐ Prime ☐ UIC ATU		☐ Completed ☐ Ongoing ☐ Pending		☐	

Section	Member-specific goal	Intervention/ Mitigation Strategy	Accountability	Accountability Other	Status	Start Date	Complete	Projection Completion Date
			☐ CMHC ☐ Community provider ☐ Facility Staff/provider ☐ Family/Social Support ☐ Health Plan ☐ Housing Locator ☐ Member ☐ Prime ☐ UIC ATU		☐ Completed ☐ Ongoing ☐ Pending		☐	
			☐ CMHC ☐ Community provider ☐ Facility Staff/provider ☐ Family/Social Support ☐ Health Plan ☐ Housing Locator ☐ Member ☐ Prime ☐ UIC ATU		☐ Completed ☐ Ongoing ☐ Pending		☐	
			☐ CMHC ☐ Community provider ☐ Facility Staff/provider ☐ Family/Social Support ☐ Health Plan ☐ Housing Locator ☐ Member ☐ Prime ☐ UIC ATU		☐ Completed ☐ Ongoing ☐ Pending		☐	

Section	Member-specific goal	Intervention/ Mitigation Strategy	Accountability	Accountability Other	Status	Start Date	Complete	Projection Completion Date
			☐ CMHC ☐ Community provider ☐ Facility Staff/provider ☐ Family/Social Support ☐ Health Plan ☐ Housing Locator ☐ Member ☐ Prime ☐ UIC ATU		☐ Completed ☐ Ongoing ☐ Pending		☐	
			☐ CMHC ☐ Community provider ☐ Facility Staff/provider ☐ Family/Social Support ☐ Health Plan ☐ Housing Locator ☐ Member ☐ Prime ☐ UIC ATU		☐ Completed ☐ Ongoing ☐ Pending		☐	
			☐ CMHC ☐ Community provider ☐ Facility Staff/provider ☐ Family/Social Support ☐ Health Plan ☐ Housing Locator ☐ Member ☐ Prime ☐ UIC ATU		☐ Completed ☐ Ongoing ☐ Pending		☐	

Section	Member-specific goal	Intervention/ Mitigation Strategy	Accountability	Accountability Other	Status	Start Date	Complete	Projection Completion Date
			☐ CMHC ☐ Community provider ☐ Facility Staff/provider ☐ Family/Social Support ☐ Health Plan ☐ Housing Locator ☐ Member ☐ Prime ☐ UIC ATU		☐ Completed ☐ Ongoing ☐ Pending		☐	
			☐ CMHC ☐ Community provider ☐ Facility Staff/provider ☐ Family/Social Support ☐ Health Plan ☐ Housing Locator ☐ Member ☐ Prime ☐ UIC ATU		☐ Completed ☐ Ongoing ☐ Pending		☐	
			☐ CMHC ☐ Community provider ☐ Facility Staff/provider ☐ Family/Social Support ☐ Health Plan ☐ Housing Locator ☐ Member ☐ Prime ☐ UIC ATU		☐ Completed ☐ Ongoing ☐ Pending		☐	

Section	Member-specific goal	Intervention/ Mitigation Strategy	Accountability	Accountability Other	Status	Start Date	Complete	Projection Completion Date
			☐ CMHC ☐ Community provider ☐ Facility Staff/provider ☐ Family/Social Support ☐ Health Plan ☐ Housing Locator ☐ Member ☐ Prime ☐ UIC ATU		☐ Completed ☐ Ongoing ☐ Pending		☐	
			☐ CMHC ☐ Community provider ☐ Facility Staff/provider ☐ Family/Social Support ☐ Health Plan ☐ Housing Locator ☐ Member ☐ Prime ☐ UIC ATU		☐ Completed ☐ Ongoing ☐ Pending		☐	

Member Preferences**:**

Section name: Provider List

Delete	Current Provider Name	Provider Type	Provider Contact
☐			
☐			
☐			

Section Name: Plan Development

Plan Development

Participant Name	Relationship	Agency (if applicable):

Individuals

☐ Class Member

Select to confirm Class Member was an active participant in this plan

☐ Facility Staff
☐ Family
☐ Friend
☐ Guardian
☐ Hospital Staff
☐ Managed Care Plan Staff
☐ Primary Care Provider
☐ Psychiatrist
☐ Specialty Provider
☐ Community Provider
☐ Other

Resources

☐ Facility Record

Describe records utilized

☐ Mental Health Center Record
☐ Neuropsych Evaluation
☐ UIC ATU Documentation
☐ Provider Reports
☐ Prime Records/Assessments
☐ Hospital Report and Discharge Summary
☐ Managed Care Plan Report
☐ Other

Service Plan Required Documentation

Signed CSP/signature page* ☐ Yes ☐ No

If no, please address barriers to obtaining these documents below or indicate if not applicable for this plan*

Medication lis*t ☐ Yes ☐ No

If no, please address barriers to obtaining these documents below or indicate if not applicable for this plan*

Face sheet* ☐ Yes ☐ No

If no, please address barriers to obtaining these documents below or indicate if not applicable for this plan*

Progress notes* ☐ Yes ☐ No

If no, please address barriers to obtaining these documents below or indicate if not applicable for this plan*

Maximus transitional assessment Summary* ☐ Yes ☐ No

If no, please address barriers to obtaining these documents below or indicate if not applicable for this plan*

Summary

☐ Signed/Approved by Member

☐ Finalize Service Plan

Finalized Date*