POLICY 320-R, ATTACHMENT A - NOTIFICATION OF MEMBER IN NEED OF SPECIAL ASSISTANCE

~~*A Contractor, TRBHA, provider, or other person qualified to make the determination that determines a member* **with a Serious Mental Illness (SMI)** *is in need of Special Assistance, in accordance with AMPM Policy 320-R, must notify the AHCCCS Office of Human Rights within five business days of the determination. If the person member[1] is not already identified as needing Special Assistance, notification is required even if someone is involved and assisting the person.*~~

PART A: PAGE 1 NOTIFICATION :(TO BE COMPLETED BY THE Contractors, AzSH , Tribal ALTCS, TRBHAs~~CONTRACTOR, TRBHA~~, PROVIDER OR OTHER PERSON QUALIFIED AND SENT TO THE OFFICE OF HUMAN RIGHTS VIA SECURE E-MAIL TO OHRTS@AZAHCCCS.GOV within five business days of the determination that a M~~m~~ember is in need of Special Assistance. If the M~~m~~ember[2] is not already identified as in need of Special Assistance, notification is required even if someone is involved and assisting the ~~person~~Member.

~~THE FOLLOWING PERSON~~MEMBER~~, WHO IS A PERSON MEMBER DETERMINED TO HAVE A SERIOUS MENTAL ILLNESS (SMI), IS IN NEED OF SPECIAL ASSISTANCE~~.

MEMBER: FIRST NAME		**LAST NAME**		**DOB**		**GENDER**	
RESIDENCE TYPE							
ADDRESS							
CITY		**STATE**		**ZIP CODE**		**PHONE NUMBER**	
GUARDIANSHIP ASSIGNED		**IF GUARDIANSHIP SELECT TYPE**					
SMI~~?~~[3]		**IF THE MEMBER HAS NOT BEEN DETERMINED TO HAVE AN ~~NOT~~ SMI DO NOT COMPLETE OR SUBMIT THIS FORM TO OHR**					
~~T/RBHA Contractor~~Health Plan[4]		**AHCCCS ID**		**~~T XIX~~Title XIX/XXI[5]**	**~~No~~[6]**	**GSA**	

BEHAVIORAL HEALTH PROVIDER		**SITE/FACILITY[7] NAME**	
~~SITE~~ PROVIDER[8] ADDRESS			

CITY		**STATE/ZIP**		**SITE PHONE**		**SITE FAX**	

CASE MANAGER		**EMAIL**		**PHONE**	
~~CLINICAL COORDINATOR~~CASE MANAGER SUPERVISOR[9]		**EMAIL**		**PHONE**	

~~CLINICAL DIRECTOR NAME~~		**~~EMAIL~~[10]**	

[1] ~~Align language with policy~~
[2] Align language with policy changed throughout
[3] Remove Question Mark
[4] Update to Health Plan
[5] POST APC CHANGE: updated to 'Title'
[6] Remove "No"
[7] Included Facility
[8] Updated 'site' to 'provider'
[9] Updated to 'case manager supervisor'
[10] Deleted 'clinical director name' and 'email'; line to be removed

Effective Date: 10/01/18
Revision Date: 08/16/18

Please select the Clinical Basis from the categories below under which the ~~person~~Member has been determined to meet criteria for Special Assistance	
☐	Cognitive ability
☐	Intellectual capacity (significantly diminished capacity)
☐	Language barrier (an inability to communicate that extends beyond what an interpreter/translator can address)
☐	Medical issue (including, but not limited to, severe psychiatric symptoms that affect communication/cognition)
☐	Full G[11]uardianship (automatically meets criteria – ~~Except limited~~)

Please detail the specific condition(s) that support the Clinical Basis selected above:

PART A: Page 2

Grievance or Appeal Pending		Currently Inpatient		Inpatient Facility & Unit	
Inpatient Contact Name				If Inpatient is Outpatient aware of notification	
Inpatient Contact Phone		Inpatient Contact Email			
How many days inpatient in the last 6 months?		Total inpatient days should include both medical and psychiatric and dates do not need to be consecutive.			

Is a Guardian/designated representative, family member, or friend~~Guardian, Relative, or a Friend~~ that is regularly involved with the ~~person~~ Member and Behavioral Health Provider?	
Is the Clinical Team in agreement with the below identified support meeting the Special Assistance Needs?	
Is the Member in agreement with the below identified support meeting the Special Assistance Needs?	

If so, by who(name)		Relationship					
Phone		Address		City		State/Zip	
Is The ~~Person~~ Member In Need Of Special Assistance Aware That You Are Submitting This Notification?	Please Select						
If ~~Person~~ Member was not informed please explain below:							
Date Completed		By Name					

[11] Enlarge font as letter G very small in PDF

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Phone Number		E-mail		Title	

PART B: Response (to be completed by the Office of Human Rights Administration (OHR)							
Updated Part B? ☐Yes ☐No				If Updated Part B indicate date of original Part B			
Member First Name		Member Last Name		DOB		Original Part A Notification Date	
Per the information provided/supplemental information obtained, the ~~person~~ member meets the criteria for Special Assistance							
If Applicable list additional information provided below:							
If No please select reason Member does NOT meet Criteria							
Check Here if meets criteria due to having Guardianship (not limited) awarded by the State of Arizona							
Guardian Name		Address					
Guardian Phone		Guardian Email					
Co-Guardian Name		Contact Info					
The following person/agency is designated to provide Special Assistance:							
OHR	Assigned Advocate		Phone				
Email							
Date Assigned							
☐ Other Person Assigned by OHR (non Guardian)[12]		☐ If Guardian, see above[13]					
First Name		Last Name		Relationship			
Address		City		State/Zip		Phone	
Email Address:[14]							
Additional Information if any:							

[12] Added 'non guardian'
[13] Added note for Guardian see above
[14] Included field for email address

NOTE: SHOULD ANY CHANGES OCCUR WITH THE IDENTIFIED ~~PERSON~~ MEMBER IT IS THE RESPONSIBILITY OF THE CLINICAL TEAM TO NOTIFY OHR.					
DATE COMPLETED		BY NAME		TITLE	
PHONE NUMBER		E-MAIL			

PART C: NOTIFICATION OF CHANGE (TO BE COMPLETED BY THE T/RBHA, PROVIDER OR OTHER PERSON QUALIFIED)							
MEMBER FIRST NAME		MEMBER LAST NAME		DOB		ORIGINAL PART A NOTIFICATION DATE	
ORIGINAL REASON ~~PERSON~~ Member MET CRITERIA (SEE ORIGINAL PART A)							
☐ COGNITIVE ABILITY ☐ INTELLECTUAL CAPACITY (SIGNIFICANTLY DIMINISHED CAPACITY) ☐ LANGUAGE BARRIER (AN INABILITY TO COMMUNICATE THAT EXTENDS BEYOND WHAT AN INTERPRETER/TRANSLATOR CAN ADDRESS) ☐ MEDICAL ISSUE (INCLUDING, BUT NOT LIMITED TO, SEVERE PSYCHIATRIC SYMPTOMS THAT AFFECT COMMUNICATION/COGNITION) ☐ FULL GUARDIANSHIP (AUTOMATICALLY MEETS CRITERIA)							
PLEASE INDICATE THE DATE WHEN THE NEED FOR SPECIAL ASSISTANCE WAS NO LONGER REQUIRED: (PART C TO BE SUBMITTED TO OHR WITHIN TEN (10) BUSINESS DAYS OF THE DETERMINATION)							
THE ABOVE REFERENCED ~~PERSON~~ MEMBER NO LONGER MEETS THE CRITERIA FOR SPECIAL ASSISTANCE FOR THE FOLLOWING REASON(S):							
WAS THE MEMBER INFORMED, DUE TO A CHANGE IN CIRCUMSTANCES, HE/SHE NO LONGER MEETS THE CRITERIA FOR SPECIAL ASSISTANCE AND UNDERSTANDS THE CHANGE?							
IF OHR WAS MEETING NEEDS, IS ASSIGNED ADVOCATE AWARE A PART C IS BEING COMPLETED?							
IF NO TO EITHER OF THE ABOVE QUESTIONS PLEASE EXPLAIN BELOW:							
NOTE: THE PART C CAN ONLY BE PROCESSED AT OHR IF SUBMITTED WITH THE ORIGINAL PART A AND B.							
DATE COMPLETED		BY NAME		TITLE			
PHONE NUMBER		E-MAIL					
CLINICAL DIRECTOR NAME		EMAIL					

AGENCY	
~~DATE COMPLETED~~[15]	

[15] Removed 'date completed; redundant