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| **Area Agency:** Choose an item. |
| **Demographics at time of writing** |
| **Individual Name**:       | **DOB**:       |
| **Service Coordinator**:       | **Plan Date**:       |
| **Risk Assessment Author**:       | **Risk Assessment Date**:       |
| **Documents used to write plan**:       |
| **RMP Author Name/Credentials**:       |
| **RMP Author Signature**:  |
| **Date Signed**:       |
| **LRMC Approval Signature:** |
| **LRMC Designee Name/Title**:       |
| **Date Signed**:       |
| **LRMC Approval Date**:       | **SRMC Endorsement Date**:       |
| ***Guardianship status:***[ ] Public Guardian, agency name/representative:      [ ] Private Guardian, name/relationship:      [ ] No Guardian |
| **Other guardianship information, if applicable**:        |
| **Purpose of plan, if explanation necessary**:       |
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| **Services provided at time of writing** |
| **Waiver Services (Residential services, day program, case management, START, behavioral, etc), vendor name and date effective (full date or year):** | **Non-waiver services (Community Mental Health Center, Med Management, Private Therapy, etc.), provider name and date effective (full date or year):** |
| **Service** | **Vendor/Date** | **Service** | **Vendor/Date** |
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| For the purposes of this plan, the following are considered to members of the clinical team:  |
|       |
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| **Diagnostic Information** |
| **Current Medical Diagnoses**:       |
| **Current Psychatric Diagnoses**:       |
| **Historical Medical Diagnoses (including rule-outs)**:       |
| **Historical Psychiatric Diagnoses (including rule-outs)**:        |
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| **Legal/Criminal** |
| **Current Legal Status (pending charges,** **current sanctions, incarcerated, etc)**:       |
| **Qualifying Offense**:        |
| **Risk Level as quoted in Risk Assessment**:        |
| **Does the Area Agency agree with this** **assessment of risk**?        |
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| **Biopsychosocial** |
| **Brief Social History, prior to age 21:** |
| **Family Structure and upbringing**:       |
| **Schooling history/information**:       |
| **Legal history prior to age 21, if any**:       |
| **Mental health care needs or other hospitalization history prior to 21**:       |
| **Brief synopsis of other pertinent information**:      |
| **Brief Social History, age 21-Current** |
| **Family Structure/Dynamics**:       |
| **Legal Involvement, if any**:       |
| **Medical/Psychiatric Challenges, if any**:        |
| **Mental health care needs or other hospitalization history**:       |
| **Current and historical experiences in the developmental service system:**  |
| **Current and historical community/day services in the developmental service system:**  |
| **Other pertinent information**:        |
| **Person-Centered Goals, Preferences and Aspirations:** |
| **Person’s preferred activities**:       |
| **Person’s treatment goals (what does he/she want to work on in treatment?)**:       |
| **Person’s employment goals**:       |
| **Person’s future aspirations**:       |
| **What supports does this person need to achieve these goals?**:       |
| **Current treatment/therapy:** |
| **What are current treatment/therapy offerings?**:       |
| **To what extent does this individual** **participate in treatment/therapy?**:        |
| **Are there any barriers to treatment at this writing?**:       |
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| **High Risk Behaviors** |
| **Current high risk behaviors:** | **Target population:** |
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| **Description of** **the intensity and duration of high risk behavior (s) listed above**:       |
| **Historic high risk behaviors:** | **Target population:** |
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| **Risk Profile** |
| **Static Risk Factors (and target population if applicable):** | **Dynamic Risk Factors (and target population if applicable):** |
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| **Protective factors:** | **Triggers:** |
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| **Risks/Recommendations/Mitigations** |
| **Dynamic Risk being addressed:** | **Assessment recommendations:** | **Mitigation approach & service provider responsible for implementation:** |
|       |       |       |
|       |       |       |
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| **Supervision Levels at time of writing** |
| **Statement about supervision levels expectation, and the frequency of review of supervision level:**  |
|       |
| **Community contact with levels of supervision** |
| **Community Location** | **Supervision Level** |
|       |        |
| **Employment** | **Supervision Level** |
|       |       |
| **Routine/Emergency Medical Care** | **Supervision Level** |
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| **Levels of supervision at home and/or with family** |
| **Home: Indoors** | **Supervision Level** |
|       |       |
| **Home: Outdoors** | **Supervision Level** |
|       |       |
| **With Family, note location** | **Supervision Level** |
|       |       |
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| **Incident Response Expectations** |
| **High-Risk Behavior** | **Provider response** |
|       |       |
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| **Program oversight expectations** |
| **Current vendor agencies expected to follow this plan**: |
|       |
| **Plan review frequency**:  |
|       |
| **Program monitoring expectations**: |
|       |
| **Staff training expectations on this plan**: |
|       |
| **Individual training expectations on this plan**: |
|       |
| **Communication expectations (specify necessary communication and frequency between members regarding this plan**):  |
|       |
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| **Restrictions and environmental modifications:** |
| ***Note: all restrictions MUST be approved by the Area Agency’s Human Rights Committee prior to being implemented.***  |
|        |
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| **Persons trained on this plan by plan author/designee (train-the-trainer):** |
| **Trainee represents the following vendor agency:**  |
| **Trainee Signature:**  |
| **Trainee name/title/credentials:** | **Date:** |
| **Trainer Signature:** |
| **Trainer name/title/credentials:** | **Date:** |
| **Retrain dates, Trainer and trainee initials:**  |  |  |  |  |  |
|  |
| **Trainee represents the following vendor agency:** |
| **Trainee Signature:**  |
| **Trainee name/title/credentials:** | **Date:** |
| **Trainer Signature:** |
| **Trainer name/title/credentials:**  | **Date:** |
| **Retrain dates, Trainer and trainee initials:** |  |  |  |  |  |
|  |
| **Trainee represents the following vendor agency:** |
| **Trainee Signature:**  |
| **Trainee name/title/credentials:** | **Date:** |
| **Trainer Signature:** |
| **Trainer name/title/credentials:** | **Date:** |
| **Retrain dates, Trainer and trainee initials:** |  |  |  |  |  |

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| **Please sign and date here if this plan includes a Risk Management Plan Training Addendum:** |
|  |
| **Please sign and date here if a Risk Management Plan Amendment is included with this plan:**  |
|  |