



CARE-PPR	<b>Permanency Planning Review</b>	(Action Code 309)	Rev. 9/05
Last Name/	<input type="text"/>	Client ID	<input type="text"/>
Suffix	<input type="text"/>	Local Case Number	<input type="text"/>
First Name	<input type="text"/>	Component	<input type="text"/>
Middle Name	<input type="text"/>		
<b>Action</b> Add: <input type="checkbox"/> Change: <input type="checkbox"/> Delete: <input type="checkbox"/>			
Review Date	MM <input type="text"/> DD <input type="text"/> YYYY <input type="text"/>	Permanency Plan Goal	<input type="checkbox"/> Does the family/LAR support goal? (Y=Yes, N=No) <input type="checkbox"/>
Contact Frequency	<input type="checkbox"/> # Visits by Family <input type="text"/>	# Visits to Family	<input type="text"/> Traumatic Brain Injury (Y=Yes, N=No) <input type="checkbox"/>
Family participated/POC Y=Yes, N=No, N/A= Not applicable	<input type="checkbox"/>	Family participated/PP Y=Yes, N=No	<input type="checkbox"/>
Located Family Y=Yes, N=No	<input type="checkbox"/>	Family Responded Y=Yes, N=No	<input type="checkbox"/>
<b>Family and Community Supports to Achieve Goal</b>			
<i><b>Note: This section is not required for individuals 18 to 21 years of age with a Permanency Plan Goal of 4.</b></i>			
Below, enter <b>Y</b> (Yes) if needed, <b>N</b> (No) if not needed, or leave blank. (The system defaults to No.)			
Architectural Modifications	<input type="text"/>	Behavioral Intervention	<input type="text"/>
Crisis Intervention	<input type="text"/>	Durable Medical Equipment	<input type="text"/>
Family Based Alternative	<input type="text"/>	In Home Health Services	<input type="text"/>
Night Time Person	<input type="text"/>	Ongoing Medical Services	<input type="text"/>
Respite-In Home	<input type="text"/>	Respite-Out of Home	<input type="text"/>
Specialized Therapies	<input type="text"/>	Specialized Transport.	<input type="text"/>
		Volunteer Advocate	<input type="text"/>
Contact Name: _____		Contact Phone: _____	
Individual is enrolled, is enrolling, or is eligible for MFP in a Medicaid Waiver (Y=Yes, N=No) <input type="checkbox"/>			
Completed by: _____		Date: _____	

# Permanency Planning Review (CARE-PPR)

**Identifying Information:** Complete the identifying information at the top of the form. The local case number is a maximum of 10 characters. The component code is the 3-digit code for your component.

**Action:** Check the **Add** box to submit permanency planning review data for the first time. If you want to add to or change permanency planning review data that was previously submitted, check the **Change** box. Check the **Delete** box to delete a previously submitted form.

## **Permanency Planning Information** *(These fields are required.)*

- **Review Date:** Enter the date of the person's permanency planning review.
- **Permanency Plan Goal:** Enter the code indicating the permanency plan goal: **1**=Return to family, **2**=Move to family-based alternative (e.g., foster, extended family care, open adoption), **3**=Alternate living arrangement determined by individual and Legally Authorized Representative (LAR) (for individuals 18 through 21 only), **4**=Remain in current residence as determined by individual and LAR (for individuals 18 through 21 only).
- **Does the family/LAR support goal and work to achieve it:** Enter **Y** (Yes) if the family/LAR agrees with the goal *if and when the needed supports can be accessed* and supports activities to achieve it. Enter **N** (No) if the family/LAR chooses for the individual to remain in the current residence even if needed supports can be accessed.
- **Contact Frequency:** Enter the code indicating the frequency of parent/guardian contact with the individual during the last six months: **1**=New Admission, **2**=Daily, **3**=Weekly, **4**=Monthly, **5**=1-3 times, **6**=None.
- **# Visits by Family:** Enter the number of visits to the facility by the parent/guardian.
- **# Visits to Family:** Enter the number of the resident's visits to the home.
- **Traumatic Brain Injury:** *(This field is not required.)* Enter **Y** (Yes) or **N** (No) to indicate if the person has a history of traumatic brain injury.
- **Within the last 6 months, did the family/LAR participate in the initial or annual meeting to discuss the Individual Plan of Care (IPC) or Individual Program Plan (IPP)?** Enter **Y** (Yes) if the family/LAR did participate, **N** (No) if the family/LAR did not participate, and **N/A** (Not applicable) if the annual meeting did not occur within the last six months. Participation may include attending a meeting or participating by telephone or other means of communication.
- **Did the family/LAR participate in this initial or review of the permanency plan (whichever is applicable)?** Answer based on the family's/LAR's participation in this permanency plan. Enter **Y** (Yes) if the family/LAR did participate, or **N** (No) if the family/LAR did not participate. Participation may include attending a meeting or participating by telephone or other means of communication.
- **Within the last six months, could the family be located in order to invite their participation in a permanency planning meeting, an annual meeting to discuss the plan of care, or when medical consents were required?** Enter **Y** (Yes) if the family could be located when needed in all circumstances described, if applicable, and **N** (No) when the family could not be located when needed in any circumstance described, if applicable. If the family could be located for some but not all circumstances described (for instance, could be located to invite their participation in an annual POC meeting but could not be located for the permanency planning meeting, enter **N** (No). Could not be located means that you no longer have a valid address, phone number, or other contact information that would enable you to make contact with the family/LAR in order to invite their participation.
- **Within the last six months, did the family/LAR respond to requests to participate in applicable permanency planning meetings, annual meeting to discuss the plan of care, or when medical consents were needed?** Enter **Y** (Yes) if the family did respond, or **N** (No) if the family did not respond. "Did respond" means the family could be located and either by phone or in writing indicated their preference to participate or not participate.

## **Family and Community Supports to Achieve Goal:**

*Note: This section must be completed for all individuals under age 18 and for individuals 18 to 21 years of age who have a Permanency Plan Goal of 1, 2, or 3. List the supports that will be needed by the individual in order to achieve the permanency planning goal. For example, if a permanency planning goal of 1 is chosen, what supports must be provided the individual and/or family while living at home. This section is not required for individuals 18 to 21 years of age with a Permanency Plan Goal of 4.*

Enter **Y** (Yes), **N** (No), or leave blank for each support. The system defaults to "No".

**Architectural Modifications:** Includes widening of doorways, lowering of counters, ramps, bathroom modifications, kitchen modifications, etc. that allow access to a person's home. Does not include modifications to public facilities.

**Behavioral Intervention for Child or Training for Family:** Includes the services of a behavioral specialist or therapist in developing a plan of intervention and training of the family in behavioral intervention as related to that child's needs for behavioral intervention.

**Child Care or After School Care:** For additional child care needs above and beyond normal child care needs for children 13 years old and under and those 14 years old and older; i.e., extra supervision, one-on-one supervision while the parent is at work.

**Crisis Intervention:** Supports for child and family to prevent institutionalization due to life threatening situations that are documented to cause impending out of home placement within a 72-hour time period with no supports.

**Durable Medical Equipment:** Adaptive aids and other disability equipment needs that increase independence in daily life. Also includes medical supplies that are needed on a regular basis. Wheelchairs, communication devices, medical supplies, adaptive eating equipment, etc. (reference to Medicaid definition of DME).

**Transportation:** Transportation that is available to the general public and contracted with a private individual; i.e., bus, taxi, per mile or trip contract, etc.

## Family and Community Supports to Achieve Goal, Continued

Family Based Alternative: Provide assistance in the referral and support for placement in alternate community program in a family, e.g., foster care, shared parenting, open adoption.

In Home Health Care Services: Identified nursing needs to be provided within the home setting.

Mental Health Services, including Counseling: Evaluation and identified mental health support needs including evaluation, testing, counseling, medication supports, behavioral interventions.

Night Time Person: Staff available for supervisory needs for health and safety identified needs, assistance in going to bathroom, turning to prevent bed sores, prevent running away, etc.

Ongoing Medical Services: Medical services that have been identified to be regular monitoring services due to the medical needs of the child, blood levels, regular follow-up visits to monitor condition or medical need, access to medical specialists.

Personal Assistance Support for Activities of Daily Living: Assistance with daily living needs including bathing, grooming, eating, mobility, etc.

Respite for Family In Home: Periodic relief of caregiving that is provided in the home of the individual. (hourly or daily)

Respite for Family Out of Home: Periodic relief of caregiving that is provided in another setting other than the person/family home. (hourly or daily)

Special Equipment: Equipment that has been identified by the appropriate licensed professional for the person to be independent in daily living. Wheelchairs, communication devices, specialized eating utensils, etc.

Specialized Therapies (e.g., Occupational Therapy, Physical Therapy, Speech Therapy): Evaluations and therapy services that are provided by the appropriate licensed therapist.

Specialized Transportation: Available public transportation that provides services to those with disabilities.

Training to Assist Person in Independent Living or Assist Family in Providing Proper Care for Unique Needs: Identified training to improve or increase the independence of the individual to live at home. Includes dressing, bathing, eating, completing chores, making bed, cooking, etc. Training of the family in how to take care of the daily needs of the child including bathing, medical care, feeding, etc.

Volunteer Advocate: A person selected by the parent or guardian, an adult relative, or a representative of a child advocacy group not employed by or under contract with the institution in which the individual resides to assist in permanency planning for individuals under age 22 residing in ICF/MR, state school, receiving waiver services of residential support, supervised living or supported living, or residing with four or more unrelated individuals.

**Contact Name**: Enter the name of the person responsible for conducting permanency planning activities.

**Contact Phone**: Enter the telephone number of the person responsible for conducting permanency planning activities.

**Individual is enrolled, is enrolling, or is eligible for MFP in a Medicaid Waiver**: Is the individual enrolled or enrolling in any Medicaid Waiver, or is the individual currently living in a nursing home and have access to a Medicaid waiver through "money follows the person"? Enter **Y** (Yes) if any of the three choices apply and **No** (No) if none of the three choices apply. If an individual is living in an HCS group home or has been offered HCS services and is in the process of enrolling in HCS, then enter **Y** (Yes). If the individual is living in an ICF/MR facility and is on the HCS waiting list but has not yet been offered HCS services, enter **N** (No). If the individual has been offered HCS services but has declined the offer and the offer is no longer valid, enter **N** (No).

**Completed By**: Indicate who completed the permanency planning instrument by entering the correct name and completion date.