

PASRR Comprehensive Service Plan (PCSP) Form

| PCSP | | |
|---|--|--|
| Submitter Information | | |
| A0100. Name | <input style="width: 90%;" type="text"/> | |
| A0200. Address | <input style="width: 90%;" type="text"/> | |
| A0300. NPI/API No. | <input style="width: 90%;" type="text"/> | |
| A0400. Provider No. | <input style="width: 90%;" type="text"/> | |
| A0500. Vendor No. | <input style="width: 90%;" type="text"/> | |
| A0600. County | <input style="width: 90%;" type="text"/> | |
| Meeting Information | | |
| Type of Meeting 1. Initial IDT/SPT 2. Annual IDT/SPT 3. Quarterly 4. LA Update | Reason Code 1. Change in Medical Condition 2. Change in Service 3. Deceased 4. Discharged 5. Refusal of Habilitation Coordination 6. Transfer 7. Transition 8. Refusal of MI Specialized Services | Transition To 1. CLASS (SG 2) 2. PACE (SG 11) 3. DBMD (SG 16) 4. MDCP (SG 18) 5. STAR+Plus (SG 19) 6. HCS (SG 21) 7. TxHmL (SG 22) 8. YES (DSHS Waiver) 9. Other |
| A0700. Type of Meeting | <input style="width: 90%;" type="text"/> | |
| A0800. Date of Meeting | <input style="width: 90%;" type="text"/> | |
| A0900. Reason Code | <input style="width: 90%;" type="text"/> | |
| A1000. Transition To | <input style="width: 90%;" type="text"/> | |
| A1100. Other | <input style="width: 90%;" type="text"/> | |
| A1200. Date of Event | <input style="width: 90%;" type="text"/> | |
| Nursing Facility Information | | |
| A1300. Provider No. | <input style="width: 90%;" type="text"/> | |
| A1400. Vendor No. | <input style="width: 90%;" type="text"/> | |
| A1500. NPI No. | <input style="width: 90%;" type="text"/> | |
| A1600. Facility Name | <input style="width: 90%;" type="text"/> | |

PASRR Comprehensive Service Plan (PCSP) Form**Local Authority Information****A1700. LA-MI Information**

A. LA-MI Provider No.

B. LA-MI Vendor No.

C. LA-MI NPI/API No.

A1800. LA-IDD Information

A. LA-IDD Provider No.

B. LA-IDD Vendor No.

C. LA-IDD NPI/API No.

Individual Information**A1900. Individual Name**

A. First Name

B. Middle Initial

C. Last Name

D. Suffix

A2000. Social Security No.**A2100. Medicare No.****A2200. Medicaid No.****A2300. Birth Date****A2400. Individual is PASRR positive for:**☐

1. IDD only 2. MI only 3. IDD and MI

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Participants Information

A2500. Meeting Participation

Identify all meeting participants:

A. Participant Type

1. Individual
2. LA - IDD
3. LA - MI
4. Legally Authorized Representative
5. Nursing Facility - RN
6. Nursing Facility
7. Specialized Services Provider
8. Other

B. Attendance Type

1. Yes - Attended in person
2. Yes - Attended via phone
3. No - Did not attend
4. No - Declined

C. Title

- | | |
|--|-------------------------|
| 1. Diversion Coordinator | 11. Service Coordinator |
| 2. Habilitation Coordinator | 12. Speech Therapist |
| 3. Licensed Clinical Social Worker (LCSW) | 13. Other |
| 4. Licensed Professional Counselor (LPC) | 14. N/A |
| 5. Licensed Psychologist | |
| 6. Occupational Therapist | |
| 7. Physical Therapist | |
| 8. Physician (MD or DO) | |
| 9. Qualified Mental Health Professional (QMHP) | |
| 10. Registered Nurse (RN) | |

| A. | B. | C. | D. Other | E. Full Name | F. Type of Meeting | G. Date of Meeting |
|-----|--------------------------|--------------------------|--------------------------|----------------------|----------------------|----------------------|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 11. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 12. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 13. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 14. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 15. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| 16. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

PASRR Comprehensive Service Plan (PCSP) Form

Alternate Placement Consideration

A2600. Alternate Placement Consideration

| | 1. PASRR Evaluation | 2. Meeting Type Date of Meeting = |
|---|--|--|
| A. Individual Is Best Served In | | <input style="width: 30px;" type="checkbox"/> 0. Nursing Facility <input style="width: 30px;" type="checkbox"/> 1. Community Setting |
| B. Does the Individual wish to transition into the community? | | <input style="width: 30px;" type="checkbox"/> 0. No <input style="width: 30px;" type="checkbox"/> 1. Yes |

Specialized Services Information

A2700. Specialized Services Indication

| | 1. PASRR Evaluation | 2. Meeting Type Date of Meeting = |
|--|---|--|
| A. I certify that the need for all habilitative therapies (not rehabilitative therapies) were discussed. | <input style="width: 30px;" type="checkbox"/> | <input style="width: 30px;" type="checkbox"/> |

Options for the drop-downs for the Specialized Services

- | | | | |
|---------------------------|-----------------|------------------|---------------|
| 1. Individual/LAR Refused | 3. Ongoing | 5. Item Received | 7. Not Needed |
| 2. New | 4. Discontinued | 6. Pending | 8. Completed |

A2800. Nursing Facility Specialized Services

For each service, select the appropriate option from the drop-down list.

| | 1. PASRR Evaluation | 2. Meeting Type Date of Meeting = |
|---|---|--|
| A. Individual/LAR Refused all Services | <input style="width: 30px;" type="checkbox"/> | <input style="width: 30px;" type="checkbox"/> |
| B. Customized Manual Wheelchair (CMWC) | <input style="width: 30px;" type="checkbox"/> | |
| C. Durable Medical Equipment (DME) | <input style="width: 30px;" type="checkbox"/> | Please See Below |
| D. Specialized Assessment Occupational Therapy (OT) | <input style="width: 30px;" type="checkbox"/> | |
| E. Specialized Assessment Physical Therapy (PT) | <input style="width: 30px;" type="checkbox"/> | |
| F. Specialized Assessment Speech Therapy (ST) | <input style="width: 30px;" type="checkbox"/> | |
| G. Specialized Occupational Therapy (OT) | <input style="width: 30px;" type="checkbox"/> | |
| H. Specialized Physical Therapy (PT) | <input style="width: 30px;" type="checkbox"/> | |
| I. Specialized Speech Therapy (ST) | <input style="width: 30px;" type="checkbox"/> | |

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A2900. Durable Medical Equipment (DME)

For each service, select the appropriate option from the drop-down list.

| | 1. PASRR Evaluation | 2. Meeting Type Date of Meeting = |
|--|--------------------------|---|
| A. Gait Trainer | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Orthotic Device | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Positioning Wedge | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Prosthetic Device | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Special Needs Car Seat or Travel Restraint | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Specialized or Treated Pressure-Reducing Support Surface Mattress | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Standing Board/Frame | <input type="checkbox"/> | <input type="checkbox"/> |

A3000. IDD Specialized Services

For each service, select the appropriate option from the drop-down list.

| | 1. PASRR Evaluation | 2. Meeting Type Date of Meeting = |
|--|--------------------------|---|
| A. Individual/LAR Refused all Services | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Alternate Placement Services | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Behavioral Support | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Day Habilitation | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Employment Assistance | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Habilitation Coordination | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Independent Living Skills Training | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Service Coordination | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Supported Employment | <input type="checkbox"/> | <input type="checkbox"/> |

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A3100. MI Specialized Services

For each service, select the appropriate option from the drop-down list.

| | 1. PASRR Evaluation | 2. Meeting Type Date of Meeting = |
|--|--------------------------|---|
| A. Individual/LAR Refused all Services | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Group Skills Training | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Individual Skills Training | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Intensive Case Management | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Medication Training (Group) | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Medication Training (Individual) | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Medication Training & Support Services (Group) | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Medication Training & Support Services (Individual) | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Psychiatric Diagnostic Interview Examination | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Psychosocial Rehabilitative Services (Group) | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Psychosocial Rehabilitative Services (Individual) | <input type="checkbox"/> | <input type="checkbox"/> |
| L. Routine Case Management | <input type="checkbox"/> | <input type="checkbox"/> |
| M. Skills Training & Development (Group) | <input type="checkbox"/> | <input type="checkbox"/> |
| N. Skills Training & Development (Individual) | <input type="checkbox"/> | <input type="checkbox"/> |

Comments
**A3200. Nursing
Facility Comments****A3300. Local
Authority Comments**

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Local Authority Confirmation

A3400. LA-MI Specialized Services and Participation Confirmation

A. I am Confirming the MI section ☐B. All MI Specialized Services selected were agreed to by the IDT ☐0. No
1. YesC. LA-MI Specialized
Services Comments

D. LA-MI Signature Date

E. LA-MI Attendance Type

- 1. Yes - Attended in person
- 2. Yes - Attended via phone
- 3. No - Did not attend

F. LA-MI Participation
Confirmation
Comments

A3500. LA-IDD Specialized Services and Participation Confirmation

A. I am Confirming the IDD section ☐B. All IDD Specialized Services selected were agreed to by the IDT ☐0. No
1. YesC. LA-IDD Specialized
Services Comments

D. LA-IDD Signature Date

E. LA-IDD Attendance Type

- 1. Yes - Attended in person
- 2. Yes - Attended via phone
- 3. No - Did not attend

F. LA-IDD Participation
Confirmation
Comments