

BAAS POLICY RELEASE (PR)	
PR NUMBER:	24-21
TO:	All BAAS Staff; Kerrileigh Schroeder; Dawn Tierney; Choices For Independence (CFI) Case Managers; Aging and Disability Resource Center (ADRC) Managers
FROM THE OFFICE OF:	Bureau Chief of Adult and Aging Services (BAAS), Wendi Aultman
SIGNATURE:	
SUBJECT:	BAAS Form Revisions
EFFECTIVE DATE:	Upon Receipt

SUMMARY

This Policy Release (PR) releases revisions to the following forms and their associated internal instructions, BEAS 3200, *How BEAS Can Help You*, BEAS 3203, *Risk Identification Mitigation Planning Tool*, BEAS 3204, *Case Review Consultation Committee Referral*, and BEAS 3205, *Case Review & Consultation Committee Recommendations*.

POLICY AND PROCEDURE

No policy or procedure is being changed by the release of this PR.

DESCRIPTION OF REVISIONS MADE TO FORMS

All of the below forms have had a name change from BEAS to BAAS as well as general updates pertaining to formatting, grammar, readability, and appearance. Additional changes to some of the forms have been made as indicated below:

- BAAS Form 3200, *How BAAS Can Help You*
 - *Now available in Spanish*
 - *Updated contact and program information*
 - *Add information pertaining to filing a ‘Grievance’*
- BAAS Form 3203, *Risk Identification Mitigation Planning Tool*
 - *Definitions pertaining to ‘Risk’ language has been updated and clarified*
 - *A guide to completing the form is now included as an additional page*
 - *Fields have been re-arranged for ease of completion*
 - *For situations where a ‘new’ or ‘revised’ Form is needed, a question was added asking “Does this section contain newly reported information”*
- BAAS Form 3203(i), Instruction sheet for *Risk Identification Mitigation Planning Tool*
 - *Updated internal workflow instructions*
- BAAS Form 3204, *Case Review Consultation Committee Referral*
 - *General language has been updated and clarified*
 - *Internal instruction page is no longer attached and is now a separate form*
- BAAS Form 3204(i), Instruction sheet for *Case Review Consultation Committee Referral*
 - *Updated internal workflow instructions*
- BAAS Form 3205, *Case Review & Consultation Committee Recommendations*

- *Internal instruction page is no longer attached and is now a separate form*
- BAAS Form 3205(i), *Instruction sheet for Case Review & Consultation Committee Recommendations*
 - *Updated internal workflow instructions*

IMPLEMENTATION

This policy is effective upon release of this PR. All prior version of the BEAS forms listed above, must be recycled and the new BAAS versions used immediately.

The New version of BAAS Form 3200, will be available for ordering through the DHHS Warehouse/Logistics via the District Office’s Quarterly Forms Order (QFO) when a supply of the new version(s) is needed.

New versions of the BAAS Forms, 3203, 3204 and 3205 will be available electronically on the DHHS website at www.dhhs.nh.gov/forms-documents-0 as well as BAAS Form 3200.

The newly translated BAAS Form 3200(Sp), *How BAAS Can Help You*, will be available on the website once translation has been completed.

BAAS Forms, 3200, 3200(SP), 3203, 3204, 3205, and the associated instructions will also be available internally, for Department staff only, on the (N:) drive upon release of this PR.

FORMS INSTRUCTIONS

<u>Remove and Destroy</u>	<u>Insert/Replace</u>
BEAS Form 3200, <i>How BEAS Can Help You</i> , All Prior Version	BAAS Form 3200, <i>How BAAS Can Help You</i> , PR # 24-21 Rev 11/24
None	BAAS Form 3200(Sp), <i>How BAAS Can Help You</i> , PR # 24-21 Rev 11/24
BEAS Form 3203, <i>Risk Identification Mitigation Planning Tool</i> All Prior Version	BAAS Form 3203, <i>Risk Identification Mitigation Planning Tool</i> , PR # 24-21 Rev 11/24
BEAS Form 3203(i), <i>Instructions to Risk Identification Mitigation Planning Tool</i> All Prior Version	BAAS Form 3203(i), <i>Instructions to Risk Identification Mitigation Planning Tool</i> , PR # 24-21 Rev 11/24
BEAS Form 3204, <i>Case Review Consultation Committee Referral</i> , All Prior Version	BAAS Form 3204, <i>Case Review Consultation Committee Referral</i> , PR # 24-21 Rev 11/24
BEAS Form 3204(i), <i>Instructions to Case Review Consultation Committee Referral</i> , All Prior Version	BAAS Form 3204(i), <i>Instructions to Case Review Consultation Committee Referral</i> , PR # 24-21 Rev 11/24
BEAS Form 3205, <i>Case Review Consultation Committee Recommendations</i> , All Prior Version	BAAS Form 3205, <i>Case Review Consultation Committee Recommendations</i> , PR # 24-21 Rev 11/24
BEAS Form 3205(i), <i>Case Review Consultation Committee Recommendations</i> , All Prior Version	BAAS Form 3205(i), <i>Instructions to Case Review Consultation Committee Recommendations</i> , PR # 24-21 Rev 11/24

DISTRIBUTION

This PR will be distributed according to the electronic distribution list for BAAS policy releases and will be available internally on the DHHS (N:) drive for staff to access and on the DHHS website at [Bureau of Adult and Aging Services \(BAAS\) General Memos \(GM\) and Policy Releases \(PR\) | New Hampshire Department of Health and Human Services \(nh.gov\)](http://www.dhhs.nh.gov/Bureau%20of%20Adult%20and%20Aging%20Services%20(BAAS)%20General%20Memos%20(GM)%20and%20Policy%20Releases%20(PR)%20|%20New%20Hampshire%20Department%20of%20Health%20and%20Human%20Services%20(nh.gov)) for public access.

What Is The Bureau of Adult and Aging Services (BAAS)?

The Bureau of Adult and Aging Services (BAAS) is part of New Hampshire's Department of Health and Human Services (DHHS), Division of Long Term Supports and Services (DLTSS).

BAAS is designated by the U.S. Administration on Aging as the state agency on aging, and provides a variety of services and programs for:

- Adults ages 60 or older;
- Adults between the ages of 18 and 60 who are experiencing a chronic illness or physical disability; or
- A family caregiver.

BAAS is committed to providing services and programs that help people live as independently as possible, in safety and with dignity, and to exercise personal choice and direction.



What Are Some Of The Programs and Supports Offered Through BAAS ?

- Choices For Independence (CFI)
- Long Term Care (LTC)
- Money Follows the Person (MFP)
- Adult Protection Services (APS)
- Home and Community Based Services (HCBS)
- Family Caregiver Support Program (FCSP)
- Aging and Disability Resource Centers (ADRC) previously known as *ServiceLink*.

Choices For Independence (CFI)

Choices for Independence (CFI) is a home and community-based 1915(c) waiver, funded by Medicaid, that provides a wide range of services designed to enable participants to remain in their homes and stay active in their communities.

Long Term Care (LTC)

Long Term Care (LTC) can be provided in a community setting, such as a residential care facility, or in a nursing facility. This type of care is available for adults who are aging and also for adults with chronic illnesses and/or physical disabilities who meet both financial and clinical requirements. determined by BAAS.

Money Follows the Person (MFP)

The Money Follows the Person program can assist adults who are aging and adults with chronic illnesses or physical disabilities living in long-term care settings to transition into community-based living settings that meet their needs. Individuals must meet program, financial and clinical requirements. In addition to transition assistance, MFP program services can include Home and Community Based Services (HCBS) such as home delivered meals, adult day and homemaker services.

Adult Protective Services (APS)

Adult Protective Services (APS) is administered by BAAS in accordance with State law (RSA 161-F:42-57). Adult Protective Service Workers (APSW) are responsible for receiving and investigating reports of abuse, neglect, exploitation and/or self-neglect of vulnerable adults. APSW's also assist in providing or arranging for protective services, when needed.

Home and Community Based Services (HCBS)

Home and Community Based Services (HCBS) help people to remain healthy and independent at home. Services require an application, and some require an eligibility determination. Examples of HCBS services include, but are not limited to: home delivered meals, congregate meals, adult day and homemaker services.

Family Caregiver Support Program (FCSP)

The Family Caregiver Support Program (FCSP) provides information, assistance and support to assist family caregivers who meet certain eligibility requirements and are caring for a loved one at home.

Grant funds may be available for eligible caregivers to provide short-term breaks from caregiving.



Aging and Disability Resource Centers (ADRC)

Free information, referral and assistance services are provided by ADRCs (*ServiceLink*), which are administered by BAAS in conjunction with other community partners.

ADRCs helps adults who are aging, adults with chronic illnesses or disabilities, and caregivers to connect with the resources they need. Medicare information and counseling is available at no cost at all ADRC sites.

ADRC representatives can provide information on Medicare benefits and services including prescription drug coverage. ADRC sites are in all 10 counties.



How Do I Apply

It's easy to apply! You can apply by:

- Contacting your local DHHS District Office;
- Contacting your local ADRC site;
- Going to <https://nheasy.nh.gov>, and completing an application online; or

Print an application from www.dhhs.nh.gov/apply-assistance, complete it and mail it in to the address indicated on it.

Can I Get Other Help?

You may also qualify for other DHHS programs such as Medical Assistance, help paying Medicare premiums, Financial Assistance or SNAP benefits. We can talk to you about other programs and assist you in applying for them.

How Can I get More Information ?

This pamphlet was designed to give you general information about BAAS. Please contact your local DHHS District Office for more information (see back for contact information).

You can also contact ADRC (*ServiceLink*) for more information about BAAS services and programs at:

Contact NH ADRC at:

1-866-634-9412 or

www.servicelink.nh.gov

By calling this number, you will be connected to an ADRC site in your area.

What Are My Rights?

You have the right to:

- Apply for assistance;
- Be treated fairly;
- Receive written notice of the decision on your case including telling you if there is no eligibility;
- Evaluations and access to treatment and other services;
- Meaningful and understandable information regarding rights of participants who have been adjudicated incapacitated, including guardians or legal representatives
- File a grievance;
- File an administrative appeal if you are not satisfied with DHHS's decision about your case, and to bring a friend or an attorney to your appeal hearing; and
- Have your case record be kept confidential.

Ask Questions

If you are not satisfied with the information, you receive or the decisions of DHHS, please ask questions. If you still are not satisfied or do not understand, ask to speak to a supervisor. Help and assistance can be found in your DHHS district office. Call, write, visit our website, or go to the office to ask questions and learn about the program rules.

Administrative Appeals

You have the right to request an administrative appeal if you disagree with any decision taken in your case. At the administrative appeal, you can explain to the appeals officer why you disagree with an action being taken.

Discrimination

DHHS decides each case based on the facts. If you feel you have been discriminated against because of age, sex (including gender identity and sexual orientation), race, creed, color, marital status, familial status, disability (physical or mental), religion, national origin, political affiliation or belief, contact the Ombudsman of the NH DHHS, 129 Pleasant Street, Concord, NH, 03301-3857; telephone 1-800-852-3345, ext. 16941. There can be no retaliation against you for having made this contact.

How To File A Grievance

You have the right to file a grievance with BAAS if you are dissatisfied. Grievances can be reported by any individual on behalf of a Choices For Independence (CFI) participant.

Grievance can be reported by submitting BAAS Form 3123 *Grievance Reporting*, by writing a statement, or by a verbal submission such as a phone call. Grievances can be reported and submitted to BAAS by:

- Email- Attach BAAS Form 3123, a written statement or providing a statement in the email, to BAASQualityManagement@dhhs.nh.gov ;
- Mailing the grievance through U.S.P.S. using BAAS Form 3123 or providing a written statement to:
**Bureau of Adult and Aging Services
Attn: Quality Coordinator
105 Pleasant Street, Concord, NH 03301;**
- Verbalizing the grievance by telephone to **603-271-2240**; or
By faxing the grievance using BAAS Form 3123 or a written statement to **603-271-4643**, Attn: Quality Coordinator.

Reporting Abuse

To report suspected abuse, neglect, self-neglect or exploitation (including financial exploitation) of a vulnerable adult or want to report a grievance on Adult Protection:

Contact BAAS Adult Protection Central Intake Unit:
1-800-949-0470 or 603-271-7014
Email: APSCentrallntake@dhhs.nh.gov

If you have a question or concern regarding a resident of a licensed long-term care facility or what to report a grievance:

Contact the Long-Term Care Ombudsman:
1-800-442-5640 or 603-271-4375
Email: OLTCO@dhhs.nh.gov

If You Have Any Questions... Please contact 1-844-ASK-DHHS (1-844-275-3447) or your local DHHS District Office below.

DEPARTMENT OF HEALTH AND HUMAN SERVICES DISTRICT OFFICES

BERLIN 650 Main St. Ste. 200 Berlin, NH 03570 603-752-7800 or 800-972-6111 Berlin.dcs@dhhs.nh.gov	LITTLETON 80 North Littleton Rd. Littleton, NH 03561 603-444-6786 or 800-552-8959 Littleton.dcs@dhhs.nh.gov
CLAREMONT Physical: 404 Washington St. Claremont, NH 03743 Mailing: 136 Maple Avenue, Suite 100, Claremont, NH 03743 603-542-9544 or 800-982-1001 Claremont.dcs@dhhs.nh.gov	MAIN Centralized Scanning Unit PO Box 181 Concord NH 03301 844-275-3447 or 603-271-9700 Maindo.dcs.@dhhs.nh.gov
CONCORD 40 Terrill Park Dr. Concord, NH 03301 603-271-6200 800-322-9191 Concord.dcs@dhhs.nh.gov	MANCHESTER 1050 Perimeter Rd. Ste 501 Manchester, NH 03103 603-668-2330 or 800-852-7493 Manchester.dcs@dhhs.nh.gov
CONWAY 71 Hobbs St. Conway, NH 03818 603-447-3841 or 800-552-4628 Conway.dcs@dhhs.nh.gov	ROCHESTER 150 Wakefield St. Ste 22 Rochester, NH 03867 603-332-9120 or 800-862-5300 Rochester.dcs@dhhs.nh.gov
KEENE 111 Key Rd. Keene, NH 03431 603-357-3510 or 800-624-9700 Keene.dcs@dhhs.nh.gov	SEACOAST 19 Rye St. Portsmouth, NH 03801 603-433-8300 800-821-0326 Seacoast.dcs@dhhs.nh.gov
LACONIA 65 Beacon St. West Laconia, NH 03246 603-524-4485 or 800-322-2121 Laconia.dcs@dhhs.nh.gov	SOUTHERN 26 Whipple St. Nashua, NH 03060 603-883-7726 or 800-852-0632 Southern.dcs@dhhs.nh.gov

**TDD Access:
Relay NH 1-800-735-2964 or 711**

Bureau of Adult and Aging Services (BAAS)

How BAAS Can Help You And What Are Your Rights ?

Department of Health and Human Services
State Office Park South
Main Building,
105 Pleasant Street
Concord, New Hampshire 03301

www.dhhs.nh.gov

This institution in an equal opportunity provider.

Risk Identification, Mitigation and Planning (RIMP) Tool

See page 12, for additional guidance on completing this form.

Individuals First and Last Name _____

Date of Birth _____

Reasons For Completing BAAS Form 3203 (Check all that Apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Case Review/ Consultation | <input type="checkbox"/> Initial Assessment | <input type="checkbox"/> Risk of Discharge |
| <input type="checkbox"/> Reassessment | <input type="checkbox"/> Redetermination | <input type="checkbox"/> Significant Change in Condition
(Specify): _____ |
| <input type="checkbox"/> Transition to Community | <input type="checkbox"/> APS Investigation | |

Instructions:

Enter information as requested for each of the risk factors. For each risk factor, there is a definition, a check box for indicators of the risk factor, the source(s) from which the information is being provided and the estimated impact. There is also space to enter any options that the assessor believes would prevent or mitigate the identified risk factor. Make sure to check all boxes that apply.

- **When completing the items on Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), if a recent Medical Eligibility Assessment (MEA) has been completed, the assessor may use it as a source of information.**

Risk Factor (1) **PHYSICAL HEALTH STATUS**

Does this section contain newly reported information? Yes No or N/A

Definitions	Indicators of Risk	Source
Ability to manage one's physical health and all medical conditions including upcoming surgeries and, particularly: <ul style="list-style-type: none"> ▪ Chronic Health Conditions: Present or last longer than 3 months. ▪ Acute Care: Active but short-term treatment for a brief but severe episode of illness or conditions resulting from an accident, other trauma or recovery from surgery. 	<input type="checkbox"/> Unaware of and/or does not understand all associated chronic medical condition(s). <input type="checkbox"/> Unable to perform all the tasks necessary to maintain individual health. <input type="checkbox"/> Does not have assistance to manage chronic medical condition(s). <p style="text-align: center;">-AND-</p> <input type="checkbox"/> Unaware of and/or does not understand all associated acute medical condition(s). <input type="checkbox"/> Unable to perform all the tasks necessary to manage acute medical conditions(s) to the extent they are unable to maintain individual health; or <input type="checkbox"/> Does not have assistance to manage acute medical condition(s).	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____
Impact		
<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What options have been presented to prevent or mitigate the identified risk? _____ _____ _____	

Risk Factor (2) MENTAL HEALTH STATUS		
Does this section contain newly reported information? <input type="checkbox"/> Yes <input type="checkbox"/> No or <input type="checkbox"/> N/A		
Definitions	Indicators of Risk	Source
Ability to Manage one's mental health.	<input type="checkbox"/> Currently has a mental health diagnosis. <input type="checkbox"/> Knowledgeable of and does understand mental health diagnosis. <p style="text-align: center;">Complete If Appropriate</p> <input type="checkbox"/> Unable to manage mental health and cope with symptoms. <input type="checkbox"/> Does not seek assistance when appropriate by contacting: <input type="checkbox"/> <i>Primary Care Physician, and/or</i> <input type="checkbox"/> <i>Mental Health Provider, and/or</i> <input type="checkbox"/> <i>Other (Specify): _____</i> <input type="checkbox"/> Person has sought out services, but they are not adequate or available.	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____
Impact		
<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate the identified risk? _____ _____ _____	
Risk Factor (3) FINANCIAL STATUS		
Does this section contain newly reported information? <input type="checkbox"/> Yes <input type="checkbox"/> No or <input type="checkbox"/> N/A		
Definitions	Indicators of Risk	Source
Adequacy of individual's income and assets to meet needs. (<i>Also See Risk Factor #7 and #11</i>)	<input type="checkbox"/> Lack of adequate income to meet needs such as medication, housing, health care, personal care supplies, food and utilities. <input type="checkbox"/> Currently does not have health care benefits such as Medicare, Medicaid, VA, etc. <input type="checkbox"/> At risk of eviction or utility disconnection.	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____
Impact		
<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate identified risk? _____ _____ _____	

Risk Factor (4) ACTIVITIES OF DAILY LIVING (ADL)

Does this section contain newly reported information? Yes No or N/A

Definitions	Indicators of Risk	Source
Ability to perform or seek assistance in maintaining personal care including, grooming, toileting, eating, bathing, dressing, and mobility. <i>(Also See Risk Factor #5 and #6)</i>	Individual indicates they are unable to independently accomplish, seek assistance or is refusing assistance when performing the following task: <i>In the chart below check all that apply.</i>	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____

Activity	Unable To Independently Accomplish	Unable To Seek Help Or Is Refusing
Eating/Feeding Self	<input type="checkbox"/>	<input type="checkbox"/>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>
Hygiene	<input type="checkbox"/>	<input type="checkbox"/>
Continence	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>

Impact	
<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate the identified risk? _____ _____ _____

Has a recent Medical Eligibility Assessment (MEA) been completed? Yes or No

Risk Factor (5) MOBILITY

Does this section contain newly reported information? Yes No or N/A

Definitions	Indicators of Risk	Source
Ability to safely move in and outside the home, including with the use of assistive devices, if applicable.	Difficulty with ability to move (<i>check all that apply</i>): <input type="checkbox"/> Within the home, and/or <input type="checkbox"/> Outside the home -AND- <input type="checkbox"/> Needs assistive device(s) or <input type="checkbox"/> Has the use of assistive device(s) that meet the individual's needs.	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____

Impact	
<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate the identified risk? _____ _____ _____

Risk Factor (6) STABILITY RISK			
Does this section contain newly reported information? <input type="checkbox"/> Yes <input type="checkbox"/> No or <input type="checkbox"/> N/A			
Definitions	Indicators of Risk	Source	
Ability to prevent falls and minimize falls risks. Individual has good balance, strong lower body muscles, clear vision, no significant health conditions impacting mobility, and are not taking medications with side effects like dizziness or drowsiness.	<input type="checkbox"/> Not stable and has fallen <input type="checkbox"/> Fallen with in the past 30 days <i>Enter the specifics regarding falls and injuries in the chart below.</i>	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____	
Risk Factors Regarding Falls and Fall Related Injuries			
<input type="checkbox"/> Has physical mobility problems: <input type="checkbox"/> Lower extremity weakness <input type="checkbox"/> Generalized deconditioning /poor endurance <input type="checkbox"/> Stiffness and rigidity <input type="checkbox"/> Slow reaction time	<input type="checkbox"/> Has problems due to medications: <input type="checkbox"/> Change/decline in cognitive functioning <input type="checkbox"/> Change/decline in physical functioning	<input type="checkbox"/> Has problems due to home safety concerns: <input type="checkbox"/> Obstacles inside home <input type="checkbox"/> Obstacles immediately outside of home	<input type="checkbox"/> Has environmental safety concerns (beyond individual control)
Impact			
<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate the identified risk? _____ _____ _____		
Risk Factor (7) INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL)			
Does this section contain newly reported information? <input type="checkbox"/> Yes <input type="checkbox"/> No or <input type="checkbox"/> N/A			
Definitions	Indicators of Risk	Source	
Ability to perform or seek assistance in performing routine and daily tasks, such as preparing meals, doing laundry, cleaning, managing money, shopping, access to and use of transportation, correspondence, telephoning, obtaining and keeping appointments, socializing and recreation.	Individual indicates they are unable to independently accomplish, seek assistance or is refusing assistance when performing the following task: <i>In the chart below, check all that apply.</i>	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____	
Activity	Unable To Independently Accomplish	Unable To Seek Help Or Is Refusing	
Preparing Meals	<input type="checkbox"/>	<input type="checkbox"/>	
Housework	<input type="checkbox"/>	<input type="checkbox"/>	
Managing Medications	<input type="checkbox"/>	<input type="checkbox"/>	

Managing Finances	<input type="checkbox"/>	<input type="checkbox"/>
Using the Telephone	<input type="checkbox"/>	<input type="checkbox"/>
Finding Resources	<input type="checkbox"/>	<input type="checkbox"/>
Driving or Arranging Transportation	<input type="checkbox"/>	<input type="checkbox"/>

Impact	
<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate the identified risk? _____ _____ _____

Has a recent Medical Eligibility Assessment (MEA) been completed? Yes or No

Risk Factor (8) MEDICATION MANAGEMENT

Does this section contain newly reported information? Yes No or N/A

Definitions	Indicators of Risk	Source
1. Ability to understand what medications have been prescribed and any accompanying directions as side effects. 2. Ability to self-administer all medications or need for assistance with things such as cueing medication, pre-packaging or injection.	<input type="checkbox"/> Takes 5 or more medications. <input type="checkbox"/> Unaware of current medications, including timing, dosage, and side effects. <input type="checkbox"/> Does not understand the purpose for one or more of the medications. <input type="checkbox"/> Unable to take medication as described or seeks assistance. <input type="checkbox"/> No designated individual to supervise medication. <input type="checkbox"/> More than one practitioner prescribing medications.	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____

Impact	
<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate the identified risk? _____ _____ _____

Risk Factor (9) SUBSTANCE USE

Does this section contain newly reported information? Yes No or N/A

Definitions	Indicators of Risk	Source
Use of any prescribed, non-prescribed over the counter substance in a manner other than prescribed, including use in a manner that results or could result in injury or illness. Includes misuse of alcohol.	The individual has (check all that apply): <input type="checkbox"/> Taking non-prescribed drugs. <input type="checkbox"/> Not taking the specific amount prescribed (taking more or less) <input type="checkbox"/> Misuse of alcohol, leading to health or safety concerns, such as combining alcohol and medications. <input type="checkbox"/> Misuse of other substances to the extent that the person's ability to care for self is impaired.	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____

	<input type="checkbox"/> Use of tobacco products to extent health is a concern.	
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Impact	
<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate the identified risk? <hr/> <hr/> <hr/>

Risk Factor (10)	COMMUNICATION
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Does this section contain newly reported information? <input type="checkbox"/> Yes <input type="checkbox"/> No or <input type="checkbox"/> N/A
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Definitions	Indicators of Risk	Source
Ability to make needs and preferences known, whether independently or using assistive devices or interpreters.	The individual (check all that apply): <input type="checkbox"/> Has difficulty communicating with caregivers regarding preferences and needs. <input type="checkbox"/> <i>Does not</i> have use of an assistive device that would aid in meeting individual communication needs. <input type="checkbox"/> Needs an interpreter. <input type="checkbox"/> Does not have a family member or friend to assist in making needs and preferences known.	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____

Impact	
<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate the identified risk? <hr/> <hr/> <hr/>

Risk Factor (11)	LIVING ARRANGEMENT
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Does this section contain newly reported information? <input type="checkbox"/> Yes <input type="checkbox"/> No or <input type="checkbox"/> N/A
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Definitions	Indicators of Risk	Source
1. Location (address) where the person lives and type of living arrangement such as in own home/apartment, residential care/assisted living or with friend/family. 2. Individual the person lives and the relationship.	Individuals Living Arrangement: <input type="checkbox"/> Homeless. <input type="checkbox"/> Not safe or safety is threatened; <input type="checkbox"/> Safety threat is preventing individual from leaving unsafe environment. <input type="checkbox"/> Has violence in the home, including domestic, family or other.	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____

Living Arrangement is hazardous due to environmental conditions observed by case manager ?		
<input type="checkbox"/> Yes (Check all that apply below) or <input type="checkbox"/> NO		
<input type="checkbox"/> Broken/missing windows or doors <input type="checkbox"/> Blocked doorways <input type="checkbox"/> Roof and/or flooring not intact	<input type="checkbox"/> Excessive Garbage <input type="checkbox"/> Debris that blocks access or egress <input type="checkbox"/> Downed Power Line	<input type="checkbox"/> Gas/Oil Leaks <input type="checkbox"/> Infestation of rodents/insects <input type="checkbox"/> Diseased, aggressive or neglected animals

<input type="checkbox"/> Exposed wiring	<input type="checkbox"/> Flooding	<input type="checkbox"/> Other (Specify): _____
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Impact	
<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate the identified risk? _____ _____ _____

Risk Factor (12)	ABUSE/NEGLECT/EXPLOITATION/SELF-NEGLECT
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Does this section contain newly reported information? <input type="checkbox"/> Yes <input type="checkbox"/> No or <input type="checkbox"/> N/A
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Definitions	Indicators of Risk	Source
Individual has the ability to identify abuse, exploitation and neglect/self-neglect.	With in past 30 days individual has experience the following (check all that apply): <input type="checkbox"/> Abuse: Emotional, Physical and/or Sexual; <input type="checkbox"/> Exploitation. <input type="checkbox"/> Neglect. <input type="checkbox"/> Self-Neglect. <input type="checkbox"/> A report was given to Adult Protective Services, within past 30 days.	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____

Impact	
<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate the identified risk? _____ _____ _____

Risk Factor (13)	CONTINGENCY PLAN: BACK-UP SERVICES
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Does this section contain newly reported information? <input type="checkbox"/> Yes <input type="checkbox"/> No or <input type="checkbox"/> N/A
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Definitions	Indicators of Risk	Source
Alternative arrangement made when designated providers are unavailable (a.k.a. 'back up plan')	<input type="checkbox"/> No current plan with identified back-up provider(s) to provide services when designated provider(s) are unavailable.	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____

Impact	
<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate the identified risk? _____ _____ _____

Risk Factor (14) CONTINGENCY PLAN: EMERGENCY		
Does this section contain newly reported information? <input type="checkbox"/> Yes <input type="checkbox"/> No or <input type="checkbox"/> N/A		
Definitions	Indicators of Risk	Source
Alternative living arrangements are made due to emergency weather conditions or other environmental concerns, such as power outage.	<input type="checkbox"/> No current plan for alternative living arrangement due to inclement weather or other environmental concern(s).	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____
Impact		
<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate the identified risk? _____ _____ _____	
Risk Factor (15) SOCIAL SUPPORTS		
Does this section contain newly reported information? <input type="checkbox"/> Yes <input type="checkbox"/> No or <input type="checkbox"/> N/A		
Definitions	Indicators of Risk	Source
Individual has a network of people and resources available to assist with social engagement.	<input type="checkbox"/> No available friend/relative to socially engage in conversation with, whether by phone, in person, computer, etc. <input type="checkbox"/> No friends/relatives available to socially interact with for social activities and/or outings.	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____
Impact		
<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate the identified risk? _____ _____ _____	
Risk Factor (16) QUALITY OF LIFE		
Does this section contain newly reported information? <input type="checkbox"/> Yes <input type="checkbox"/> No or <input type="checkbox"/> N/A		
Definitions	Indicators of Risk	Source
The extent to which an individual's life is consistent with preferences (self-report).	Individual is not satisfied with: <input type="checkbox"/> Current or soon to be living arrangement. <input type="checkbox"/> Plan for care: <input type="checkbox"/> Access to and quality of services. <input type="checkbox"/> Choice regarding services. <input type="checkbox"/> Ability to do things in the community.	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____

	<input type="checkbox"/> Other (Specify): _____ <input type="checkbox"/> Level of respect and dignity by caregivers/providers.	
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Impact

<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate the identified risk? _____ _____ _____
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Risk Factor (17) LEGAL

Does this section contain newly reported information? Yes No or N/A

Definitions	Indicators of Risk	Source
Ability to manage one's affairs including but not limited to financial and/or medical.	Unable to manage the following Legal Affairs: <input type="checkbox"/> Financial <input type="checkbox"/> Medical Care Individual indicated they have a: <input type="checkbox"/> Guardian over individual <input type="checkbox"/> Guardian over estate <input type="checkbox"/> Durable power of attorney <input type="checkbox"/> Other (Specify): _____ <input type="checkbox"/> None of the above	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____

Impact

<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate the identified risk? _____ _____ _____
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Risk Factor (18) INFORMED DECISION-MAKING ABILITY/COGNITIVE STATUS

Does this section contain newly reported information? Yes No or N/A

Definitions	Indicators of Risk	Source
1. Individual is able to make informed decisions; and 2. The individual is able to make a choice after gathering relevant information, considering values and preferences, and analyzing potential outcomes.	<input type="checkbox"/> Individual did not understand one or more questions asked in Risk Factors # 1 thru # 17. <input type="checkbox"/> Individual provided an inappropriate response to one of more questions asked in Risk Factors # 1 thru # 17. <input type="checkbox"/> Individual has problems with: <input type="checkbox"/> Thinking <input type="checkbox"/> Memory <input type="checkbox"/> Judgement	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____

Impact	
<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate the identified risk? _____ _____ _____

Risk Factor (19) OTHER

Does this section contain newly reported information? Yes No or N/A

Definitions	Indicators of Risk	Source
_____ _____ _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Individual <input type="checkbox"/> Legal Representative/Guardian <input type="checkbox"/> Observation by Person Completing form <input type="checkbox"/> Review of Documentation <input type="checkbox"/> Other (Specify): _____

Impact	
<input type="checkbox"/> No Current Indicators <input type="checkbox"/> Likely Harmful to Health and Welfare <input type="checkbox"/> Immediate Risk to Health and Welfare <input type="checkbox"/> Unanticipated Death or Permanent Loss of Function	What are the options to prevent or mitigate the identified risk? _____ _____ _____

RISK FACTORS IDENTIFIED

Check all that apply from the sections above that had Risk Factors Identified
 ‘*’ Shown below indicates these are Required components of a comprehensive assessment pursuant to He-E 805

1. <input type="checkbox"/> Physical Health Status*	11. <input type="checkbox"/> Living Arrangements*
2. <input type="checkbox"/> Mental Health Status*	12. <input type="checkbox"/> Abuse/Neglect/Exploitation /Self Neglect*
3. <input type="checkbox"/> Financial Status*	13. <input type="checkbox"/> Contingency Plan: Back Up Services
4. <input type="checkbox"/> Activities of Daily Living (ADL) *	14. <input type="checkbox"/> Contingency Plan: Emergency
5. <input type="checkbox"/> Mobility*	15. <input type="checkbox"/> Social Supports*
6. <input type="checkbox"/> Stability/Risk of Falling*	16. <input type="checkbox"/> Quality of Life
7. <input type="checkbox"/> Instrumental Activities of Daily Living (IADL) *	17. <input type="checkbox"/> Legal*
8. <input type="checkbox"/> Medication Management*	18. <input type="checkbox"/> Informed Decision-Making Ability/Cognitive Status*
9. <input type="checkbox"/> Substance Use (Drug/Alcohol) *	19. <input type="checkbox"/> Risk of Discharge
10. <input type="checkbox"/> Communication	20. <input type="checkbox"/> Other (Specify): _____

RISK MANAGEMENT STRATEGIES AND PLANNING - (Attach additional pages as needed)

1. Consider the indicators identified for each risk factor
2. Identify the options chosen to prevent or mitigate the identified risk factor
3. Identify who is responsible for arranging for the additional support(s)/services(s)

Risk Factor #	Plan To Prevent/Mitigate Risk	Responsible Party for Arranging/Maintaining Supports

SUMMARY- (Optional)

If BAAS Form 3203 is being completed due to case review/consultation, provide a summary/description of the individual

SIGNATURES

Signatures indicate involvement in the Risk Management, Mitigation Strategies, Planning Process. Including comprehension of the risks identified and the available options discussed to manage the risk.

Participants SignaturePrinted NameDate Signed

Guardian/Representative SignaturePrinted NameDate Signed

Relationship To Individual: _____

Signature of Person Completing AssessmentPrinted NameDate Signed

Agency: _____ Position: _____

Guide To Completing This Form

When BAAS Form 3203 is being completed for the ***first time***, the assessor enters all the information specified. When a ***revision*** is required, the assessor will complete ***a new*** form and answer **yes** or **no** in each section if it contains newly reported information or change(s) in status for individual.

Reason For Completing This Form?

Case Review/Consultation: The individual is a recipient of services under a BAAS program, and the case is being presented to the BAAS Case Review and Consultation Committee (CRCC) because there is substantial risk to health and/or safety, and this cannot be resolved within the scope of customary policies and procedures.

Initial Assessment: The person:

- Is identified as an alleged victim during an Adult Protection Program investigation and has received a score on the SDM Risk Assessment indicating moderate or high risk; or
- Is a new or current Choices for Independence (CFI) participant who is transitioning from an institutional setting to a CFI community-based setting, or
- Is living in the community and is newly approved to receive other long-term services and supports.

Reassessment: If the individual is a recipient of the Division of Long Term Supports and Services (DLTSS) and has been receiving services for at least one year, a new form 3203 must be completed as part of an annual reassessment.

Redetermination: The individual is a recipient of CFI Program service, is due for the annual redetermination required by the CFI Program, a new Form 3203 must be completed as part of an annual reassessment.

Transition to Community: The individual has been determined eligible to participate in the CFI program or has been designated as an eligible referral for the Money Follows the Program (MFP).

Significant Change in Condition: The individual is a participant in the CFI Program, and the CMA has determined that there has been a significant change in condition.

- Significant Change in Condition" means a substantial modification in a participant's physical, mental, emotional, cognitive or functional status that requires documentation of deterioration or improvement.

Signatures: If the recipient refuses to sign Form 3203, the assessor shall note this in the signature space for the recipient .

Please return the completed BAAS Form 3203, *Risk Identification, Mitigation and Planning tool* and BAS Form 3204, *Case Review Consultation Committee Referral* to:
CRCC@dhhs.nh.gov

Case Review and Consultation Committee (CRCC) 'Referral'

Name of Referring Agency : _____
Name of Representative Completing This Form: _____
Referring Party's Supervisor: _____
Referring Party's Administrator (if applicable): _____
Date Submitted: _____

Service Recipient Profile

Last Name: _____ First Name: _____ Middle Initial: _____
Address, City, State, Zip: _____
Date of Birth: _____ Age: _____
Date Services Opened: _____ Medicaid ID (MID) #: _____

Living Arrangement (check one)

Own Home Relatives Home Assisted Living Nursing Facility Other: _____

Legal Representative

Activated DPOA Guardian Authorized Representative N/A Other: _____

Family and Friends Involvement

Using the space below indicate the tasks performed by friends and family members for the recipient. List as much detail as possible, such as frequency if applicable.

Diagnosis

Using the space below indicate the diagnosis(es), including physical/mental health and developmental disabilities.

The above diagnosis information was provided by: A Medical Practitioner or Recipient's Statement

Program Area(s) Providing Services To The Recipient

- Adult Protective Services Community-based services (other than CFI) Long Term Care (LTC) / Choices For Independence (CFI)/MCO/Fee For Service

Please indicate below, the types of services being provided

Other Providers Delivering Services To The Service Recipient (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Bureau of Mental Health (BMH)- Identify CMHC: _____
<input type="checkbox"/> Bureau of Adult and Aging Services (BAAS)-Identify CMA: _____
<input type="checkbox"/> Bureau of Drug and Alcohol Services (BDAS)- Identifying Provider(s): _____
<input type="checkbox"/> Bureau of Developmental Services (BDS)-Identify Area Agency: _____ | <input type="checkbox"/> Bureau of Homeless Services (BHS)-Identify Shelter: _____
<input type="checkbox"/> Glenclyff -Date of Admission: _____
<input type="checkbox"/> New Hampshire Hospital (NHH)- Date of Admission: _____
<input type="checkbox"/> Other (Specify): _____ |
|--|--|

Presenting Issue / Problem

Using the space below describe the issue or problem, which causes the recipient to be at risk.

Efforts Made To Resolve Presenting Issue / Problem

- Case conference or team meetings: _____
 Hospital or NF discharge planning meetings(s): _____
 Elder Wrap: Specify date(s) and participants: _____
 None of the above (Specify): _____

Using the space below add any comments or additional information, add as much detail as possible:

Recommendations And Outcomes From Efforts Listed Above

List any recommendations, barriers to implementation or actions taken from above information.

Individual's Goals And Barriers To Achieve Goals

In the space below indicate the individual's goals and what the barriers are, if any.

Risk Identification, Mitigation and Planning Tool

BAAS Form 3203 or a comparable tool.

Attached? Yes or No Date Completed or Revised? (Must be within 30 days) _____

IMPORTANT: Community resources must be exhausted prior to referring a case to the CRCC. Referrals made without exhausting available community resources will be rejected.

Community Providers Contacted

Which providers did you contact to request needed services? (Attach additional pages if needed)

Provider Name	Reason services were declined (if applicable)	Date provider was contacted
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please return the completed BAAS Form 3203, *Risk Identification, Mitigation and Planning tool* and BAAS Form 3204, *Case Review Consultation Committee Referral* to:
CRCC@dhhs.nh.gov

FOR BAAS CRCC SUBCOMMITTEE USE ONLY

DO NOT Schedule CRCC meeting at this time. **Comments:** _____

Schedule CRCC meeting:
Date: _____
Time: _____ AM or PM

Enter Names of Invitees: _____

Schedule IIT meeting:
Date: _____
Time: _____ AM or PM

Enter Names of Invitees: _____

Schedule Technical Assistance:
Date: _____
Time: _____ AM or PM

Enter Names of Invitees: _____

Case has been referred to (name of agency) : _____

Date of referral to another agency: _____

CRCC recommendation(s) are recorded on BAAS Form 3205 and distributed to CRCC meeting attendees.

Case Review and Consultation Committee (CRCC) 'Recommendations'

Service Recipient Profile

Last Name: _____ First Name: _____ Middle Initial: _____
 Date of Birth: _____ Age: _____
 Date of CRCC Referral: _____ MID # _____

FOR BAAS CRCC SUB-COMMITTEE USE ONLY

DO NOT Schedule CRCC meeting at this time. **Comments:** _____

<input type="checkbox"/> Schedule CRCC meeting: Date: _____ Time: _____ <input type="checkbox"/> AM or <input type="checkbox"/> PM	Enter Names of Invitees: _____ _____ _____
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Action Plan:

Identify the recommendation(s), any responsible agency/individual and timeline for each.

Recommendations(s)	Responsible Agency/Individual	Timeline	Status