STATE OF HAWAII
Service Plan

Member Name ________________________________ **Member ID #** ______________________ **Service Plan Date** ____________
Service Coordinator Name ____ Phone Number _________________________
Authorized Representative Name ____ Phone Number _________________________
[ ] Child with Special Healthcare Needs (CSHCN) [ ] Adult with Special Healthcare Needs (ASHCN)
[ ] Home and Community Based Services (HCBS) [ ] Nursing Facility (NF) [ ] At Risk

SECTION A. AUTHORIZED SIGNATURES	
I authorize the attached Service Plan.	
A1. MEMBER/AUTHORIZED REPRESENTATIVE	**DATE**
	/ /
	/ /
	/ /
A2. SERVICE COORDINATOR/TITLE	**DATE**
	/ /
	/ /
	/ /
A3. SENT TO PHYSICIAN (For information/review/comment, Annual and as necessary)	**DATE**
	/ /
	/ /
	/ /
A4. NON AGENCY CAREGIVERS (If applicable)	**DATE**
	/ /
	/ /
	/ /

SECTION B. SPECIAL INFORMATION

☐ Advance Directives Copy Attached to Service Plan Yes ☐ No ☐
☐ Physician Orders for Life-Sustaining Treatment (POLST) Location :_______________________
☐ Infection Control Guidelines Copy Attached to Service Plan Yes ☐ No ☐
☐ Disaster Preparedness Form Copy Attached to Service Plan Yes ☐ No ☐
☐ Individualized Emergency Back Up Plan Copy Attached to Service Plan Yes ☐ No ☐
☐ Call 911 for Emergencies
☐ CPR ☐ No CPR ☐ Comfort Care Only (CCO)
☐ Allergies: _____________________________ Other: _____________________________

SECTION C. DISEASE DIAGNOSIS(ES)

Disease Diagnosis(es)	ICD Code	Date of Onset
		/ /
		/ /
		/ /

SECTION D. PHYSICIAN(S) AND PROVIDER(S)

Physician(s)/Provider(s) Name	Specialty	Address	Phone Number	Fax Number

Preferred Hospital:

SECTION E. MEDICATIONS

Medication Name	Indication	Dose	Route	Frequency	Prescribing Physician/Provider	Compliant	Comments
						☐ Yes ☐ No	
						☐ Yes ☐ No	
						☐ Yes ☐ No	

Pharmacy: Address: Phone:
Delivered: Yes ☐ No ☐ Mailed: Yes ☐ No ☐ Frequency:

STATE OF HAWAII
Service Plan

Member Name ________________________________ **Member ID #** _____________________ **Service Plan Date** ____________
Service Coordinator Name ____ Phone Number _________________________
Authorized Representative Name _______________________________________ Phone Number _________________________
[ ] Child with Special Healthcare Needs (CSHCN) [ ] Adult with Special Healthcare Needs (ASHCN)
[ ] Home and Community Based Services (HCBS) [ ] Nursing Facility (NF) [ ] At Risk

SECTION F. MEDICAL EQUIPMENT AND SUPPLIES				
Medical Equipment and Supplies	**Vendor/Phone Number**	**Amount**	**Frequency**	**Comments**

SECTION G. PROBLEMS AND GOALS						
Problem # _____:			Date Identified: / /		Date Resolved: / /	
Problem Statement:						
Goal:						
Priority	**Intervention**	**Barrier**	**Person(s) Responsible**	**Target Date**	**Review Date**	**Resolved Date**
				/ /	/ /	/ /
				/ /	/ /	/ /
				/ /	/ /	/ /
				/ /	/ /	/ /
				/ /	/ /	/ /
Problem # _____:			Date Identified: / /		Date Resolved: / /	
Problem Statement:						
Goal:						
Priority	**Intervention**	**Barrier**	**Person(s) Responsible**	**Target Date**	**Review Date**	**Resolved Date**
				/ /	/ /	/ /
				/ /	/ /	/ /
				/ /	/ /	/ /
				/ /	/ /	/ /
				/ /	/ /	/ /

SECTION H. INTERVENTIONS				
*Check appropriate service and complete information. Complete the Personal Assistance/Nursing Task section as indicated**				
H1. AT RISK SERVICE				
SERVICES **DHS 1147/1147e Functional Points _____**	**START DATE**	**PROVIDER(S)**	**FREQUENCY**	**END DATE**
☐ Adult Day Care (ADC)				
☐ Adult Day Health (ADH)				
☐ Home Delivered Meals				
☐ Personal Emergency Response Systems (PERS)				
☐ Personal Assistance Level I (PA1 Chore)* ☐ Agency ☐ CDPA				
☐ Personal Assistance Level II (PA2 Personal Care)* ☐ Agency ☐ CDPA				
☐ Personal Assistance Level II (PA2 Delegated)* ☐ Agency ☐ CDPA				
☐ Skilled (or private duty) Nursing*				

STATE OF HAWAII
Service Plan

Member Name _______________________________ **Member ID #** _____________________ **Service Plan Date** ____________
Service Coordinator Name ____ Phone Number _________________________
Authorized Representative Name ______________________________________ Phone Number _________________________
[ ] Child with Special Healthcare Needs (CSHCN) [ ] Adult with Special Healthcare Needs (ASHCN)
[ ] Home and Community Based Services (HCBS) [ ] Nursing Facility (NF) [ ] At Risk

H1. AT RISK SERVICE (cont.)				
SERVICES	**START DATE**	**PROVIDER(S)**	**FREQUENCY**	**END DATE**
☐ Other				
H2. HCBS SERVICES				
SERVICES **DHS 1147/1147e Level _____ Expiration Date _____**	**START DATE**	**PROVIDER(S)**	**FREQUENCY**	**END DATE**
☐ Service Coordination (SC)		RN SW		
☐ Adult Day Care (ADC)				
☐ Adult Day Health (ADH)				
☐ Assisted Living Facility (ALF)				
☐ Community Care Management Agency (CCMA)		RN SW		
☐ Counseling and Training ☐ Nutrition ☐ Coping/Support ☐ Crisis Intervention ☐ Family Training ☐ Caregiver Training ☐ Non Agency Caregiver Training ☐ Other				
☐ Environmental Accessibility Adaptations (EAA)				
☐ Home Delivered Meals				
☐ Home Maintenance				
☐ Moving Assistance				
☐ Non-Medical Transportation				
☐ Personal Assistance Level I (PA1 Chore)* ☐ Agency ☐ CDPA				
☐ Personal Assistance Level II (PA2 Personal Care)* ☐ Agency ☐ CDPA				
☐ Personal Assistance Level II (PA2 Delegated)* ☐ Agency ☐ CDPA				
☐ Skilled (or private duty) Nursing*				
☐ Personal Emergency Response Systems (PERS) ☐ Basic Reassurance ☐ Enhanced Reassurance/Calls				
☐ Residential Care ☐ Expanded Adult Residential Care Home (E-ARCH) ☐ Community Care Foster Family Home (CCFFH)				
☐ Respite ☐ In-home ☐ Hourly ☐ Overnight ☐ Community based ☐ Hourly ☐ Overnight ☐ Institutional ☐ Hourly ☐ Overnight				
☐ Other _____				

STATE OF HAWAII
Service Plan

Member Name ________________________________ **Member ID #** _____________________ **Service Plan Date** ____________
Service Coordinator Name ____ Phone Number _________________________
Authorized Representative Name _______________________________________ Phone Number _________________________
[ ] Child with Special Healthcare Needs (CSHCN) [ ] Adult with Special Healthcare Needs (ASHCN)
[ ] Home and Community Based Services (HCBS) [ ] Nursing Facility (NF) [ ] At Risk

H2. HCBS SERVICES continued				
SERVICES	**START DATE**	**PROVIDER(S)**	**FREQUENCY**	**END DATE**
☐ Specialized Medical Equipment/Supplies (SMES)				
☐ Other ______				

H3. INSTITUTIONAL SERVICES *(Complete if pending discharge)*

TYPE OF FACILITY **DHS 1147/1147e Level** _____ **Expiration Date** _____	**START DATE**
☐ ICF/ID Facility Name: __________ Name of Contact Phone: __________	
☐ Nursing Facility Facility Name: ___________ Name of Contact: _____________________ Phone: __________	
☐ Hospital Facility Name: ___________ Name of Contact: _____________________ Phone: __________	
☐ Discharge Planning Pre-Discharge Assessment Date: _______________ Anticipated Discharge Date: _______________ Discharge Location: Anticipated Discharge Planning Meeting Date: _______________ Discharge Date: _______________	
☐ Other	

H4. ADDITIONAL SERVICES				
SERVICES	**START DATE**	**PROVIDER(S)**	**FREQUENCY**	**END DATE**
☐ Dental				
☐ Home Health Agency ☐ HHA* ☐ LPN* ☐ RN* ☐ OT ☐ PT ☐ Speech				
☐ Hospice				
☐ Transportation, Medical				
☐ Department of Education (DOE) School Based Services ☐ Home Schooling ☐ Skilled Nursing ☐ Behavioral Health ☐ Speech ☐ OT ☐ PT ☐ Special Education				
☐ Department of Health (DOH) ☐ Early intervention (0-3) ☐ OT ☐ PT ☐ Speech ☐ Skilled Nursing ☐ PHN ☐ Audiology ☐ Healthy Start ☐ DD/ID Waiver ☐ WIC ☐ CAMHD ☐ AMHD (Legally Encumbered) ☐ ADAD ☐ Other				
☐ Department of Human Services (DHS) ☐ CWS ☐ APS ☐ Foster care ☐ LIHEAP ☐ SNAP ☐ VOC Rehab ☐ Financial Assistance ☐ Other				
☐ Community Care Services (CCS)				
☐ HIV/AIDS Services				
☐ Congregate Meals				
☐ Housing Assistance				

STATE OF HAWAII
Service Plan

Member Name ________________________________ **Member ID #** _____________________ **Service Plan Date** ____________
Service Coordinator Name ____ Phone Number _________________________
Authorized Representative Name _______________________________________ Phone Number _________________________
[ ] Child with Special Healthcare Needs (CSHCN) [ ] Adult with Special Healthcare Needs (ASHCN)
[ ] Home and Community Based Services (HCBS) [ ] Nursing Facility (NF) [ ] At Risk

H4. ADDITIONAL SERVICES (cont)				
SERVICES	**START DATE**	**PROVIDER(S)**	**FREQUENCY**	**END DATE**
☐ Disabled Parking Permit				
☐ Homeless Shelter				
☐ Legal Assistance ☐ Guardianship				
☐ Volunteer ☐ Companion				
☐ Transportation, Non-Medical				
☐ Other State Agencies				
☐ Other Services				

SECTION I. PERSONAL ASSISTANCE/NURSING TASKS *(Select all that apply)*
*Include Frequency & Specific Instructions *Skilled Nursing RN/LPN only*

I1. VITAL SIGNS	**Frequency**	**Special Instructions**
☐ Temperature		
☐ Pulse		
☐ Respiration		
☐ Blood Pressure		
☐ Oxygen Saturation		
☐ Height and Weight		
Other:		
I2. PERSONAL ASSISTANCE LEVEL I (PA1 Chore)	**Frequency**	**Special Instructions**
☐ Routine House Cleaning ☐ Bathroom ☐ Kitchen ☐ Bedroom ☐ Changing linen ☐ Make bed ☐ Empty Trash		
☐ Laundry		
☐ Shopping and Errands		
☐ Attendant services		
☐ Meal preparation		
Other:		
I3. PERSONAL ASSISTANCE LEVEL 2 (PA 2 Personal Care)	**Frequency**	**Special Instructions**
☐ Bathing ☐ Bed ☐ Shower ☐ Shampoo		
☐ Dressing		
☐ Grooming ☐ Oral care ☐ Shave		
☐ Hair and Skin care ☐ Brush ☐ Comb ☐ Nail Care ☐ Foot Care		
☐ Toileting (do not include transfer and ambulation)		
☐ Transfers and Ambulation		
☐ Eating/Feeding		☐ Prepare/Serve Meals ☐ Assist/Feed meals ☐ Record Intake
☐ Medication Assistance		☐ Remind ☐ Assist
Other:		
I4. PERSONAL ASSISTANCE LEVEL 2 (PA 2 Delegated)	**Frequency**	**Special Instructions**
☐ Task: _______________		

STATE OF HAWAII
Service Plan

Member Name ________________________________ Member ID # ______________________ Service Plan Date ____________
Service Coordinator Name ____ Phone Number __________________________
Authorized Representative Name ____ Phone Number __________________________
[ ] Child with Special Healthcare Needs (CSHCN) [ ] Adult with Special Healthcare Needs (ASHCN)
[ ] Home and Community Based Services (HCBS) [ ] Nursing Facility (NF) [ ] At Risk

☐ Task: _______________		
I5. MEALS/FEEDING	**Frequency**	**Special Instructions**
☐ Record Feeding Intake		
☐ Tube Feeding*		Feeding Orders:
☐ G Tube care		
☐ Monitor skin condition for adequate hydration		
Other:		
I6. CARDIO/RESPIRATORY CARE	**Frequency**	**Special Instructions**
☐ Oxygen*		Oxygen Orders:
☐ Oral Suctioning		
☐ Suctioning*		Every ___ hours or as needed to maintain clear airway
☐ Nebulizer/Aerosol Treatments: *		
☐ Humidifier		
☐ Apnea Monitor		
☐ Pulse Oximeter		
☐ Tracheostomy Care*		
☐ Ventilator Type		FIO2__%, VT___, Peep__, Rate___, PS__ ☐ Check ventilator settings every shift
☐ O2 concentrator		____L/min
☐ Resuscitator/Ambu bag on hand		
☐ Chest physiotherapy		
☐ Cough stimulator		
☐ See manuals/information provided by equipment vendors For specific instructions about respiratory equipment		
Other:		
I7. WOUND CARE	**Frequency**	**Special Instructions**
☐ Decubitus Care ☐ Dressing ☐ Clean ☐ Sterile*		
Other:		
I8. MEDICATIONS	**Frequency**	**Special instructions**
☐ Administer as ordered by physician*		
☐ Update medication list		
☐ All caregivers to know medication, purpose, effects and side effects		
☐ Blood glucose monitoring		
Other:		
I9. BOWEL AND BLADDER ELIMINATION	**Frequency**	**Special Instructions**
☐ Brief/Diaper Change		☐ Check site and skin daily
☐ Bedpan ☐ Urinal ☐ Commode		
☐ Toilet		
☐ Catheter* ☐ Catheter Care ☐ Catheter Irrigation* ☐ Condom care		☐ Empty Drainage Bag ☐ Record Output ☐ Drain bag: Empty ½ full or more often
☐ Check for bowel movement (BM)		
☐ Digital Stimulation ☐ Suppository		
☐ Enema ☐ Fleet *		
Other:		

STATE OF HAWAII
Service Plan

Member Name ________________________________ **Member ID #** _____________________ **Service Plan Date** ____________
Service Coordinator Name ____ Phone Number _________________________
Authorized Representative Name _______________________________________ Phone Number _________________________
[ ] Child with Special Healthcare Needs (CSHCN) [ ] Adult with Special Healthcare Needs (ASHCN)
[ ] Home and Community Based Services (HCBS) [ ] Nursing Facility (NF) [ ] At Risk

I10. MOBILITY	**Frequency**	**Special Instructions**
☐ Turning and Repositioning:		
☐ Transfers		
☐ Chair		
☐ Manual Wheelchair		
☐ Front Wheeled Walker (FWW)		
☐ Patient Lift		
☐ Walk		
☐ Exercise		
☐ Safety Belt		
☐ Side Rails		
Other:		

SECTION J. DISEASE MANAGEMENT/EDUCATION

Focus	**Learning Needs**	**Referral To**	**Date of Referral**	**Frequency**	**Date (s) Conducted**	**End Date**	**Comments**
Asthma							
Diabetes							
Other:							

SECTION K. REFERRALS

Service/Specialty	**Reason for Referral**	**Point of Contact/Provider**	**Date of Referral**	**Person Responsible**	**Date Completed**	**Comments**

SECTION L. TEAM MEMBER RESPONSIBILITES TO ACCOMPLISH GOALS

L1. PHYSICIAN MONITORING

Name: **Phone:** **Fax:**

☐ Review Service Plan
☐ Coordinate overall medical care of member
☐ Perform Health and Physical Exam as needed
☐ Provide requested medical information, complete and return forms
☐ Complete Annual DHS 1147/1147e
☐ Other

L2. SERVICE COORDINATOR

Name: ☐ **SW** ☐ **RN** **Phone:** **Fax:**

☐ Implement the Service Plan and coordinate services of the member with Physician(s) and other providers
☐ Review and update Service Plan every ______ month(s), if not occurred earlier due to the occurrence of a significant event
☐ Review current medications during each home visit
☐ Monitor the member and the primary caregiver status through
  ☐ Home Visits every _____ month(s) and as needed
  ☐ Phone Contacts every ____ and as needed
☐ Monitor the member within 48 hours after or next business day: hospitalization, acute medical or emotional crisis, adverse event report
☐ Monitor operating status of smoke alarm at every home visit
☐ Identify fire hazard(s) and establish Fire Safety Plan
☐ Provide referrals or resources to members and caregivers as needed
☐ Teach/provide health information based on participant needs
☐ Assist with ordering equipment and supplies
☐ Assure that all backup caregivers have been trained & are signed off by health professional i.e., PT, OT, RN, etc.
☐ Complete Annual DHS 1147/1147e

STATE OF HAWAII
Service Plan

Member Name ________________________________ **Member ID #** _____________________ **Service Plan Date** ____________
Service Coordinator Name ____ Phone Number ________________________
Authorized Representative Name ______________________________________ Phone Number ________________________
[ ] Child with Special Healthcare Needs (CSHCN) [ ] Adult with Special Healthcare Needs (ASHCN)
[ ] Home and Community Based Services (HCBS) [ ] Nursing Facility (NF) [ ] At Risk

☐ Other

L3. CONSULTING SERVICE COODINATOR *(If applicable)*

Name: ☐ **SW** ☐ **RN** **Phone:** **Fax:**

☐ Implement the Service Plan and coordinate services of the member with Physician(s) and other providers
☐ Review and update Service Plan every ______ month(s), if not occurred earlier due to the occurrence of a significant event
☐ Review current medications during each home visit
☐ Monitor the member and the primary caregiver status through
 ☐ Home Visits every _____ month(s) and as needed
 ☐ Phone Contacts every ____ and as needed
☐ Monitor the member within 48 hours after or next business day: hospitalization, acute medical or emotional crisis, adverse event report
☐ Monitor operating status of smoke alarm at every home visit
☐ Identify fire hazard(s) and establish Fire Safety Plan
☐ Provide referrals or resources to members and caregivers as needed
☐ Teach/provide health information based on participant needs
☐ Assist with ordering equipment and supplies
☐ Complete Annual DHS 1147/1147e
☐ Assure that all backup caregivers have been trained & are signed off by health professional i.e., PT, OT, RN, etc.
☐ Other

L4. PRIMARY CAREGIVER (PC) AND MEMBER (M)

PC M
☐ ☐ Responsible for members care and safety when paid personnel are not present.
☐ ☐ Maintain operating smoke alarm at all times.
☐ ☐ Maintain operating telephone.
☐ ☐ Maintain a clear pathway from member’s bed to the closest exit.
☐ ☐ Report all hospitalizations, health problems, injuries, falls, skin breakdown or other health problems to SC within 24 hrs.
☐ ☐ Report worker "no show" or problems with assigned worker to the Home Health/Care Agency, then to the SC.
☐ ☐ Report 2 hours in advance to Home Health/Care agency when canceling services.
☐ ☐ Use 24 hour emergency number 911 for all emergencies.
☐ ☐ Assure that all backup caregivers have been trained & are signed off by health professional i.e., PT, OT, RN, etc.
☐ ☐ Self-Management Plan : __________________-
☐ Other

L5. ALL CAREGIVERS

☐ Report any significant medical and/or social changes to the SC and/or doctor.
☐ Notify SC of any difficulty with equipment supplies
☐ Maintain a clean environment and prevent the spread of disease with frequent hand washing. Use INFECTION CONTROL barriers as needed.
☐ See home binders for information and instructions on ________________ (Be specific)
☐ Communicate with member regularly and with dignity and respect. Face the member when speaking, talk clearly, and pronounce words.
☐ Sing songs, play soothing or happy music (radio/TV), talk while providing care.
☐ Verbally interact with member during activities
☐ Give verbal cues prior to touching member due to ______________ impairment.
☐ Check supplies and equipment. Notify ___________ of low quantity of supplies on hand or equipment repairs as needed
☐ Provide a safe environment and knows members emergency backup plan.
☐ Other

SECTION M. ADDITIONAL COMMENTS

STATE OF HAWAII
Service Plan

Member Name ________________________________ **Member ID #** _____________________ **Service Plan Date** ____________
Service Coordinator Name ____ Phone Number _________________________
Authorized Representative Name _______________________________________ Phone Number _________________________
[ ] Child with Special Healthcare Needs (CSHCN) [ ] Adult with Special Healthcare Needs (ASHCN)
[ ] Home and Community Based Services (HCBS) [ ] Nursing Facility (NF) [ ] At Risk

APPENDICES	
Appendix A. Treatments and Therapies	
1. BiPAP/CPAP 2. Catheter care 3. Chemotherapy 4. Chest physiotherapy 5. Cough Insufflator/Exsufflator* 6. Dialysis 7. Enteral Feeding* 8. Home Health 9. Hospice care 10. IV therapy* 11. Occupational therapy 12. Oxygen therapy	13. Palliative care 14. Personal Emergency Response System (PERS) 15. Physical therapy 16. Psychological therapy 17. Radiation 18. Respiratory therapy 19. Speech language therapy 20. Suctioning* 21. Tracheostomy care* 22. Transfusion 23. Ventilator care* 24. Wound care* 99. Other
Appendix B. Medical Equipment and Supplies	
1. Bath chair/shower bench 2. BiPAP/CPAP 3. Cane 4. Catheter Supplies 5. Chest Vest 6. Commode 7. Cough Insufflator/Exsufflator* 8. Enteral Feeding Supplies* 9. Feeding Pump* 10. Grab bars 11. Hand held shower head 12. Hospital Bed 13. Incontinence supplies 14. Nebulizer* 15. Ostomy Supplies	16. Oxygen concentrator* 17. Oxygen tank* 18. Patient lift 19. Personal Emergency Response System (PERS) 20. Pulse oximeter* 21. Scooter 22. Specialty mattress 23. Stander 24. Suction machine* 25. Toilet Chair 26. Tracheostomy Supplies* 27. Transfer board 28. Walker 29. Wheelchair 99. Other
Appendix C. HCBS Services	
1. Adult Day Care (ADC) 2. Adult Day Health (ADH) 3. Assisted Living Facility (ALF) 4. Community Care Management Agency (CCMA) Services 5. Counseling and Training 6. Community Care Foster Family Home (CCFFH)/Expanded Adult Residential Care Home (E-ARCH) 7. Environmental Accessibility Adaptations (EAA) 8. Home Delivered Meals	9. Home Maintenance 10. Moving Assistance 11. Non-Medical Transportation 12. Personal Assistance Services – Level I (PA I) 13. Personal Assistance Services – Level II (PA II) 14. Personal Assistance- Level II (Delegated) (PA II- Delegated) 15. Personal Emergency Response Systems (PERS) 16. Respite Care 17. Skilled (or private duty) Nursing (SN) 18. Specialized Medical Equipment and Supplies 99. Other
Appendix D. Institutional Services	
1. Acute Waitlisted ICF/SNF 2. Nursing Facility (NF), Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF)	3. Sub-Acute Facility 4. Rehabilitation Center
Appendix E. Diseases	

STATE OF HAWAII
Service Plan

Member Name ________________________________ **Member ID #** _____________________ **Service Plan Date** ____________
Service Coordinator Name ____ Phone Number _________________________
Authorized Representative Name ____ Phone Number _________________________
[ ] Child with Special Healthcare Needs (CSHCN) [ ] Adult with Special Healthcare Needs (ASHCN)
[ ] Home and Community Based Services (HCBS) [ ] Nursing Facility (NF) [ ] At Risk

1. Asthma	8. High Blood Pressure
2. Cancer	9. HIV/AIDS
3. Chronic Obstructive Pulmonary Disorder (COPD)	10. Seizures
4. Diabetes	11. Shortness of Breath
5. End Stage Renal Disease (ESRD)	12. Transplant
6. Heart Disease	99. Other
7. Hepatitis B/C	

Appendix F. Acronyms

1. **ADC** Adult Day Care	20. **EPSDT** Early and Periodic Screening, Diagnostic, Treatment
2. **ADH** Adult Day Health	21. **HCBS** Home and Community Based Services
3. **ADLs** Activities of Daily Living	22. **IADLs** Instrumental Activities of Daily Living
4. **ALF** Assisted Living Facility	23. **ICF** Intermediate Care Facility
5. **AMHD** Adult Mental Health Division	24. **LIHEAP** Low Income Home Energy Assistance Program
6. **APS** Adult Protective Services	25. **LTSS** Long-Term Services and Supports
7. **ARCH** Adult Residential Care Home	26. **MQD** Med-QUEST Division
8. **ASL** American Sign Language	27. **NF** Nursing Facility
9. **BMI** Body Mass Index	28. **PA** Personal Assistance
10. **CAMHD** Child and Adolescent Mental Health Division	29. **PERS** Personal Emergency Response Systems
11. **CCFFH** Community Care Foster Family Home	30. **PCP** Primary Care Provider
12. **CCMA** Community Care Management Agency	31. **SC** Service Coordinator
13. **CWS** Child Welfare Services	32. **SHCN** Special Health Care Needs
14. **DDD** Developmental Disabilities Division	33. **SN** Skilled Nursing (Private Duty)
15. **DHS** Department of Human Services	34. **SNAP** Supplemental Nutrition Assistance Program
16. **DOE** Department of Education	35. **SNF** Skilled Nursing Facility
17. **DOH** Department of Health	36. **SP** Service Plan
18. **EAA** Environmental Accessibility Adaptations	37. **VOC Rehab** Vocational Rehabilitation Division, Department of Human Services
19. **E-ARCH** Expanded Adult Residential Care Home	