Assisted Living Facility with Limited Mental Health License

Community Living Support Plan and Cooperative Agreement

Name of the Assisted Living Facility (ALF): _______________________________________________

ALF Administrator’s Name: ___________________________________________________________

ALF Address: _____________________________________________________ Phone #: __________

Resident’s Name: ________________________ ALF Admission Date: ______________________

Resident’s current Health Plan: ______________________________ ______________________

☐ Medicaid ☐ Medicare ☐ Other ____________________________________________________

The resident is a recipient of (check one)

Resident’s Power of Attorney/Legal Guardian, if applicable:______________________________

Address: _____________________________________________________ Phone #: __________

Resident’s Primary Care Physician: ________________________________________________

Address: _____________________________________________________ Phone #: __________

Resident’s Psychiatrist: __________________________________________________________

Address: _____________________________________________________ Phone #: __________

Case Management Agency or Community Mental Health Center (CMHC): 

___________________________________________________________

Address: _____________________________________________________ Phone #: __________

Resident’s Case Manager: __________________________________ Phone #: ______________

Substance Abuse Mental Health (SAMH) Program Office Contact #: ______________________

Behavioral Health Care After-hours and Emergency Contacts:

◆ 911 for immediate assistance
◆ CMHC 24/7 Hotline: __________________
◆ Health Plan’s Behavioral Health 24/7 Emergency contact #: _______________________

In addition to the required health assessment completed within (30) thirty days of admission on AHCA’s 1823 Form, the below assessment was conducted to determine the appropriateness for placement:

☐ An Alternate Care Certification for Optional State Supplementation (OSS) Form, CF-ES Form1006 Form
☐ A discharge statement or form from a State Mental Hospital, completed (90) ninety days prior to admission
☐ A signed statement that the resident has been assessed and found appropriate for residency in an ALF that was conducted by a psychiatrist, clinical psychologist, clinical social worker, or psychiatric nurse, or a person (clinician) supervised by one of these professionals (under FAC 58A-5.029(2))

The resident’s appropriateness for placement assessment was received by the ALF on _______.

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Indicate the specific needs of the resident to enable the resident to live in the Assisted Living Facility.

1. Pursuant to 429.28(1)(j), list below the applicable clinical mental health services to be provided or arranged by the mental health provider in order to meet the resident's needs. (E.g., psychiatrist, ARNP, therapist, substance abuse treatment provider(s), etc.)

<table>
<thead>
<tr>
<th>Agency</th>
<th>Service</th>
<th>Provider Name</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

2. List below other non-clinical support services and activities to be provided by or arranged for by the mental health care provider, case manager or other State Agencies.

<table>
<thead>
<tr>
<th>Agency/Provider</th>
<th>Service</th>
<th>Phone #</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

3. Pursuant to 429.41(3)(h)(4), the responsibilities of the facility are to assist the resident in attending appointments and activities. List below any services arranged for or provided by the ALF.

<table>
<thead>
<tr>
<th>Type of Appointment or Activity</th>
<th>Transportation Provider</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

4. List additional services and activities currently available to the resident at the ALF: __________

________________________________________________________________________________________

________________________________________________________________________________________

5. List any special needs of the resident (e.g., related to head injuries, special medical, forensic issues, etc.) and any precipitating factors, which may indicate the need for professional services. Please include contact information, if applicable: ____________________________

________________________________________________________________________________________

________________________________________________________________________________________
6. Please assist the resident with completing Sections I and II.

Section I - Triggers

Please ask the resident the following question: What are some of the things that make you angry or very upset?

Please check or *fill in the answers below:

<table>
<thead>
<tr>
<th>Triggers</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being touched</td>
<td></td>
</tr>
<tr>
<td>Loud noises</td>
<td></td>
</tr>
<tr>
<td>Taking my belongings without asking</td>
<td></td>
</tr>
<tr>
<td>Name calling</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

Section II - Calming Strategies

Please ask the resident the following question: Please share with us as many activities that you believe will be helpful when you are angry or very upset?

Please check or *fill in the answers below:

<table>
<thead>
<tr>
<th>Calming Strategies</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listen to music</td>
<td>Exercise</td>
</tr>
<tr>
<td>Read a book</td>
<td>Do artwork (painting, drawing, etc.)</td>
</tr>
<tr>
<td>Wrap-up in a blanket</td>
<td>Hug an object of significance</td>
</tr>
<tr>
<td>Writing my feelings down</td>
<td>Drink a beverage</td>
</tr>
<tr>
<td>Watch television</td>
<td>Read spiritual material</td>
</tr>
<tr>
<td>Talk to staff</td>
<td>Go for a walk</td>
</tr>
<tr>
<td>Talk with peers</td>
<td>Other:</td>
</tr>
<tr>
<td>Call a friend or family member</td>
<td>Other:</td>
</tr>
<tr>
<td>Take time in a quiet room/comfort room</td>
<td>Other:</td>
</tr>
<tr>
<td>Take a shower</td>
<td>Other:</td>
</tr>
</tbody>
</table>

7. The following people are peer supports for the ALF resident:

Name: ______________________ Relationship: ________________ Phone #: __________

Name: ______________________ Relationship: ________________ Phone #: __________

Name: ______________________ Relationship: ________________ Phone #: __________

8. In accordance with 429.02(8) F.S., the below list of action steps should be used on behalf of the ALF resident to ensure he/she has accesses to emergency, after-hours and weekend behavioral health services:

1. __________________________________________________________________________
2. __________________________________________________________________________
3. __________________________________________________________________________
4. __________________________________________________________________________
5. __________________________________________________________________________
9. Identify any barriers that may prevent the resident from receiving services that are deemed necessary and how they will be addressed. (E.g., transportation, insurance coverage, elopement risks, resident’s refusal to sign the plan, etc.): ________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

10. Date of the last Community Living Support Plan on record_____________________

11. Other comments: ________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________

The signatures below affirms that this document serves as a written statement of understanding between the Mental Health Provider and the Assisted Living Facility (ALF) developed by the Mental Health Case Manager to ensure delivery of the appropriate services for the identified ALF Resident. Upon obtaining consent from the ALF Resident, the ALF Administrator may receive a copy of the Treatment Plan from the Mental Health Provider and a copy of the Service Plan from the Intensive or Targeted Case Manager.

* Signatures:

____________________________________________________________________________
ALF Resident                                                   Date

____________________________________________________________________________
Power of Attorney/Legal Guardian, if applicable                  Date

____________________________________________________________________________
ALF Administrator or Designee                                      Date

____________________________________________________________________________
Case Manager                                                Date

____________________________________________________________________________
Case Manager Supervisor or Designee                           Date

____________________________________________________________________________
Mental Health Provider or Designee                             Date

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