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: _____

The resident is a recipient of ☐ Medicaid ☐ Medicare ☐ Other _____.
(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 the 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.)

Agency	Service	Provider Name	Phone #

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.

Agency/Provider	Service	Phone #

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.

Type of Appointment or Activity	Transportation Provider	Frequency

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:

	Being touched		Other:
	Loud noises		Other:
	Taking my belongings without asking		Other:
	Name calling		Other:
	Other:		Other:

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:

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

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