pennsylvania
DEPARTMENT OF AGING

Service Plan for Protective Services & Informed Consent

CONFIDENTIAL

Service plans must provide for the least intrusive service or environment that can effectively and safely address the adult's needs and preferences and be in the most integrated setting. Service plans are updated as needed. If any or all services are refused, potential risks must be documented, and the individual must be notified of those risks.

Confidentiality:
This service plan is confidential and intended solely for the purpose of initiating the delivery of services. You should not otherwise disseminate, distribute, or copy this service plan. If you have received this service plan in error please notify the OAPSA Investigator. If you are not the intended recipient you are notified that disclosing, copying, distributing or taking any action in reliance on the contents of this information is strictly prohibited under Title 6, Chapter 15 §15.81(7) and §15.101-15.105

Individual Information:	
Individual's Name *(First, MI, Last)*	
Date of Birth *(mm/dd/yyyy)*	Individual ID Number *(SAMS ID)*
Date Service Plan Developed (mm/dd/yyyy)	Individual MCI Number

Areas of Risk: Regardless of the allegations received in the report the investigator must assess for all potential areas of risk.	
Areas of Risk	**Description (include summary of substantiated allegation(s) & events/actions that impact adult's risk to health & safety):**
☐ **Abuse**	
☐ **Neglect**	
☐ **Exploitation**	
☐ **Abandonment**	

Goals:

Services Needed to Support Goal Attainment: ***Address all areas of risk identified by the investigation***

Is this a crisis care plan to reduce or eliminate imminent risk (used in emergency situations only): ☐ Yes ☐ No
Crisis care plan must have a Start and End Date entered below.

Identified Areas of Risk	Services to Support Needs	Person Responsible/Title	Start Date	End Date	Individual Consent
1.					☐Yes ☐No
2.					☐Yes ☐No
3.					☐Yes ☐No
4.					☐Yes ☐No
5.					☐Yes ☐No
6.					☐Yes ☐No
7.					☐Yes ☐No

Reassessment of Progress	***Date of Assessment***	***Consumer Initials to Acknowledge Reassessment***

Service Plan Development: ***Who participated in the development of the plan? Indicate all that apply.***

OAPS Investigator	Name: _____ Email: _____ Phone: _____ Signature: _____ Date: _____
Individual or Guardian	Name: _____ Signature: _____ Date: _____ ☐ Unable to sign* ☐ Refused to sign* *Reason Unable or Refused to sign: Date Plan Mailed or Given to Individual or Representative: _____

Individual's Caregiver (ex. Family, informal supports)	Name: _____ Relationship: _____ Signature: _____ Date: _____ ☐ Unable to sign* ☐ Refused to sign* *Reason Unable or Refused to sign: _____ ☐ Discussed by Telephone* Date: _____
Provider Staff/Other	Name and Title: _____ Agency/Other: _____ Signature:_____ Date: _____
Administrative Entity (AE) or Managed Care Organization (MCO)	Name and Title: _____ Agency/Other: _____ Signature:_____ Date: _____ Date Discussed by Telephone: _____ Date Plan Mailed or Given to Representative: _____
Supports or Service Coordinator	Name: _____ Agency: _____ Signature: _____ Date: _____ ☐ Emailed to Supports Coordinator Date: _____ ☐ Other: (Mailed, faxed, etc.): _____ Date: _____

Potential Risk(s) associated with refusal of services: ***(This section must be completed for every service plan to ensure the older adult or guardian can make an informed decision to accept or reject identified services above. PSI should have a corresponding note in the care plan documenting the service plan presentation, detailing the older adult's or guardians concerns and participation.)***

☐ **Individual Consents to Protective Services**

- I am aware that I am eligible to receive protective services from the PDA (AAA) and I understand why the services are necessary.
- I understand and consent to the services above and further understand that I may withdraw consent for protective services at any time.

☐ **Individual Partially Consents to Protective Services**

- I am aware that I am eligible to receive protective services from the PDA (AAA) and I understand why the services are necessary.
- I understand and consent only to the services indicated above and further understand that I may withdraw consent for protective services at any time.

☐ **Individual Refuses Consent to Protective Services**

- I am aware that I am eligible to receive protective services from the PDA (AAA) and I understand why the services are necessary.
- I understand that by signing this document, I am refusing to accept the protective services outlined above and I am aware of the potential risk(s).
- I understand that if I want assistance in securing protective services at any time, I can contact the Protective Services Hotline at 1-800-490-8505.

_____ _____

Individual Signature **Date**