Idaho Department of Health and Welfare
INDIVIDUAL SUPPORT PLAN

For people living in Certified/Specialized Family Homes, this ISP meets the requirements of a Negotiated Service Agreement in Certified Family Home rules, IDAPA 16.03.19, when accompanied by a current Health and Well Being Form and Residential Habilitation Implementation Plan(s).

Name _____

Address _____

Telephone _____ Date of Birth _____

Social Security # _____ Medicaid # _____

Guardian (if any) _____ Guardian Address _____

Guardian Phone # _____ Family Contact (if any) _____

Region _____ Field Office _____

ISP Start Date _____ End Date _____

DHW Signature _____

Date of Person Centered Planning Meeting (PCP) _____ Initial Plan ☐ Annual ☐ Healthy Connections? Yes ☐ No ☐

TSC _____ TSC Address _____ TSC Telephone # _____

Community Living Arrangement _____

Frequency of Plan Monitoring: ☐ 30 days ☐ 60 days ☐ 90 days

Person Centered Planning Team Participants				
Participant Signature:		Do you support the plan? Agree ☐ Disagree ☐		
Planning Team Member Signatures	Do you support the plan?	Relationship to Participant	Other Planning Team Member Signatures	Relationship to Participant
	Agree ☐ Disagree ☐			
	Agree ☐ Disagree ☐			
	Agree ☐ Disagree ☐			
	Agree ☐ Disagree ☐		Information also gathered from the following:	
	Agree ☐ Disagree ☐		Name	Relationship to Participant
	Agree ☐ Disagree ☐			
	Agree ☐ Disagree ☐			
	Agree ☐ Disagree ☐			

Personal Summary

Participant Name: _____ Medicaid Number: _____ Age: _____ Date of Birth: _____

PCP Date: _____ ISP Start Date: _____

Instructions: Keep description to one page or less.

Current Status: in a short narrative report, describe the participant to others using the areas that apply. (Tell about the person focusing on a strengths based approach): Health, Living Situation, Family Relations, Behavioral Issues, Employment, Legal Status, Co-Occurring diagnosis, Communication, Mobility, Financial Status, Dietary requirements, Adaptive Equipment (orthotics, hearing aids, etc.)

Measurable, achievable Life Quality Domains: List the wants and the goals under one of the three categories listed below

1= Live a healthy lifestyle	3= Live as independently as I am able	5= Work at a job I like	7= Manage my personal finances
2= Obtain/ Maintain a personal Residence	4= Engage in socially appropriate interaction	6= Participate actively in my community	8= Manage my personal time 9= Other

What goals or needs will maintain or enhance independence?

What goals or needs will maintain or enhance quality of life?

What goals or needs will increase or maintain self-determination?

Name_____ Date of PCP Meeting_____

Idaho Department of Health and Welfare
ISP Supports and Services

Measurable, achievable Life Quality domains to use as a guide when writing goals:

1 = Live a healthy lifestyle	3 = Live as independently as I am able	5 = Work at a job I like	7 = Manage my personal finances
2 = Obtain/Maintain a personal residence	4 = Engage in socially appropriate interactions	6 = Participate actively in my community	8 = Manage my personal time 9 = Other

Identify in the grid below the goals to be accomplished within the year using the number associated with the life quality domains above.

Supports and Services	Goals to be Addressed within Plan Year	Frequency	Agency or Provider (Paid or Un-paid)	Start Date (When different than Proposed ISP Start Date)

HW0760 June 2003

Idaho Department of Health and Welfare
ISP Supports and Services Authorization

| Region _____ Field Office _____ |
| ISP Start Date _____ |
| ISP End Date _____ |
| DHW Signature _____ |

Date ISP Completed _____ Initial Plan ☐ Annual ☐   Waiver Participant? Yes ☐ No ☐
Participant Name _____ TSC _____
Department authorization on this page is only prior authorization for TSC, and for DD/ISSH Waiver services.

Waiver Participant Initials: _____ I have been informed of and understand my choice of waiver services. I choose to receive waiver services rather than to accept placement in an ICF/MR. I understand that I may, at any time, choose facility admission.

Service Provider	Service Type	Proposed Start Date	Service Code	Units & Frequency of Service (#/day/week/month)	Unit Cost ($/hr/day)	Annual Cost
Waiver:						
						Annual Sub Total
State Plan:						
						Annual Sub Total
						Medicaid Annual Total

Authorization is requested for the services listed above by the following people:

PARTICIPANT SIGNATURE: _____   GUARDIAN SIGNATURE (if any): _____   PLAN DEVELOPER SIGNATURE: _____

DATE: _____   DATE: _____   DATE: _____

The purpose of the ISP Checklist is to assist Plan Developers in developing Individual Support Plan (ISPs) for people with developmental disabilities. ISPs are submitted to the Department for authorization of TSC, DD/ISSH Waiver services and DDA services. For Initial ISPs, attach the following documents
- Health and Well Being Form, and
- Residential Habilitation Implementation Plans for Certified Family Homes.

FOR ANNUAL ISPS, ATTACH THE FOLLOWING DOCUMENTS:

- Health and Well Being Form
- Provider Status Reviews
- Plan Monitor Summary
- Residential Habilitation Implementation Plans for Certified Family Homes

Initial and Annual ISPs will serve as Negotiated Service Agreements for DD/ISSH Waiver participants living in Certified Family Homes; the Health and Well Being Form and Residential Habilitation Implementation Plans are required at the time of the ISP authorization.

DIRECTIONS FOR COMPLETING ISP PAGES

FOR ALL PAGES, CHECK FOR THE FOLLOWING:

- Legible writing

- Participant's name is written on each page of the forms

- All planning team participants have signed

- All pages and fields are completed

- No duplication of services or supports exists

- Supports and services listed on the ISP Supports and Services Authorization page are identified on the Supports and Services pages

- ISPs, ISP Supports and Services pages, and Addendums are submitted and authorized prior to implementation

- The ISP Supports and Services Authorization page is signed by the participant or legal guardian, if any, TSC and/or Plan Developer

CHECK FOR THE FOLLOWING:

- The header is completed fully

- If a guardian is named, a copy of the guardianship papers is on file with the Department

- The "Date of PCP Meeting" is the date the Plan Developer facilitated the Person Centered Planning Team process

- The "Start Date" is the date the services are authorized to begin by the Department

- The "End Date" is the last date the services are authorized by the Department

- Check "Initial Plan" if the ISP is the participant's first ISP, in this or any other region

- Check "Annual" for a plan following the Initial Plan that is submitted to the Department within 365 days of the Initial Plan or a previous Annual Plan. A new Annual Plan must be developed whenever Waiver services are added to the ISP

- Check "Yes" if the person is enrolled in Healthy Connections

- "Community Living Arrangement" identifies the participant's residential arrangement; it includes the name of the residential service provider and/or agency when one is used

- **"Planning Team Members" includes the names of all people participating in the person centered planning process and their relationship to the participant; this section includes signatures of participants who are physically present at the meeting.**

- **" Do you support the plan" - Each member of the team indicates they believe the plan meets the needs and represents the participant's choice, It is not a requirement that everyone agree, however, when there is disagreement, the Plan Developer should try to resolve the issue so that is not a barrier to implementing the plan.**

- "Information Also Gathered from the Following; Name, Relationship to Individual" includes names of all people who submitted information relative to the person centered planning process but were not present at the person centered planning meeting

- Check the "Frequency" of plan monitoring. Plan monitoring frequency is determined by the person centered planning team and must be at least every 90 days

CHECK FOR THE FOLLOWING:

- **The "Personal Summary" must be updated yearly and include a narrative report that gives the current status of the participant. The narrative should focus on a strength based approach The description should include all of the following areas that apply. Health, living situation, family relations, behavioral issues, employment, legal status, co-occurring diagnosis, communication, mobility, financial status, dietary requirements, and adaptive equipment.**

- **The "Personal Summary" should also identify long term goals that fall into one of the 3 outcome areas:**

  1. **What goals or needs will maintain or enhance independence;**
  2. **What goals or needs will maintain or enhance quality of life; and**
  3. **What goals or needs will maintain or increase self-determination.**

- **The person centered planning team uses nine standard Life Quality Domains as a guide when writing these goals. They are as follows;**

- **1 = Live a healthy lifestyle**

- **2 = Obtain/Maintain a personal residence**

- **3 = Live as independently as possible**

- **4 = Engage in socially appropriate behaviors**

- **5 = Work at a job I like**

- **6 = Become an active participant in my community**

- **7 = Manage my personal finances**

- **8 = Manage my personal time**

- **9 = Other**

- **Long term goals are the basis for goals identified in the ISP Supports and Services Page, and objectives on implementation plans. They are designed to assist the person to reach a level of greater independence, less support, or maintenance in one or more of the life quality domains. Each goal must have a service and support identified. They should be numbered with the domain and one or 2 levels beyond that depending on the number of goals being addressed under the long term goal.**

- **Not all domains require a goal; however, each domain should be considered during the person centered planning team process to ensure that all individual participant needs are being met.**

For those quality domain areas that are not addressed, give a statement as to why are not being addressed this year.

EXAMPLE:

Outcome area: What goals or needs maintain or enhance independence?
3A. Joe wants to increase good grooming habits.
3B. Joe wants to increase homemaking skills

Outcome area : Goals or needs that will enhance quality of life
1A. Joe want s to become physically active
1B. Joe wants to lose 20 lbs.

Outcome area: Goals or needs that will increase or maintain self-determination.
7A. Joe wants to learn how to budget his money
8A. Joe would like to develop a hobby.

- Whenever possible, the person's own words should be used when identifying the goals under the Personal Summary in the person centered planning team process

- For some individuals, goals may need to be identified by the planning team or Plan Developer on behalf of the person

- Goals may be addressed in more than one plan year if there have been no significant changes in the participant's situation

- The date of the PCP meeting must be completed

SUPPORTS AND SERVICES PAGE HW0762.2

Services and Supports Defined:

Services are paid for by the Department and enable the individual to reside safely and effectively in the community.

Supports are unpaid services and activities not paid for by the Department that enable the individual to reside safely and effectively in the setting of his choice.

For the purposes of developing a plan:

Formal services: Services are paid and have objective based data. i.e. supported living, DDA or CSE.

Informal services: Services are paid but do not have objective based data. i.e. transportation, DME, service coordination.

Formal/Informal Supports: Services or activities that are not paid and generally do not have an objective base program.

For the ISP Supports and Services Page

- The "Date of the PCP" should match the date on the ISP, Page one (HW0762.1).

- The "Supports and Services" column identifies the type of service and where it is being delivered.

- **For example, if a participant is receiving individual developmental therapy from a DDA in a center, the plan would read "Center Based Developmental Therapy., or**

- **If a participant is receiving nursing services in his home, the ISP Supports and Services page would read "Nursing services in the home."**

- The "Goals To Be Addressed within Plan Year" column identifies the short term goals the participant will be working towards within the plan year.

- **The goals are numbered to reflect the corresponding Life Quality Domains and the "Long Term Goals" identified on the "Personal Summary".   If there is more than one goal being addressed within that "Long Term Goal, take the numbering out 1 or more places.**

- **For example, The long term goal is "3.A. Joe wants to improve grooming habits" The short term goals are: 3.A.1 "Joe will independently groom" 3.A.2 " Joe will independently initiate bathing" The 3 corresponds with the Life Quality number 3 = "Live as independently as I am able." The next level of numbering links the "Goals to be addressed within the plan year" back to the "Long Term Goals" on the " Personal Summary".**

- **Every "Long Term Goal" must have services or supports identified, however, not every service or support will have a specific goal   These activities should be identified with the number of the "Life Quality Domain" they relate to.**

- **For example, The service is "Non-medical Transportation", It would be identified with "Life Quality Domain" 6 "Participate actively in my community".**

- This list could provide the structure when facilitating the meeting and discussing the long-term goals section of the plan.

- **The "Frequency" column identifies how often the service or support will be used. Ranges may be used as long as the requested frequency does not exceed Medicaid limitations; For developmental therapy, identify individual or center based therapy.**

- Frequency is identified numerically by daily, weekly, or monthly values.

- **For example, if Residential Habilitation is requested and the participant lives in a Certified/Specialized Family Home, the frequency for this service is "daily",**

- **If a participant wants the TSC to assist him in accessing vocational services and requires a vocational evaluation, the frequency to access that service may be "one time", or**

- **For services that occur weekly identify the number of time they occur during the week. The frequency may be "3x/week".**

- The "Agency or Provider (Paid or Un-paid)" column identifies both paid services and un-paid supports.

- It identifies the direct provider of service or the agency responsible for the service, and the person or organization providing un-paid supports or services.

- Complete the "Start Date" when the corresponding service has a different start date than the proposed ISP start date.

- **For example, if the ISP date is 1/01/03, but supported employment services aren't scheduled to begin until the beginning of March, the start date column would have the date of 3/01/03 for that service.**

EXAMPLES OF THE ISP COLUMNS DESCRIBED ABOVE ARE AS FOLLOWS

SUPPORTS AND SERVICES	GOALS TO BE ADDRESSED WITHIN PLAN YEAR	FREQUENCY	AGENCY OR PROVIDER (PAID AND UN-PAID)	START DATE WILL BE (WHEN DIFFERENT THEN PROPOSED ISP START DATE)
1.Residential Habilitation/ Supported Living	1.A Completes an exercise program 1.B Monitor diet 1. Annual physical/dentist 3.A.1 Independently maintain grooming 3.A.2 Independently initiate bathing 6.A Attend Church 6.B Provide community integration activity 6. Non-Medical Transportation	3x/week Daily 2x/yr Daily 1x/week 3x/week 1800 mi/year	John Doe, CFH provider Primary physician, Dr. Baker Dentist, Dr. Jones	3/10/03

2. Home/ community based DDA	3.A. 1Independently groom 4.A Appropriate Social interaction 6.C. Community safety 7A. Increase budgeting skills	5 hr/week, Ind. Comm. DT 15 hrs/week group comm. DT.	DDA	
3. Medical Transportation	6. Transportation to and from DDA.	10mi/trip	Transportation Agency	01/05/03
4. Service Coordination/ Plan Development	9. Develop plan 1xper year 9. Monitor services and supports. 5. A Refer to Voc Rehab.	1 x/mo. 1 x	Jane Smith, TSC agency	
5. Unpaid Support	4.A Go on community outing with family Community integration 9. Payee/legal guardian	1x/mo	Mother	

FOR THE ISP SUPPORTS AND SERVICES AUTHORIZATION PAGE HW0760

CHECK FOR THE FOLLOWING

- The "ISP Supports and Services Authorization" page contains all costs necessary to determine cost effectiveness for the following services:

- **Waiver**

- **Plan Development**

- **Plan Monitoring**

- **Initial and Ongoing TSC**

- **DDA**

- **Medical Transportation**

- **DME**

- **All therapies outside of a DDA that are secondary to the participants developmental disability**

- The "Service Type" field lists any support or service requiring Medicaid funding

- State Plan costs are all those services delivered under the Medicaid State Plan

- Services or supports with separate bill codes must be listed on separate lines

- The "Service Provider" is a listing of providers by the individual and/or agency name

- The "Proposed Start Date" should match the "ISP Start Date" on (HW0762.1) or the Start Date on the support and services section when that date is different than the ISP start date

- "Code, Units & Frequency of Service" must be printed in units and frequency by number, day, week, and month of those units requested.

- **For example, the service of Residential Habilitation, Hourly Supported Living, would be requested at six hours per day, seven days per week, or 6 hrs/daily,**

- **Refer to the "DD Reimbursement Rate Chart" for Medicaid state plan and DD/ISSH Waiver bill codes and reimbursement rates,**

- **The "Unit Cost" must be current to the "DD Reimbursement Rate Chart", and**

- **See also "Guidelines for DME/SME for DD/ISSH Waiver participants."**

- **Annual costs must be calculated using factors of units, frequency and unit cost.**

- **Factors that are constant to identified frequencies include the following:**

Frequency	Constant Multiplier
Weekly	52 weeks in a year
Monthly	12 mos. in a year
Daily	365 days in a year

The following example is for Developmental Therapy, Plan Development and Service coordination and transportation:

Service	Units/Frequency	Unit cost	Annual cost
Home based Ind. DT	2 hrs/5 days /week	$19.68/hr	$10,233.60
Community Grp DT	4hr/5 days/week	$ 8.40/hr	$8,736.00
Plan Developer	12hr/year	$40/hr	$480.00
Service Coordination	1time/mo	$108.33/mo.	$1299.96
Transportation	20mi/day	$.35/mi	$1820.00
Total			**$22,569.56**

Annual Costs are calculates as follows:

- ➤ **Home based individual therapy is calculated as [(2x5) x$19.68] = $196.80/week. $196.80x 52wks= $10,233.60.**

- ➤ **Community based Group DT. [(4x5) x $8.40] = $168.00/week x 52 weeks = $8,736/year**

- ➤ **Plan Developer: 12 hours x $40/hr = $480/yr**

➤ **Service Coordination: 1x$108.33/month x 12 months = $1299.96/year**

➤ **Transportation: [(20x5) x$.35]= $35/week x 52 weeks = $1820**

- **Add the subtotal costs of all waiver services and enter that amount in the annual cost column at the "Annual Sub Total" heading**

- **Continue adding subtotals for "State Plan" Medicaid services and enter those totals in the appropriate "Annual Sub Total" headings**

- **Calculate the total for all Medicaid services (including waiver, state plan, medical equipment/supplies and all therapies outside of a DDA that are secondary to the participants developmental disability) and enter that amount at the "Medicaid Annual Total" heading under the annual cost column.**

WAIVER PARTICIPANT INITIALS

- Is the participant's initials (with assistance and witnessed if necessary) in the space noted after he has been informed that waiver services are an option to placement in an ICF/MR and he chooses waiver services?

- This option must be fully explained to the participant, identifying the differences, opportunities, benefits, and risks of both.

- It is important to explain all services and supports identified and requested, and the persons or agencies responsible.

PARTICIPANT SIGNATURE

- Is the participant's signature and date of signature (with assistance and witnessed, if necessary)?

GUARDIAN SIGNATURE

- Is a space for the legal guardian or legal representative's signature and date of signature, when the participant has a guardian or legal representative?

- Department staff may not accept a signature of a person other than the participant unless copies of the guardianship or legal documents are reviewed and maintained in the Department's participant file.

PLAN DEVELOPER SIGNATURE

- Is the PD's signature and date of signature?

AUTHORIZATION

- **Each service is authorized for the total amount in AIM by its specified code. Each plan must consist of units and frequency for each code being billed by a provider. Providers must as accurately as possible determine the frequency for each type of service.**

- **Agencies must bill according to the units/frequency column for each services; however, annualized costing allows for some flexibility when there are unusual circumstances or schedules.**

DDA Service Mix:

To Increase DDA services "flexibility" and meet variable client needs while staying within agreed upon annual budget the following should occur to provide the ability for DDAs to offer a "mix" of their services.

Determine a budget for developmental therapy based upon:
- **assessed participant current needs**
- **past use of developmental therapy**
- **a component of the participant's entire budget**

Person centered team:
- **Determined budget based upon above listed criteria.**
- **Identify goals of developmental therapy.**
- **Frequency of services daily/weekly basis.**
- **Establish "Service Mix" combination of group or individual, community or center based.**

Service "Mix" concepts for agencies:
- **DDA services are calculated on an annual basis thus the provider can change the service mix but must remain within budget on an annual basis.**
- **DDA's may flexibly provide the services within the mix adjusting to the type and amount of therapy based on unique circumstance for the participant needs such as illness, increased behavioral concerns, transportation, etc.**
- **DDAs must keep track of utilization for each service within the mix . If they go over the authorized amount, they must submit a addendum form for continued service authorization with justification as to why the service was depleted.**

ISP Addendum Instructions HW0761

- Addendums to the ISP are required when there is a change in any of the following circumstances, and it has not been anticipated in the Initial or Annual ISP:

Addendum requests will be complete when:

- A current service provider requests an addition or modification to the ISP;

- The requesting provider initiates the process using the ISP Supports and Services Addendum (HW0761);

- The provider should notify the plan developer of their intention, in the event that another provider is also initiating an addendum so that one addendum could include both services if everyone is in agreement;

- When two service providers submit separate addendums for the same participant at the same time, the Plan Developer may generate one overall addendum to encompass both changes for submission to the Department for authorization, making sure the overall addendum contains all necessary signatures;

- The provider is responsible to discuss the requested change (s) with the waiver participant and/or guardian and obtain necessary signatures; and

- The service provider forwards the request to the Plan Developer who reviews and completes the costing information and submits it to the Department for authorization.

A NEW SERVICE BY A NEW SERVICE PROVIDER IS REQUESTED TO AN EXISTING ISP:

- The Plan Developer initiates and completes the process using ISP Supports and Services Addendum (HW0761) for submission to the Department for authorization.

A WAIVER PARTICIPANT LIVING IN A CERTIFIED FAMILY HOME WILL BE ON A VACATION, AND VACATION ACTIVITIES ARE NOT REFLECTED ON THE CURRENT ISP:

- The Residential Habilitation Agency initiates the process using the ISP Supports and Services Addendum (HW0761).

- The provider is responsible to discuss the requested change(s) with the participant and or guardian and obtain necessary signatures.

- The service provider forwards the request to the Plan Developer who will review and complete the costing information and submit to the Department for authorization.

> Use applicable directions from the ISP and Supports and Services Authorization page to complete the cost for new or modified service(s).

ADDING INITIAL WAIVER SERVICES WITH A NEW ANNUAL PLAN

- A person who has an ISP in effect and chooses to use DD/ISSH waiver services before the next Annual ISP may not add waiver services with an Addendum, but must develop a new Annual Plan process.

- The Plan developer convenes the person centered planning team, and facilitates the process required to develop an Annual Plan.

- The new Annual ISP must include the following:

- **ISP Signature Page HW062**

- **New ISP Personal Summary page HW0762.1**

- **ISP Supports and Service page, HW0762.2**

- **ISP Supports and Services Authorization page, HW0760**

- **Physician Letter, including any need for nursing services and frequency of physician contact**

- **Health and Well Being form**

- The date of this new Annual ISP becomes the new annual plan start date.

- This is a requirement because Waiver eligibility must be redetermined every 365 days and services cannot be authorized for more than 365 days.

FOR INFORMATION ON COMMUNITY CRISIS SUPPORTS, PLEASE REFER TO COMMUNITY CRISIS SUPPORT GUIDELINES.

GUIDELINES FOR VACATIONS IN CERTIFIED FAMILY HOMES

- Use these guidelines when participants participate or are expected to participate in vacations with Certified Family Home (CFH) providers and those providers request reimbursement for the services to be provided during that time.

- For the purposes of these guidelines, a vacation is time when waiver participants are away from their normal living arrangement and their normal routine.

- Weekends and holidays are not considered vacations, as they are typically leisure in nature.

- **Participants and their Individual Support Plan (ISP) teams must discuss participant interest in and willingness to participate in the vacation.**

- **This process should occur at the initial stages of development of the ISP and be reviewed at subsequent person-centered planning meetings.**

- **Documentation must include an estimated length of the vacation and any modification of residential habilitation services required for those services in a different location.**

- **The choice of participation must be offered to participants at the time of the meetings and again immediately prior to the vacation.**

- **The decision to participate or not, will be honored as indicated on participant ISPs and documentation in TSC progress notes.**

- The duration of the vacation cannot interfere with participants' progress in activities to become more independent nor can it jeopardize participant health, welfare, or current employment status.

- **<u>The PCP team should determine on a case-by-case basis the requested vacation length and effects on the outcome for participants, based on the services identified on the ISP.</u>**

- According to the Medicaid Eligibility Rules and waiver rules, participants will lose Medicaid eligibility if they are out of the state longer than one (1) month (IDAPA 16.03.05.106).

- If it is determined by Department staff that Residential Habilitation services can be provided according to the ISP while the participant is on vacation, the Residential Habilitation Agency may be authorized to bill for affiliate services during that time.

- Documentation requirements continue as usual.

GUIDELINES FOR DEVELOPING COST EFFECTIVE PLANS

- Every effort must be made to develop services and supports that provide the most cost effective services to meet the participant's assessed needs.

- Not all participants may require constant individual supervision.

- Some considerations may be given to increasing the hours when a participant could gain more independence by spending time without paid supports in his home or by increasing time on the job without a job coach.

- The method used to maintain cost effectiveness should meet the participant's personal goals. All community services are intended to foster self-determination and increase a person's quality of life with the greatest degree of independence possible.

- Most generally, costs for individuals living in Certified Family Homes will have cost effective plans

- It is more likely that services for participants using Supported and other hourly services will exceed cost effectiveness.

- Plan review should be completed in the same way to assure plans meet the participant's needs in the most cost effective manner.

- The information below provides a variety of options to consider when determining cost effectiveness.

- **<u>Look for sources of natural supports instead of paid supports for some services and supports identified on the ISP.</u>**

- **<u>Assess the combination of Residential Habilitation, DDA, and waiver Supported Employment. The combination of these services must not exceed 168 hours per week; however, the number of hours identified on ISPs for these three services can be individualized.</u>**

- **Consider a lower cost alternative to individual developmental therapy, such as groups in the home and community.**

- **Reconsider the need for constant job coach presence on the job. For instance, to increase work independence, evaluate whether there times the person can work without the presence of a job coach. Job coach services must be reevaluated periodically to assess whether decreasing levels of coaching can be attained.**

- **Consider the use of Adult Day Care for DD/ISSH Waiver participants as an option when skill training and job training are not needed to meet the person's goals, but the participant does desire socialization and requires supervision.**

- **Where Supported Living is used, review the need for a full 168 hours each week. Consider whether a personal emergency response system (PERS) or other alternatives could be used for any period of time during a day, and whether the person requires constant oversight and services.**

- **If the cost of the plan exceeds the negotiated participant budget authorized by the Assessor, the Plan Developer and PCP team must complete the Extenuating Circumstances form to document the need for services above the budget authorized by the Assessor. This form must be attached to the ISP and submitted to the Department for authorization.**

ISPs CONTAINING SUPPORTED LIVING SERVICES

- There are three Residential Habilitation agency bill codes and reimbursement levels for Supported Living: one-person, group and wrap around.

- **When the residents in a group living setting are absent for short periods of time, leaving only one resident remaining, the individual supported living rate may be billed.**

- **To allow Residential Habilitation agencies the ability to make staffing adjustments for temporary absences of the residents in a group living setting, Department staff may prior authorize up to 21 days per year (within 12 consecutive months) at the individual rate to substitute for days when the other residents are absent for at least one full day.**

- Substitute rates cannot be used for time periods of less than a full calendar day, midnight to midnight.

- To request anticipated Supported Living substitute reimbursement levels on an ISP or Addendum, complete the following steps.

- Include the need and explanation for the enhanced level of Supported Living on the Services and Supports page of the Initial or Annual ISP or Addendum.

- Include the number of substitute days in the Service Authorization page or Addendum that are anticipated at the individual rate.

- When requesting prior authorization on an Initial or Annual Plan, the total period of time for Supported Living is 365 days, or 52 weeks.

- Use separate lines on the Service Authorization or Addendum page for the two Supported Living daily rates, one for the usual rate and one for the substitute, individual rate.

- The total number of days for the combination of services cannot exceed 365 days.

- The line for prior authorization of the usual Supported Living service (group) is based on a waiver participant receiving Supported Living services daily, for the number of days in the prior authorization period of time.

- The line for prior authorization of the rate is based on the number of days/weeks the individual service is being requested; however, the average daily cost figure is based on the difference between the group and individual service rate.

- The number of prior authorized individual days for persons typically receiving group supported living cannot exceed 21 days, unless it is reported that a roommate is expected to be gone on vacation, etc. for more than the 21 days. Compute the daily rate for both Supported Living rates according to the projected number of days that each service will be provided.

- To calculate the annual rate, multiply the projected number of hours per day times the rate, times the number of days and divide by 365 to arrive at the annual rate.

STATUS REVIEW

PARTICIPANT: _____ **MEDICAID NUMBER:** _____ **PLAN START DATE:** _____

PROVIDER AGENCY: _____ **TYPE OF SERVICE:** _____

SEMI-ANNUAL REVIEW (MO/YR): _____ **ANNUAL REVIEW (MO/YR):** _____

PROFESSIONAL COMPLETING REIVEW: _____

Key for Reporting Life Quality Domains	Key for Reporting Progress Towards Outcomes	Key for Reporting Informal Services and Supports
1 = Live a healthy lifestyle	1 = Achieved (100% of established criteria)	P = Pending
2 = Obtain/Maintain a personal residence	2 = Substantial Progress (50% or better of the established criteria)	D = Discontinue
3 = Live as independently as I am able	3 = Some Progress (Less then 50% of the established criteria)	C = Complete
4 = Engage in socially appropriate behavior	4 = No progress (No change from previous report)	O = Ongoing
5 = Work at a job I like	5 = Decline in Progress (Below established baseline)	
6 = Become an active participant in my community	6 = Maintenance	
7 = Manage my personal finances		
8 = Manage my personal time		
9 = Other		

FORMAL SERVICES (PROGRAM OBJECTIVES/DATA COLLECTION)

DOMAIN/GOAL	BEHAVIORAL OBJECTIVE	June	July	Aug.	Sep.	Oct.	Nov. Status Review	Dec.	Jan.	Feb. Status Review	Mar.	Apr.	May
Comment:													
Comment:													
Comment:													
Comment:													
Comment:													

INFORMAL SERVICES (PAID SERVICES/NO DATA COLLECTION)

	June	July	**Aug**	Sept	Oct	**Nov** Status Review	Dec	Jan	**Feb** Status Review	Mar	Apr	**May**
Domain Category:												
Comment:												
Domain Category:												
Comment:												
Domain Category:												
Comment:												
Domain Category:												
Comment:												
Domain Category:												
Comment:												

Key for reporting services: **P=Pending; O=On-going; C=Complete; D=Discontinue**

INFORMAL SUPPORTS (NON-PAID SERVICES)		June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Domain Category:													
Comment:													
Domain Category:													
Comment:													
Domain Category:													
Comment:													
Domain Category:													
Comment:													
Domain Category:													
Comment:													
Key for reporting services: **P=Pending; O=On-going; C=Complete; D=Discontinue**													

PROVIDER STATUS REVIEW INSTRUCTIONS

1. Each provider of Medicaid services shall complete a provider Status Review with the exception of the following providers:

   - Specialized medical equipment

   - Home delivered meals

   - Environmental modification

   - Non-medical transportation

   - Personal emergency response system

   - Respite care

   - Chore service

   - Independent residential habilitation providers

2. The program coordinator develops the Status Review plans and status reviews for residential habilitation.

3. The DDA shall complete the Status Review for Occupational Therapy, Physical Therapy and Speech Therapy delivered through their agency.

4. When Occupational Therapy, Physical Therapy, and Speech Therapy are delivered outside the DDA, it will be the responsibility of the Plan Monitor to give a status report on these therapies on their Plan Monitor summary.

5. Each provider must submit a status review to the Plan Monitor two (2) times per year. The first time is six (6) months after the plan start date. The second is due at the annual person centered planning meeting. This information should be used as part of the discussion for the annual plan.

6. The Provider Status Review includes the status of **formal services (**behavioral objectives), **informal** services and **informal supports** they are responsible for on the plan of service. **It also includes the baseline and status for each formal service, behavioral objective, and the status of informal services and supports.**

As of June 2004, there is not a standardized form for the Provider Status Review. Each provider may continue to use the form that they presently use to report data on a monthly, quarterly, semi-annual or annual basis; however, at the minimum the form must contain:

- **The short-term goals linked to a domain for that service. The short term goals should be further identified by:**

- **Formal Services (Program Objectives/Data Collection necessary)**

- **Informal Services (Paid Services/No Data Collection) i.e. Non-medical transportation**

- **Informal Supports (Non-Paid Services) i.e. finding or attending a church**

- **Quantifiable measures for the behavioral objective reported using the Department's key**

- **The six (6) month Status Review is due no later than ten (10) days following the 6 month due date on the plan. The Annual Status Review should be completed and presented at the annual Person Centered Planning meeting (PCP) and submitted with the plan.**

- **LIFE QUALITY DOMAINS – SEE ATTACHED FORM**

- **PROVIDER STATUS REVIEW SECTIONS DEFINED (SUGGESTED FORM)**

1. **Cover Sheet/Demographics**

   - **Fill out the *Participant's name, Medicaid Number, Plan Start Date, Provider Agency, Type of Service, Professional Completing Review, and the date for either a semi-annual review or an annual review (fill out only one date).***

2. **Column 1 – Domain Goal**

   - This column identifies the short-term goals the provider is responsible to work on with the participant during the plan year. Using the number corresponding with the Life Quality Domain, identify each goal associated with that domain. Life Quality Domains are listed numerically and consecutively. If there is more than one goal within each domain identify each goal within a domain with an "alpha" notation. **Some providers may have goals in several domains.**

3. **Column 2 - Behavioral Objectives**

   - This column identifies the Behavioral Objective, the provider is responsible to work on during the plan year. Using the number corresponding with the Life Quality domain, and the short-term goal alpha designation, add a numeric number to define the objective, i.e. 2.A.1. If there is more than one objective number them consecutively, i.e. 2.A.2, etc.

- Add a baseline after each objective. This may be a short narrative, or a percentage can be used if it includes criteria.

4. **Monthly/Six Month and Annual Columns – Formal Services/Data Collection**

- The Behavioral Objectives Reporting Key may be used on a monthly basis. Percentages or some other designation may be used. For the monthly information. The key **must** be used for the Six Month Status Review and the Annual Status Review. Identify the progress towards outcomes monthly or at least at the 6 month Status Review and place the corresponding key number in the column. This number will be transferred to the Plan Monitor Status Summary.

- **BEHAVIORAL OBJECTIVES REPORTING KEY – SEE ATTACHED FORM**

- **INFORMAL SERVICES**

  - Using the numeric notation from column one identify the **informal** service being delivered to accomplish that goal. These are **paid** activities/programs **with non-objective based data**. Services may include but are not limited to linking services, monitoring, and maintenance oversight. (i.e**.** CFH provider will transport to health club 2x per week).

- **STATUS OF SERVICES**

  - Using the key for reporting, identify the status of each service.

- **INFORMAL SUPPORTS**

  - Informal supports are natural supports that are not paid.

- **STATUS OF INFORMAL SUPPORTS**

  - Using the key, identify the status of each informal support.

- **SERVICES AND INFORMAL SUPPORTS REPORTING KEY – SEE ATTACHED FORM**

- **PROVIDER COMMENTS**

  - The provider must make a comment in this column when an objective has deteriorated, made no progress, or discontinued. A comment is also required if there is a problem achieving the outcome of the objective.   A comment must be made about a service that is pending or discontinued.

Instructions: The Plan Monitor will complete a Status Summary two (2) times per year. This summary is based on the Provider Status Reviews that are submitted to the Plan Monitor six (6) months aft
Plan Monitor should contact the participant at the (6) month review to assure they are satisfied with their services. The Plan Monitor will use the provider information as a tool to evaluate plans and ini
based on evaluating the goals to be accomplished within plan year.   List plan goals and identify progress in each column by placing a number 1 in the column The Plan Monitor must report on natural
service provider type and add the provider name, i.e., CSE-Work Inc. **Place a number one (1) in each category/domain that applies. (The columns will calculate themselves.)**

PLAN MONITOR STATUS SUMMARY

Participant Name: **Medicaid Number:**   **Plan Start Date:**

Semi- annual review date: **Annual review date:**

Use the semi-annual date line for the 6 month review and the Annual date line for the annual review. Do not put dates on both lines.

KEY FOR REPORTING LIFE QUALITY DOMAINS	KEY FOR REPORTING PROGRESS TOWARDS OUTCOMES	KEY FO...
1 = Live a healthy lifestyle	1 = Achieved (100% of established criteria)	P = Pending
2 = Obtain/Maintain a personal residence	2 = Substantial Progress (50% or better of the established criteria)	O = Ongoing
3 = Live as independently as I am able	3 = Some Progress (Less than 50% of the established criteria)	C = Complete
4 = Engage in socially appropriate behavior	4 = No Progress (No change from previous report)	D = Discontinue
5= Work at a Job I like	5 = Decline in Progress (Below established baseline)	* = Change
6 = Become an active participant in my community	6 = Maintenance	
7 = Manage my personal finances	* = Change in Plan	
8 = Manage my personal time		
9 = other		

Formal Services - Objective Based Data (Paid)

GOALS TO BE ADDRESSED WITHIN PLAN YEAR	Pending	Ongoing	Complete	Discontinue	Change	Achieved (100% of established criteria)	Substantial Progress (50% or better of the established criteria)	Some Progress (Less than 50% of the established criteria)	No Progress (No change from previous report)	Decline in Progress (Below established baseline)	Maintainence	
Totals	0	0	0	0	0	0	0	0	0	0	0	

Informal Services - Non-Objective Based Data (Paid)											
GOALS TO BE ADDRESSED WITHIN PLAN YEAR	Formal Service	Informal Service	Complete	Discontinue	Informal Supports	Achieved (100% of established criteria)	Substantial Progress (50% or better of the established criteria)	Some Progress (Less than 50% of the established criteria)	No Progress (No change from previous report)	Decline in Progress (Below established baseline)	Maintainence	
Totals	0	0	0	0	0	0	0	0	0	0	0	

GOALS TO BE ADDRESSED WITHIN PLAN YEAR	Formal Service	Informal Service	Complete	Discontinue	Informal Supports	Informal Supports - Non-Paid					
						Achieved (100% of established criteria)	Substantial Progress (50% or better of the established criteria)	Some Progress (Less than 50% of the established criteria)	No Progress (No change from previous report)	Decline in Progress (Below established baseline)	Maintainence
Totals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

ter the plan start date and with the annual plan. T
itiate action to resolve any concerns. The review
supports and services. Use a bolded heading for ea

_____

OR REPORTING SERVICES

Plan Monitor Comments

Plan Monitor Comments

Plan Monitor Comments

June 2004-R

PLAN MONITOR STATUS SUMMARY

1. The Plan Monitor must complete a Status Summary two (2) times per year. This review is based on the Provider Status Reports that are submitted to the Plan Monitor six (6) months after the plan start date and to the person centered planning meeting for the annual meeting.

2. The Plan Monitor should contact the participant after reviewing the 6 month Provider Status Reports to assure they are satisfied with their services.

3. The Plan Monitor will use the provider information as a tool to evaluate plans and initiate action to resolve any concerns. The review is based on evaluating the goals to be accomplished within the plan year.

4. The type and amount of information is based on individual plans. Comments shall include concerns, need for follow-up, or need to reconvene the person-centered planning team. If there is no need for a comment, use a phrase similar to "no comment".

5. The Plan Monitor will file the semi annual Provider Status Reports and their Plan Monitor Summaries in the agency participant file. The annual Provider Status Reports and Plan Monitor Summary will be used as part of the information for the annual person-centered planning process and attached to the annual plan submitted to the Assessor.

PLAN MONITOR STATUS SUMMARY SECTIONS DEFINED

o The first is "Formal Services" – Objective Based Data (Paid).

o The second is "Informal Services" – Non-Objective Based Data (Paid). Transportation would be an example of this.

o The third is "Informal Supports" – Non Paid. Attending church would be an example of this.

- There are separate keys for reporting the domains, the progress toward outcomes, and the services. **Place a number one (1) in each category/domain that applies. (The columns will calculate themselves.)**

GOALS TO BE ADDRESSED WITHIN PLAN YEAR

- This column identifies the short-term goals the participant is working on during the plan year. Use a bolded heading for each service provider type and add the provider name, i.e., **CSE-Work Inc.** Then using the number corresponding with the Life Quality Domain, identify each goal associated with that domain that is listed on the plan. Life Quality Domains are listed numerically and consecutively in the key at the top of the form. Some provider types may use more than one domain. Continue by listing the domains and the goals under each provider type.

PLAN MONITOR COMMENTS

- Comments must include concerns, need for follow-up or need to reconvene the person-centered planning team. If progress is being made at the six month review, the comment may include "Continue until annual review date". If there is no need for a comment, use a phrase similar to "no comment".