

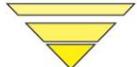
# Individual Support Plan Guide



**FACILITATING  
INDIVIDUALIZED SERVICES AND SUPPORTS**

**February 19, 2016**

MISSOURI DIVISION OF  
DEVELOPMENTAL  
DISABILITIES



Improving lives THROUGH supports and services  
THAT FOSTER self-determination.

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MISSOURI DEPARTMENT OF MENTAL HEALTH

## **Table of Contents**

	<b><u>Page</u></b>
<b>Introduction</b>	3
THE INDIVIDUAL SUPPORT PLANNING TEAM	4
FACILITATING THE PERSON CENTERED PLANNING PROCESS	
Choosing the Support of a Facilitator	
Understanding Communicating Styles	5
<b><u>PART II: CREATING THE INDIVIDUAL SUPPORT PLAN</u></b>	
Review of Previous Years Information, Assessments and Supports	6
ISP Timetable	
ISP Components	7
Demographics & Contributors/Support Team	8
Vision for a Good Life: What is important to the Individual?	9
What Does Everyone Need to Know or Do to Support the Individual?	10
Relationship and Community Based Supports (Non Division Supports)	11
<b><u>MISSOURI QUALITY OUTCOME LIFE DOMAIN AREAS</u></b>	11
 <b>DAILY LIFE &amp; EMPLOYMENT</b>	
Career Planning- Community Life Engagement	12
 <b>COMMUNITY LIVING</b>	
Choice Housing	15
Transitioning into Different Living Settings	17
 <b>SOCIAL AND SPIRITUALITY</b>	20
 <b>HEALTHY LIVING</b>	21
 <b>SAFETY &amp; SECURITY</b>	
Supports Needed for Safety	24
Behavioral Risk and Prevention	25
Individual Rights/Due Process	27
 <b>CITIZENSHIP &amp; ADVOCACY</b>	
Personal Income (Formerly Management of Individual Funds)	30
Self-Directed Supports	32
Choice of Service, Provider and Option of Self-Directed Supports	34
Conflict Resolution	36
PERSONAL OUTCOMES AND IMPLEMENTATION PLAN	37
BUDGET/AUTHORIZATION PAGE	39
MONITORING OF ISP	40
APPENDIX A: ADDITIONAL REFERENCES / RESOURCES	41
APPENDIX B: IMPLEMENTATION PLAN	42
APPENDIX C: ISP TEMPLATE EXAMPLES	43

## Introduction

The Division of Developmental Disabilities requires that each person eligible for Division supports have an Individual Support Plan (ISP).

In January of 2014, the Centers for Medicare and Medicaid Services (CMS) published a final rule **42 CFR 441.301(c)(1)** regarding changes to Home and Community-Based Waiver Services (HCBS). The rule will help people get the services they need in truly integrated settings. You can read more about this rule by going online to: [www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf](http://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf) The final rule includes six standards that all home and community-based services need to meet: 1) integration into the community; 2) individual choice; 3) individual rights; 4) autonomy; 5) choice regarding services and providers; 6) person-centered planning. This guide has been updated to ensure compliance with the rule. The Person Centered Planning section of the rule distinguishes between the person centered planning process **42 CFR 441.301(c)(1)** and the person centered individual service plan **42 CFR 441.301(c)(2)**. You can find references to the CFR throughout this guide.

**The Individual Support Plan (ISP)** is a document that results from the person centered planning process, which identifies the strengths, capacities, preferences, needs and personal outcomes of the individual. The ISP includes a personalized mix of paid and non-paid services and supports that will assist the person to achieve personally defined outcomes. The ISP Guide will provide a brief overview of person centered planning process requirements, but the purpose of this document will focus on the creation of the Individual Support Plan.

Additionally this guide has been updated to match the new Missouri Quality Outcomes which were updated August 2015. The Missouri Quality Outcomes (MOQO) were developed to emphasize quality of life for individuals receiving services and supports. The MOQO are key to facilitating discussion during the Person Centered Planning process and developing the ISP. MOQO includes the different life domains that everyone experiences as we age and grow. Everyone (whether they have a disability or not) has to figure out: what they are going to do during the day— go to school, volunteer, get a job; where they are going to live; how they are going to stay healthy and safe; and so on. We all have people in our life and supports in our communities that allow us to have a good life.

**Icons\***  
Each MOQO has a correlating "Charting the Life Course" icon to assist in using the guides together.

-  Daily Life
-  Community Living
-  Social Spirituality
-  Healthy Living
-  Safety & Security
-  Citizenship & Advocacy
-  Supports to Families

The icons\* on the left represent the different life domains.



**Visit MO Family to Family to learn more about "Charting Your Life Course" [mofamilytofamily.org](http://mofamilytofamily.org)**

\*Icons taken from [www.lifecoursetools.com](http://www.lifecoursetools.com), a free online resource from Missouri Family to Family © UMKC Institute for Human Development, UCEDD 2012-2014

The ISP Guide has been organized to match the life domains of the Missouri Quality Outcomes.

## **PART I: OVERVIEW OF INDIVIDUAL SUPPORT PLANNING PROCESS**

A person centered planning process is the means by which information is gathered to create an individualized support plan.

The Person Centered Planning process ensures:

- *“The individual will lead the person centered planning process where possible. The individual’s representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual’s representative. In addition to being led by the individual receiving services and supports, the person-centered planning process”:* **42 CFR 441.301(c)(1)**
- *Includes people chosen by the individual.* **42 CFR 441.301(c)(1)(i)**
- *Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.* **42CFR 441.301(c)(1)(ii)**
- *Is timely and occurs at times and locations of convenience to the individual.* **42 CFR 441.301(c)(1)(iii)**
- *Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.* **42 CFR 441.301(c)(1)(iv)**
- *Includes strategies for solving conflict or disagreement within the process, including clear conflict-of interest guidelines for all planning participants.* **42 CFR 441.301(c)(1)(v)**
- *Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.* **42 CFR 441.301(c)(1)(vi)**
- *Offers informed choices to the individual regarding the services and supports they receive and from whom.* **42 CFR 441.301(c)(1)(vii)**
- *Includes a method for the individual to request updates to the plan as needed* **42 CFR 441.301(c)(1)(viii).**
- *Records the alternative home and community-based settings that were considered by the individual.* **42 CFR 441.301(c)(1)(ix)**

### **THE INDIVIDUAL SUPPORT PLANNING TEAM**

The development of the ISP (the ISP is the document) reflects a person-centered planning process. It involves as many people or organizations as needed to achieve the personal outcomes for each individual. The Person Centered Planning process helps people achieve their personal life goals and evolves as the individual’s life evolves. The planning team consists of an individual and his/her support team.

The Support Team helps individuals develop their Individual Support Plan. A strong individual support planning team builds and sustains relationships; team members will have community contacts and naturally occurring relationships and resources. Team members cooperate in solving problems and helping individuals attain their potential, achieve life goals, and to realize their dreams.

## **FACILITATING THE PERSON CENTERED PLANNING PROCESS**

The individual may choose to facilitate their own planning process or choose a facilitator. It is important that the Person Centered Planning Process, “Provides *necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions*”. **42 CFR 441.301(c)(1)(ii)**

Tools that can assist the individual in directing their own planning process include:

- **Individual Support Plan (ISP) Individual and Family Guide** PDF Document *(In development)*
- [My Choice!: Guide for Creating your Own Individual Support Plan when Self-Directing Supports Online Viewing](#) *(This document will be updated in 2016)*

### Choosing the Support of a Facilitator

The individual may ask anyone to help them facilitate their planning process. It may also be a friend, a support coordinator or professional affiliated with another agency or provider. Since individual support planning is about relationships, a facilitator either has a relationship with the individual, or establishes a relationship with the individual prior to the meeting. The facilitator’s ability to ask the right questions, and to communicate directly with the focus individual, will enhance the plan and its process. The facilitator’s credibility with the individual, community and support system will dramatically influence the success of the planning process.

Look for a facilitator who has the following attributes: Team player, works well with others; Flexible and open-minded, does not make assumptions; Individual-centered and skilled at keeping the focus of the meeting on the individual; Good listening skills and ability to interpret behavior as communication; Skilled at checking back with the individual and the team; Consistent and experienced with follow-through.

### Understanding Communicating Styles

To support others in self-determination, team members must be experienced in listening to and understanding the individual’s communication style. All communication is purposeful, and all people have a need to communicate. Some individuals have difficulty communicating. Most people express ideas, feelings and desires through words, gestures and body language to convey messages and to respond to others. In some situations, the individual’s method of communication may be perceived as inappropriate. Communication requires a willingness to use all available means in order to understand and to be understood (e.g., pictures, sign language, gestures, body language, augmentative devices, interpreters, etc.). Alternative methods, including interpreters as needed for communication, should always be available at the planning meeting

**The Planning team may use a variety of approaches and resources during the planning process. See Appendix A for list of resources.**

## PART II: CREATING THE INDIVIDUAL SUPPORT PLAN

The Individual Support Plan (ISP) is a document that results from the person centered planning process, which identifies the strengths, capacities, preferences, needs and personal outcomes of the individual. The ISP includes a personalized mix of paid and non-paid services and supports that will assist the person to achieve personally defined outcomes.

The ISP:

- Is based on assessments which allows for the gathering of comprehensive information concerning each individual's preferences, individual needs, goals and abilities, health status and other available supports gathered and used in developing the individual plan. Emphasize social networks as an important factor in the quality of life for the individual
- "Documents that informed choices have been offered to the individual regarding the services and supports they receive and from whom". 42 CFR 441.301(c)(1)(vii)
- Result in a comprehensive plan—Address the individual's need for supports, healthcare or other supports in accordance with his/her expressed preferences and goals).
- "Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter." 42 CFR 441.301(c)(2)(vii)
- The Support Coordinator is responsible for "writing" the plan, and is responsible for gathering information from all team members in order to develop a comprehensive document that is representative of the input from all members of the circle. *Providers of HCBS for the individual or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan.* 42 CFR 441.301(c)(1)(vi)

### REVIEW OF PREVIOUS YEARS INFORMATION, ASSESSMENTS AND SUPPORTS

There should be a review of the previous year's information. A review of current supports and their progress towards previous outcomes should be conducted in order to identify the ongoing support needs.

The following should be considered:

- Were the supports provided in the manner with which authorized?
- Did the supports address the outcomes and support needs of the individual as identified in the plan?  
Does the level of the current supports meet the individual's need?

There should be a review of service / support definitions to ensure that the required components for those supports are included in the final plan document.

The ISP must "Reflect clinical and support needs as identified through an assessment of functional need." 42 CFR 441.301(c)(2)(iii) and "Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed" CFR 44.301(c)(2)(vi)

Assessments & Tools Used in Creating the ISP	
List assessments and tools used for planning	Mandatory

## **ISP TIMETABLE**

INITIAL ISP: CMS / Home and Community Based programs require that each individual found eligible for supports which is initially support coordination, have a plan in place within 30 days of eligibility.

The initial plan shall not exceed 365 days. Before the start of any waived support, there must be a plan in place to identify the approved supports / services.

ANNUAL ISP: While the planning process is ongoing, each plan is only valid for 365 days.

An annual individual support planning meeting shall be held 60-90 days prior to the date of expiration so that the renewed plan starts on the same date of the new year. This will provide enough notice to all support team members and to allow adequate time to gather the information needed. The ISP shall not be extended and therefore, there shall not be any gap in implementation dates. If the individual has a DMH funded support other than support coordination, it must be authorized with each new plan in order to be entered into the support delivery system.

The Support Coordinator is responsible for ensuring that the planning meeting process is in place and that planning support team is invited or has a means for contributing to the ISP.

It is the Support Coordinators responsibility to ensure the ISP meeting “Is timely and occurs at times and locations of convenience to the individual.” **42 CFR 441.301(c)(1)(iii)**

## **ISP COMPONENTS**

The following sections are an outline of “core components” that are areas to be covered in the ISP. This is a combination of *system required* components and a balance of areas that reflects what is most important to (preferences, interest, goals and what makes a good life, etc.) the individual and what is most important for the individual (health and safety needs for example) to assist in the development of a comprehensive plan.

Each table indicates whether subcategories are mandatory, optional or contingent:

<b>Mandatory</b>	These are the required areas to be reflected in the ISP.
<b>Contingent</b>	If it is applicable to the individual / family / it is required. If not, it is not necessary to reflect in the ISP.
<b>Optional</b>	Any additional information chosen by the individual, family, guardian.

NOTE: The following components may be reflected in the ISP by also referring to other documents or sources of information that assist in providing support to the individual.

**DEMOGRAPHICS & CONTRIBUTORS/SUPPORT TEAM**

Components of the plan that must be developed in the area of demographics. Include information about legal status, restrictions placed by the court system, and dated signatures of the individual, legal guardian (if appropriate), the support coordinator and all individuals and providers are responsible for implementation of the ISP.

CONTRIBUTORS/Support Team: Those who contributed to the plan through interviews, reports, letters, questionnaires, etc. and those present at the plan meeting. NOTE: The support coordinator assures that individuals and their guardians receive a copy of the ISP document as well as all providers of services that are actively delivering funded supports. The ISP is to: “Be distributed to the individual and other people involved in the plan”. **42 CFR 441.301(c)(2)(x)**

<b>DEMOGRAPHIC and CONTRIBUTORS INFORMATION</b>	
Full Legal Name (may use middle initial)	Mandatory
Nicknames and/or alias	Optional
Date of Birth	Mandatory
DMH ID	Mandatory
Individual Plan Meeting Date	Mandatory
Individual Plan Implementation Date	Mandatory
Regional Office/Habilitation Center	Mandatory
TCM Agency	Mandatory
Healthcare Resources Utilize (Including Medicare, Medicaid, dental insurance, Spend down and private health insurance)	Mandatory
<b>LEGAL DEMOGRAPHICS</b>	
Legal Status	Mandatory
Guardianship (Name, address, phone number and relationship to the individual)	Mandatory
Specific restriction placed by court	Contingent
Consent for Treatment	Mandatory
Signatures* The ISP must: “Be finalized and agreed to, with the informed consent of the individual (Guardian) in writing, and signed by all individuals and providers responsible for its implementation.” <b>42 CFR 441.301(c)(2)(ix)</b> *Provider Bulletin on <a href="#">Individual/Guardian Signatures on ISP's PDF Document</a> is available.	Mandatory
Voter Status	Contingent
Custody (children)	Contingent
<b>CONTRIBUTORS</b>	
States how the individual participated in the development of their ISP	Mandatory
List those who contributed and how they did so	Mandatory
If the individual is not present at the planning meeting, the team must justify the individual’s absence and how the individual was otherwise involved in the	Mandatory

**VISION FOR A GOOD LIFE: WHAT IS IMPORTANT TO THE INDIVIDUAL**

This area includes a description of what the individual thinks is important to have a good life. When reading the plan, it should be easy to distinguish the difference between what is important to the individual from what is important to others.

**WHO IS IMPORTANT TO THE INDIVIDUAL?**

Caring for and about other people and having other people care for and about us is what makes our lives meaningful. Many people who receive services have lost touch with or never developed relationships with people who are not paid to be with them. It is important to know about the individual’s *social support network*. This includes who is important to the individual, what the individual likes to do with them and about how often. The information discussed during this part of the planning may assist individuals in maintaining relationships, as well as discovering desires to develop new relationships.

It is important that the team intentionally assist individuals in building relationships with people they already know or can facilitate meeting new people in order to create new relationships with the foundations identified here.

<b>VISION FOR A GOOD LIFE and WHO IS IMPORTANT</b>	
What an overall ‘Good Life’ looks like: Hopes, Dreams & Wants	Mandatory
Needs or conditions that must be in place to achieve a good life	Mandatory
Personal Strengths and Assets	Mandatory
Preferences Likes (Special Interests) & Dislikes	Mandatory
What the Individual Would Like to Try	Mandatory
Support Preferences (e.g., Does the individual prefer a female or male for his/her support needs or for a specific task / activity such as bathing?)	Mandatory
Reflects cultural considerations of the individual <b>42 CFR 441.301(c)(1)(iv)</b>	Mandatory
Information about the general topic of important relationships	Mandatory
Information about relationships the individual may want to enhance or explore	Contingent

**WHAT DOES EVERYONE NEED TO KNOW OR DO TO SUPPORT THE INDIVIDUAL?**

This information helps define *what is important to know and do in order to support* the individual. The support section of the plan is a crucial component in order to ensure that assessed needs are met. It is an area that identifies “how” the supports need to be provided day to day.

*The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State’s 1915(c) HCBS waiver, the written plan must: 42 CFR 441.301(c)(2); Reflect the individual’s strengths and preferences. 42 CFR 441.301(c)(2)(ii)*

Supports describe:

- The role of the supporters: what are they supposed to do – specifically to assist in the way the individual prefers?
- Specifics about what works and does not work for the individual.
- The specifics or protocols necessary to develop and/or maintain the health, safety, behavioral or risk issues for the individual.

The support sections are the tool for:

- New staff working with the individual or family.
- Matching the characteristics of staff to the individual supported.
- Use as a teaching and learning tool developed by those who know and care about the individual.
- Use during a type of transition (for example: traveling from home to work, change in schedules, transitioning from weekday to weekend, change in staff, etc.)

Support must reflect the assessed needs of the individual in order to maintain or enhance a good life and ensure health/safety.

<b>WHAT WE NEED TO KNOW IN ORDER TO SUPPORT THE INDIVIDUAL*</b>	
*Not required that this be a separate sections of the ISP it may be incorporated within the MOQO Life Domains	
A description of how supports should be delivered	Mandatory
Describe supports that are currently effective and need to continue to ensure consistency in the way supports are delivered	Mandatory
Rituals and routines important to and for the individual	Contingent
Primary Language Used (Required if the primary language is other than spoken English. If sign language is used, state what type of sign)	Contingent
Method of Communication (Required if the primary mode of communication is other than speaking: communication boards, interpreter, etc.)	Contingent
How an individual learns best (including <i>how the individual learns</i> optimizes opportunities to reach preferred outcomes)	Contingent
A “ <b>Communication Chart</b> ” may be used to describe supports when we are trying to figure out how an individual is using their communication: Add link to tool	Contingent

**RELATIONSHIP AND COMMUNITY BASED SUPPORTS (NON-DIVISION SUPPORTS)**

The intent of division services is to supplement and strengthen existing natural supports, such as those provided by family, friends, and the community. Supports MUST not be duplicative. Planning teams need to determine an individual’s eligibility for Mo HealthNet (state plan) services; Division of DD funded services should not supplant or duplicate state plan services. Referrals for state plan Personal Care Assistance should not be made when the intent is to teach, prompt or accompany the individual into the community.

The ISP must: *“Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.”* **42 CFR 441.301(c)(2)(v)**. The ISP must: *“Prevent the provision of unnecessary or inappropriate services and supports”*. **42 CFR 441.301(c)(2)(xii)**

Natural supports and relationships are an integral part of everyone’s lives and should be fostered and encouraged by all planning team members (circle of support) to assist with the development of a well-rounded *circle* for the individual.

Information should:

- define the support,
- define the purpose of the support
- define the frequency of the support

This information should assist in providing a global picture of all supports available to the individual and to describe the supports needed to wrap around other *available* supports in the community.

<b>NATURAL SUPPORTS AND NON-DIVISION SUPPORTS</b>	
*Not required to be a separate section of the ISP. It may be incorporated within the MOQO Life Domains.	
Information about natural supports available to the individual	Mandatory
<b>Information about State Plan Services:</b> These supports shall be accessed prior to Division funded supports. (When using Personal Assistant Services- The ISP must clarify whether Personal Assistance is for hands on assistance (State Plan Services) versus cueing/prompting/training (DD) and whether the service is to be performed in the home only (State Plan Services) versus community (DD). ISP must document referral to DHSS for State Plan personal care or reason for not being referred to DHSS. )	Mandatory
Information about enrollment in Non-Division Waiver programs	Mandatory
Information about community-based supports currently being assessed or utilized (i.e. clubs, community associations, gyms, library, animal shelter etc....)	Mandatory

**MISSOURI QUALITY OUTCOME LIFE DOMAIN AREAS**

The following components of the ISP have been organized based on the Missouri Quality Outcomes (MOQO) quality of life domains. Each domain will contain information about supports received by the individual based on assessed need including information on “What does everyone need to know to support the individual?” It also includes information on waiver, relationship and community based supports (non-Division supports); the frequency and duration of the supports and if it is mainly a support provided or a personal outcome area which requires a Personal Outcome Implementation Plan.



### Daily Life & Employment

#### People Participate in Meaningful Daily Activities of Their Choice

This section of the ISP is designed to support individuals to make informed choices and encourage self-determination in pursuing daily activities of their choice while exploring the full range of options; including employment, volunteering, use of free time and participating in activities of their choice. Outcomes/Supports should be individualized to assist in achieving maximum potential.



#### Daily Life & Employment / Career Planning- Community Life Engagement

The Americans with Disabilities Act (ADA) prohibited the discrimination of individuals with disabilities in employment, services, activities and programs. It requires supporting all individuals with access to the most integrated setting in the community which enables individuals with disabilities to interact with people without disabilities to the fullest extent possible. The U.S. Supreme Court’s Olmstead Decision in 1999 re-affirmed the rights of all individuals with disabilities to full inclusion in their communities without unjustified segregation. Subsequent U.S Supreme Court decisions and U.S. Department of Justice enforcement has focused on state and local activities regarding assurances of competitive employment in the community, career planning and eliminating the discriminatory overreliance on segregated day/employment services.

The Centers for Medicare and Medicaid Services (CMS) regulation for Home and Community Based Services (HCBS) implemented new requirements to assure community settings which enhance expectations and protections for individuals receiving long term support and services. This is CMS’s assurance that the ADA and Olmstead Decision are being supported for all individuals with intellectual/developmental disabilities.

This ensures the Home and Community-Based setting: 1) Is integrated in and supports full access to the greater community; 2) Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources; 3) Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid HCBS.

**Clear and convincing documentation is required which assures full compliance with Title II of the ADA, Olmstead Ruling and the HCB Community Setting Rule for Individuals who explicitly report having no interest in employment.**

#### Transition Youth

Although schools may not require transition planning until age 16 (or younger if determined by the Individualized Education Program planning team), *the Division of Developmental Disabilities Individualized Support Plan must reflect supports and actions that will be taken to improve employment and post-secondary outcomes beginning at the age of 6.*

**Ages 6 to 16: The ISP must contain information in the profile and, if applicable, goals/outcomes to reflect the work that is being done with the individual, schools, families to:** Build and practice self-determination skills; Ensure career assessments and interest inventories are being conducted for career planning; Continue to develop social and other “soft skills” that are critical to success; Explore interests, aptitude, abilities and understanding adult roles; Assist the individual to learn about available work and career opportunities; Expand and build social capital (community connections/business leaders); Participate in monitored early work experiences such as volunteerism, job shadowing and community service; Develop, improve and practice independent living skills.

**Age 16 and above: The ISP should consider adding the following in addition to the above:** Identify community support programs (Vocational Rehabilitation, Centers for Independent Living, County Boards, Missouri Job Centers, etc.) that may be needed and ensure appropriate referrals have been made; Match career interests, skills and academic coursework with real work experiences in the community; Develop and improve job interviewing skills, resume development, expertise in completing job applications; Identify accommodations that may be needed; Describe how the individual will learn about what benefits and services (Social Security, Medicaid, Personal Assistance Services, etc.) they are currently receiving and how to manage them.

**Employment / Career Planning Assessments and Tools Used in Planning**

<b>Assessment/Tools</b>	<b>Purpose</b>
<a href="#">Career Planning ISP Questions</a>	Tool used to assure meaningful and purposeful support coordination has occurred which affirms protected rights of employment, opportunities to explore employment, informed choice and individualized employment planning.
<a href="#">Charting the LifeCourse - Daily Life and Employment</a>	Facilitates discussion and assists the individual with beginning the process of exploring employment and career planning.
<a href="#">Youth Transition and Employment Webpage on Employment</a>	The Employment page of the Division of DD website has many helpful resources for employment supports.
<a href="#">DisabilityBenefits101</a>	Benefits calculator funded by DD to educate and provide individualized guidance on earned income, asset development and increased financial independence.
<a href="#">The Career Planning Guide – Missouri DD Council</a>	Facilitates discussion and assists the individual with beginning the process of exploring employment and career planning.
<a href="#">My Next Move</a>	Interactive tool to assist individuals learn more about their career options; and the tasks, skills and salary information of these career options.

<b>Daily Life &amp; Employment/Career Planning ISP REQUIREMENTS FOR EVERYONE</b>	
Supports or 'Personal Outcomes' discovered during review the <a href="#">Career Planning ISP Questions</a> .	Mandatory
Documentation of benefits counseling and planning to assist individuals and stakeholders with making informed choices on asset development and financial literacy.	Mandatory
<b>ADDITIONAL REQUIREMENTS FOR EMPLOYED INDIVIDUALS</b>	
Identify the following information: Name of employer, average number of hours worked a week, hourly wage and job title.	Mandatory
If waiver funded services are used to maintain employment: Describe how natural supports are being developed and the specific-targeted job skills being developed. Include the methodology for evaluating the need for continuation of these services.	Mandatory
For Individuals in Group Supported Employment: Document the justification for Group Supported Employment if the individual demonstrates the capacity to work in an individual setting similar to those not receiving HCB services.	Contingent
<b>ADDITIONAL REQUIREMENTS FOR INDIVIDUALS WITHOUT CAREER PLANNING OUTCOMES</b>	
Describe the rationale for excluding employment as an outcome. Outline the activities, experiences and conversations which will occur promoting future career planning outcomes.	Mandatory

CFR  
 DD Waiver Manual-  
 Support Coordinator Manual  
 Division webpage: <http://dmh.mo.gov/dd/progs/employment.html>  
<http://dmh.mo.gov/dd/olmstead/>  
<http://dmh.mo.gov/docs/dd/employmentpolicyfinal.pdf>



**Community Living**

**People Live in Communities They Choose, With Whom They Choose and in Homes and Environments Designed to Meet Their Needs**

*This section of the ISP emphasizes individuals being leaders in selecting the community and home of their choice. The home is designed to meet the individual's unique needs. Individuals actively choose who they live with and where.*



**COMMUNITY LIVING: CHOICE HOUSING**

In January of 2014, the Centers for Medicare and Medicaid Services (CMS) announced a new Home based and Community Support Rule (HBCS) that may help people get the services they need in truly integrated settings. The new rule sets forth standards for the settings where people receive home and community-based services. Division of DD housing goal is to ensure the development quality, affordable, accessible housing for people with disabilities in safe locations where they can access support services, transportation, employment, and recreation throughout their lifespan.

**Assessments and Tools Used in Planning**

Assessment/Tools	Purpose
<a href="#">Community Living and Choice Housing ISP Questions</a>	Tool used for planning to ensure the individual has chosen where they live, have privacy and have the support they need in their home.
<a href="#">"It's My Home: A Guide for Individuals and Families to Understand the Division of Developmental Disabilities' Housing Initiative with added information from the Final HCBS Rule" PDF Document</a>	This guide helps facilitate discussion about information which is important to individuals regarding their home. And provides information about the Division's Housing Plan, and what the guiding principles mean for individuals and families.
<a href="#">Housemate Survey Tool</a> <a href="#">Housemate Survey Tool (Brief Version)</a>	Identifies an individual's preferences and interests to assist in determining compatibility of potential housemates. This is a more comprehensive version of this tool.
<a href="#">Safe and Sound: Tips to consider when looking for compatible housemates</a>	Used to assist the planning team in determining compatibility of potential housemates.
<a href="#">Housing Resources Tip Sheet</a>	Used to help identify resources which may assist the individual in obtaining affordable, accessible housing

**HOUSING ISP REQUIREMENTS**

Reflect that the setting in which the individual resides is chosen by the individual. <b>42 CFR 441.301(c)(2)(i)</b>	Mandatory Residential Services
Records the alternative home and community-based settings that were considered by the individual. <b>42 CFR 441.301(c)(1)(ix)</b>	Mandatory Residential Services
Supports or personal outcomes discovered during Housing Assessment.	Mandatory Residential Services Contingent for others
The housing/residential setting options identified for an individual are supported by an assessed need and documented in the person centered service plans based on the individual's needs and preferences <b>(42CFR 441.301(4)(ii))</b>	Mandatory Residential Services

## Authority and Other References

The setting...*“Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.”* —

### **42 CFR 441.301(c)(4)(iv)**

“The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual’s needs, preferences, and, for residential settings, resources available for room and board.” —42 CFR. 441.301(c)(4)(ii)

“The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.” —42 CFR. 441.301(c)(4)(i)

The setting...*“Ensures an individual’s rights of privacy, dignity and respect, and freedom from coercion and restraint.”* —

### **42 CFR 441.301(c)(4)(iii)**

Support Coordinator Manual Section : Community Living: Housing

<http://dmh.mo.gov/docs/dd/scmanual/scmanualhousingsection.docx>

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## COMMUNITY LIVING: TRANSITIONING INTO DIFFERENT LIVING SETTINGS

1. **Moving to a New Supported Living Setting**
2. **Transitioning from Habilitation Center**

1. **Moving to a New Supported Living Setting:** Planning and collaboration are key elements to a successful transition for an individual moving to a new supported living setting such as an ISL, host home, or group home. A transition meeting is required whenever an individual is moving into a new supported living setting from their natural home or another supported living situation. The purpose of the transition meeting is to plan all supports the individual will require to be successful in their new home.

Participants in the transition meeting include the individual, his or her family and/or guardian, sending and receiving support coordinators, sending and receiving service providers, Regional Office Community Living Coordinator, Regional Office RNs and Behavior Resource staff, as needed, and any other staff necessary to provide input in the transition planning process.

2. **Transitioning from Habilitation Center to New Supported Living Setting:** Individuals living in a habilitation center may choose to receive their supports in a community setting. There are many options available for individuals who want to receive their supports in the community, including Individualized Supported Living and Self Directed Supports. The transition team for individuals choosing to transition to the community from a habilitation center includes the individual and his or her family and/or guardian, staff from the habilitation center, staff who will support the individual in the community, the receiving Support Coordinator and Regional Office staff. A transition coordinator leads the team in the planning process and writes the transition plan. The Support Coordinator who will be assigned to the individual once he or she moves is involved in the transition planning process and provides support monitoring and follow up during the transition period.

Assessments and Tools Used in Planning	
Assessment/Tools	Purpose
<a href="#">Provider Profile Directory</a>	Used to provide individuals, families and guardians information about potential service providers
<a href="http://dmh.mo.gov/docs/dd/scmanual/consumerprofile.pdf">Consumer Referral Profile Form at http://dmh.mo.gov/docs/dd/scmanual/consumerprofile.pdf</a>	Used to provide information about the individual's support needs to prospective providers. The profile is posted on the referral database along with the ISP and other current documents.
<a href="#">Housemate Survey Tool (Brief Version)</a>	Identifies an individual's preferences and interests to assist in determining compatibility of potential housemates
<a href="#">Housemate Survey Tool</a>	Identifies an individual's preferences and interests to assist in determining compatibility of potential housemates. This is a more comprehensive version of this tool.
<a href="#">Safe and Sound: Tips to consider when looking for compatible housemates</a>	Used to assist the planning team in determining compatibility of potential housemates
<a href="#">Checklist for Community Moves</a>	Used to plan action steps necessary to complete a transition
<a href="#">Community Transition Service Tipsheet</a>	When an individual is transitioning from a congregate living setting to a less restrictive community-based living arrangement this tip sheet assists in planning for start-up costs
<a href="#">Money Follows the Person Brochure</a>	When an individual is transitioning from a nursing facility, this brochure is used to provide information about the Money

	Follows the Person program to individuals, families, and guardians.
<b>Additional Resources if moving from Habilitation Center</b>	
<a href="#">4.270 Appendix A: Initial Transition Meeting Discussion Guide</a>	Used by the transition team to plan all the action steps necessary for a successful transition to the community.
<a href="#">4.270 Appendix B: Risk Screening Guide for Support Coordinators</a>	Used to assist in identifying potential and/or actual individual risks in areas of health, personal and environmental safety, individual rights, socialization, and financial. Risk information ascertained from this guide and additional sources helps determine if the person is or may be experiencing any risk issues that can be prevented or mitigated through formal and/or informal supports, and must be addressed in the Transition Plan.
<a href="#">h4.270 Appendix F: Housemate Compatibility Tool</a>	Used to assist the planning team in determining compatibility of potential housemates.
<a href="#">Community Transition Service Tipsheet</a>	When an individual is transitioning from a congregate living setting to a less restrictive community-based living arrangement this tip sheet assists in planning for start-up costs.

<b>ISP REQUIREMENTS: COMMUNITY TRANSITION</b>	
The ISP must be updated or amended to include current information regarding the change in living situation. It must include adequate supports for health and safety and to minimize difficulty in adjusting to any changes in his/her life that may occur with the change in living arrangements or supports.	Mandatory
Outcomes and action steps may need to be developed at the post-move review meeting held within one month of the move.	Contingent
In the case of an individual who is transitioning from a nursing home or habilitation center and who is participating in Money Follows the Person, the ISP must include the following statement throughout their MFP participation period: <i>“As <u> Name </u> is moving into a <u> number </u> person ISL/group home, he/she is eligible for the Money Follows the Person Demonstration. <u> Name’s </u> guardian has been notified of this option and has signed the agreement for their participation for one year. During this time, surveys will occur prior to discharge from <u> institution </u>, at one year and again at two years. If <u> name </u> is hospitalized or placed in an inpatient setting, regardless of the amount of time, the MFP project director (Julie Juergens: 573-751-8021) must be contacted. This will be the responsibility of <u> Support Coordinator name </u>, Support Coordinator. The <u> area </u> Regional Office provides a 24 hour call-in number for emergency back-up assistance if needed. <u> Name </u> and his/her guardian have been provided this number in the event that emergency back-up is needed.”</i>	Mandatory if transitioning from a nursing home or habilitation center and who is participating in ‘Money Follows the Person’
Additional individualized back-up plans should also be noted.	Mandatory
When the Community Transition Service is used, the ISP must identify that the services are necessary for the person to move from the congregate setting. The ISP must include a	Mandatory

specific list of approved transition start-up costs. See the <a href="#">Community Transition Service Tipsheet</a> for additional information.	
<b>Transitioning from Habilitation Center to Community Living Setting</b>	
The Transition Plan must identify all supports, services, accommodations, equipment, furnishings, etc. needed for the individual to be successful in the community.	Mandatory
Following the 30 day review meeting, the receiving Support Coordinator completes an addendum to the ISP which includes objectives for implementation in the community.	Mandatory

Authority and Other References

<p><a href="#">Division Directive 5.010</a> ( soon to be converted to Transition Manual)</p> <p>DD Waiver Manual- Section F</p> <p>Support Coordinator Manual Section I: Community Living</p> <p>Division webpage:</p> <p><a href="http://dmh.mo.gov/dd/olmstead/">http://dmh.mo.gov/dd/olmstead/</a></p> <p><a href="http://dmh.mo.gov/dd/communitytransitionprocess.html">http://dmh.mo.gov/dd/communitytransitionprocess.html</a></p> <p><a href="http://dmh.mo.gov/dd/progs/mfp.html">http://dmh.mo.gov/dd/progs/mfp.html</a></p>
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**Social and Spirituality**

**People Are Active Members of Their Communities While Determining Valued Roles and Relationships through Self-Determination**

*This section of the ISP is about is about presence and participation in the community, based on interests determined by the individual. Individuals are integrated into their community, including community service, in the same way as neighbors and fellow community members. Individuals have natural supports in their lives and relationships that are not based on their disability.*

**Assessments and Tools Used in Planning**

Assessment/Tools	Purpose
<a href="#">Personal Relationship ISP Questions</a>	Tool used for planning to assist in ensuring individuals have the support they need to enhance personal relationship.
<a href="#">Community Connections ISP Questions</a>	Tool used for planning to assist in ensuring individuals have the support they need to access the community.
<a href="#">LifeCourse Integrated Supports Star</a>	All people need support to lead good lives. Using a combination of many different kinds of support helps to plot a trajectory toward an inclusive, quality, community life. This tool will help families and individuals brainstorm the supports that they already have or might need in order to work in partnership to make their vision for a good life possible.
<a href="#">Charting the LifeCourse: Experiences and Questions Booklet</a>	This booklet helps individuals and families know the questions to ask and things to think about throughout the life course, in order to have the experiences that help lead to the good life that they envision. Most of the questions and life experiences in this booklet could apply to anyone, whether they have a disability or not! Community Living Section Pages 8 & 9

**COMMUNITY MEMBERSHIP ISP REQUIREMENTS**

Supports or 'Personal Outcomes' discovered during Personal Relationship ISP Questions.	Mandatory
Supports or 'Personal Outcomes' discovered during Community Connections ISP Questions.	Mandatory

**Authority and Other References**

"Home and community-based settings must have all of the following qualities, and such other qualities as the [Secretary](#) determines to be appropriate, based on the needs of the individual as indicated in their person-centered service plan: (i) The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS." —42 CFR 441.301(c)(4), (c)(4)(i)  
Support Coordinator Manual Section : [Community Membership](#) PDF Document

 <p><b>Healthy Living</b></p>	<p align="center"><b>People Are Able to Choose Health/Mental Health Resources and Are Supported in Making Informed Decisions regarding their Health and Well-Being</b></p> <p align="center"><i>ISP helps ensure the individual's right to receive physical, emotional and mental health care from the practitioner of their choice. Individuals receive information and education on ways to maintain their health and well-being. Individuals are supported in making healthy choices.</i></p>
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Healthy Living emphasizes the individual's right to receive physical, emotional and mental health care from the practitioner of their choice. Individuals receive information and education on ways to maintain their health and well-being. Individuals are supported in making healthy choices. This section identifies and addresses all health issues, conditions, risks and related supports.

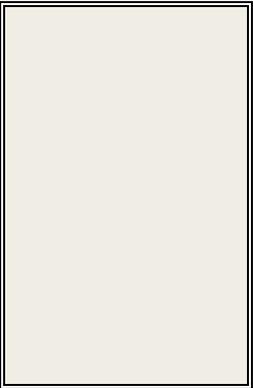
The ISP should be a written guide for supports and personal outcomes that will enhance the person's quality of life and keep him/ her safe and in optimum health.

As part of ongoing support to an individual, consider health and medical risks and address those identified risks in the individual's plan. As part of the information gathering process, there are a number of resources available that should be considered including: consultations, formal assessments by medical professionals, diagnoses, and recommended prevention measures for an individual's age, race and gender, and the individual's medical records.

<b>Assessments and Tools Used in Planning</b>	
<b>Assessment/Tools</b>	<b>Purpose</b>
<a href="#">Healthy Living ISP Questions</a>	Questions designed to determine the needs and preferences of the individual when developing the ISP. Use the questions to start conversation about what the individual needs to do in order to be successful and self-determined throughout their lives and to help them think about their choices, decisions, and experiences that can help them build the future they desire.
<a href="#">Health Reference Manual</a>	This is a tool to understand and discuss healthcare issues. Health Reference Manual is utilized with the Health Inventory. The manual includes teaching strategies and guidelines for supports for each health indicator.
<b>Self-Medication Assessment</b>	<i>In development</i>
<b>Health Inventory</b> <a href="http://dmh.mo.gov/docs/dd/directives/3090inventory.doc">http://dmh.mo.gov/docs/dd/directives/3090inventory.doc</a>  <a href="http://dmh.mo.gov/docs/dd/directives/3090.pdf">http://dmh.mo.gov/docs/dd/directives/3090.pdf</a>	<b>This tool is used with individuals who receive DMH residential services. The Health Inventory is to be completed by the Support Coordinator in accordance with the HIPS process.</b> It is used to identify an individual's applicable health risks and conditions which should be addressed in the person-centered plan including necessary guidance to staff. Once identified in the ISP, medical conditions, which require greater detail to direct delivery of care, may be found in a Implementation Plan*. <b>*See Appendix</b>

<b>ISP Requirements</b>	
Supports and Personal Outcomes identified from Healthy ISP Questions including: Prevention (e.g., healthy diet, exercise, weight management, stress management, counseling, etc.); Maintenance of current health issues ( <i>Knowledge</i> of diagnoses is important); Improvement of current status of health.	Mandatory
Primary Care Physician (name / contact / service or specialty and minimum frequency)	Contingent
Other Medical Specialist Physician (name / contact / service or specialty and minimum frequency)	Contingent
Known or Suspected Health Risks: Choking, Falls, Skin Breakdown, Choking/Aspiration , Bowel , Dehydration	Mandatory
Purpose of medications, treatments, or procedures (i.e., parameters, protocols for contacting physician, such as diabetes, hypertension, seizures etc.)	Contingent
Dietary needs	Contingent
Allergies/Sensitivities/Reactions	Contingent
Mental Health supports (counseling, therapy, medications, etc.)	Contingent
PRN psychotropic medication protocol	Contingent
Self-administration (supports needed to maintain this skill). Note: If the individual is learning to self-administer, this is expected to be addressed as an outcome.	Mandatory for those receiving medications during funded services
Adaptive equipment	Contingent
If specific (more detailed) supports are not in the plan, then note where the information is located and that supporters must use this information to guide what supports they provide. (e.g., bowel and bladder management and other individual/private information).	Contingent
Family Medical History (if available)	Contingent
Diagnoses	Contingent
<b>Additional Requirements for Recipients of Comprehensive Waiver Residential</b>	
Medical, vision, hearing, oral care conditions and supports (per HIPS process 3.090 Health Identification and Planning System Process). including Immunizations and cancer screenings.	Mandatory for Residential Services

All Health Indicators marked on the Health Inventory (Annual and Change of Health) should be addressed in the ISP. The plan should identify the issue, condition, or risk requiring support and identify what that support is, who is providing at what frequency etc. The Health Reference Manual serves as a guideline for identifying possible supports needed. The agency Nurse should also contribute to the planning process. Some areas may result in a measureable outcome and may be time limited or on-going. Items which require additional detail to guide staff in how to support the individual may be referred to additional supporting documents such as a Health Care Plan developed by the Nurse etc.



#### Authority and Other References

Division Directive 3.090: Health Identification and Planning System (HIPS) Process

?Directive 3.060: Community RN (IF MODIFIED)

\*Add waiver resource





**Safety & Security**

**People are Educated about Their Rights and Practice Strategies to Promote Their Safety and Security**

*The ISP helps to ensure individuals living free from harm, being educated about their rights and living in healthy environments where safety and security are a high priority, while supporting the individual's rights to live independently, make personal choices and take some risks.*



**SAFETY & SECURITY: SUPPORTS NEEDED FOR SAFETY**

An emergency is an event, which can place an Individual in immediate risk to one's health, life, property or environment. An Individual can be prepared when events occur by discussing personal safety and planning with one's family, support network, local emergency planners, EMS and others. Being prepared is knowing one's community resources, having the necessary knowledge of what to do in the event of an emergency and having the necessary supports, services and supplies to keep one safe and healthy. Being prepared is an Individual's best protection and one's responsibility.

**Assessments and Tools Used in Planning**

Assessment/Tools	Purpose
<a href="#">Safety and Security ISP Questions</a>	Review with Individual or Representative. If potential or actual risk is determined, the individual and planning team should address in the ISP with services and supports.
<a href="#">Preparing for Disaster for People with Disabilities and other Special Needs</a>	For the millions of Americans who have physical, medical, sensory or cognitive disabilities, emergencies such as fires, floods and acts of terrorism present a real challenge. The same challenge also applies to the elderly and other special needs populations. Protecting yourself and your family when disaster strikes require planning ahead. This booklet will help you get started.
<a href="#">Preparing Makes Sense for People with Disabilities and Special Needs</a>	The likelihood that you and your family will recover from an emergency tomorrow often depends on the planning and preparation done today. While each person's abilities and needs are unique, every individual can take steps to prepare for all kinds of emergencies from fires and floods to potential terrorist attacks. By evaluating your own personal needs and making an emergency plan that fits those needs, you and your loved ones can be better prepared. This guide outlines commonsense measures individuals with disabilities, special needs, and their caregivers can take to start preparing for emergencies before they happen. Preparing makes sense for people with disabilities and special needs.
<a href="#">Red Cross Types of Emergencies</a>	Visit as indicated to obtain more in depth information on types of emergency and planning.

**ISP REQUIREMENTS**

Provide information on: <a href="#">Preparing for Disaster for People with Disabilities and other Special Needs</a> & <a href="#">Preparing Makes Sense for People with Disabilities and Special Needs</a>	Contingent
Supports or 'Personal Outcomes' discovered during Review of Safety and Security ISP Questions	Mandatory
Supports needed for potential home dangers, cooking , water temperature, chemicals, etc.	Contingent
Mobility support needs, falls, supports and adaptations for evacuation , etc.	Contingent
Criminal and / or other behavior that places the individual or others at risk	Contingent
Altered levels of supervision, restrictions, probation and /or parole	Contingent

**Authority and Other References**

Division webpage <http://dmh.mo.gov/docs/dd/riskguide.pdf> ; [The DD Guideline Quality of Services Review # 54](#) ; [The DD Division Directive #1.050, Emergency Procedures](#)



## **SAFETY & SECURITY: BEHAVIORAL RISK AND PREVENTION**

Support Coordinators must, as part of their ongoing support to an individual, consider the risk of behavioral crisis. These include the likelihood of problem behaviors escalating to an extent that the individual or others are placed in danger of injury, that the individual will experience a crisis such that more intensive services will be required including specialized behavioral services, police involvement or psychiatric hospitalization.

All of these place the individual at risk of losing their home and supports in the community, therefore, the planning and development of strategies must be employed to prevent this if possible. An ongoing risk assessment process is the best way to identify high risk behavioral situations.

An individual's behavior is greatly influenced by environmental factors and these should be addressed in a positive, preventative and teaching based approach so that the individual is supported for success and the best quality of life possible. Restrictions, negative consequences, and extreme responses such as police involvement and hospitalization rarely result in positive changes for an individual or in successful resolution of behavioral risk. After assuring immediate safety, the most important risk reduction strategy is to work to improve the individual's quality of life.

Consideration of the behavioral risk factors will assist the support coordinator or team to implement strategies to prevent escalation of risk of crisis or worsening problem behaviors.

If the individual has had incidents of behavior problems that have resulted in significant danger to self, others or property, hospitalization, involvement of law enforcement or loss of services or access to the community in the past six months, the team should consider the need for additional support services such as behavior analysis supports. The team should also consider behavioral services if the individual is requiring psychotropic medications. Applied Behavior Analysis services start with a Functional Behavior Assessment and include the development of a Behavior Support Plan, training for support persons in use of the plan strategies, monitoring the implementation of the plan and development of strategies to be used when the behavioral services are discontinued following the success of the plan. Behavior Support plans are valid only as long as behavioral services are provided to support the plan's implementation. Behavior Support plans should be included as a section of the individual support plan, and should not be paraphrased or reworded.

It is possible that Person Centered Strategies Consultation (PCSC) might be appropriate. This can be obtained through the regional behavior resource team or by another Medicaid waiver provider of the service. PCSC could assist a team to assess current issues related to the individual's quality of life and the strategies that the circle of supports is attempting to use to assist the individual in having the best quality of life possible. Improving the strategies and the implementation of the person centered, positive support strategies and the individual's quality of life might alleviate a behavioral issue. This should be considered especially if the team feels that the quality of life could be improved.

<b>Assessments and Tools Used in Planning</b>	
<b>Assessment/Tools</b>	<b>Purpose</b>
<a href="#"><u>Behavioral Risk ISP Questions</u></a>	Behavioral Risk ISP Questions has been developed to assist with identifying potential and/or actual risk in the area of health, personal and environmental safety, individual rights, socialization and financial. If any risk factors are identified the ISP must identify how the risk will be addressed.
<a href="#"><u>Assessment of Common Risk Factors</u></a>	Tool to create the Crisis Safety Plan in order to plan for high risk

	situations with strategies to prevent them or to assist the person through the situations
<a href="#">Crisis Safety Plan</a>	To provide the individual and circle of supports a consistent, and planned series of interventions to prevent and address crisis situations all of which are designed towards safety of the individual and others
Functional Behavioral Assessment	Completed by a qualified licensed behavioral services provider and provides information about the situations that are related to challenging behaviors, identifying the likely contributing variables and possible strategies to reduce or eliminate the challenging behaviors.

ISP REQUIREMENTS	
Supports or 'Personal Outcomes' discovered during review the Behavioral Risk ISP Questions	Mandatory
Supports or personal outcomes discovered during <b>Assessment of Behavioral Risk Factors</b> and resulting " <a href="#">Crisis Safety Plan</a> "	Mandatory
Must Identify the " <a href="#">Crisis Safety Plan</a> " and where it is located.	Contingent
Functional Behavioral Assessment attached to ISP	Contingent
Behavior Support Plan attached to ISP	Contingent

Authority and Other References

CFR Chapter 630 Department of Mental Health Section 630.705  
 DD Waiver Manual- Applied Behavior Analysis Services and Person Centered Strategies Consultation Service  
 Support Coordinator Manual  
 Division webpage- <http://dmh.mo.gov/dd/progs/behaviorservices.html>



## SAFETY & SECURITY: INDIVIDUAL RIGHTS/DUE PROCESS

Individuals are provided information on rights upon entry to the waiver and annually during the individual support planning process. The support coordinator will provide a rights brochure, developed by the division, to the individual and guardian.

The Division has a process in place (Division Directive ([4.200 – Human Rights Committee PDF Document](#); [Due Process Components Guide PDF Document](#)) to protect the rights for all individuals and outlines a referral process to have any limitations or modifications reviewed by a Due Process Review Committee.

Assessments and Tools Used in Planning	
Assessment/Tools	Purpose
<a href="#">A Guide for Individuals with Developmental Disabilities to Understanding Rights and Responsibilities</a>	Tools used to help individuals and families understand rights of individuals receiving services. <i>(any of the tools listed can be used)</i>
<a href="#">Individual Rights of Persons Receiving Services</a>	
<a href="#">Brochure for community services PDF Document</a>	
<a href="#">ASL Video</a>	
<a href="#">Los derechos de los consumidores PDF Document</a>	Tool used for planning to assist in ensuring individuals have the support they need to protect their rights.
<a href="#">Individual Rights ISP Questions</a>	

When the individual’s planning team determines that a limitation of rights is necessary, the **ISP process** *must* ensure the following requirements are documented in the individualized service plan and referred to the Due Process Review Committee.

INDIVIDUAL RIGHTS ISP REQUIREMENTS	
Information about how individual is informed of rights.	Mandatory

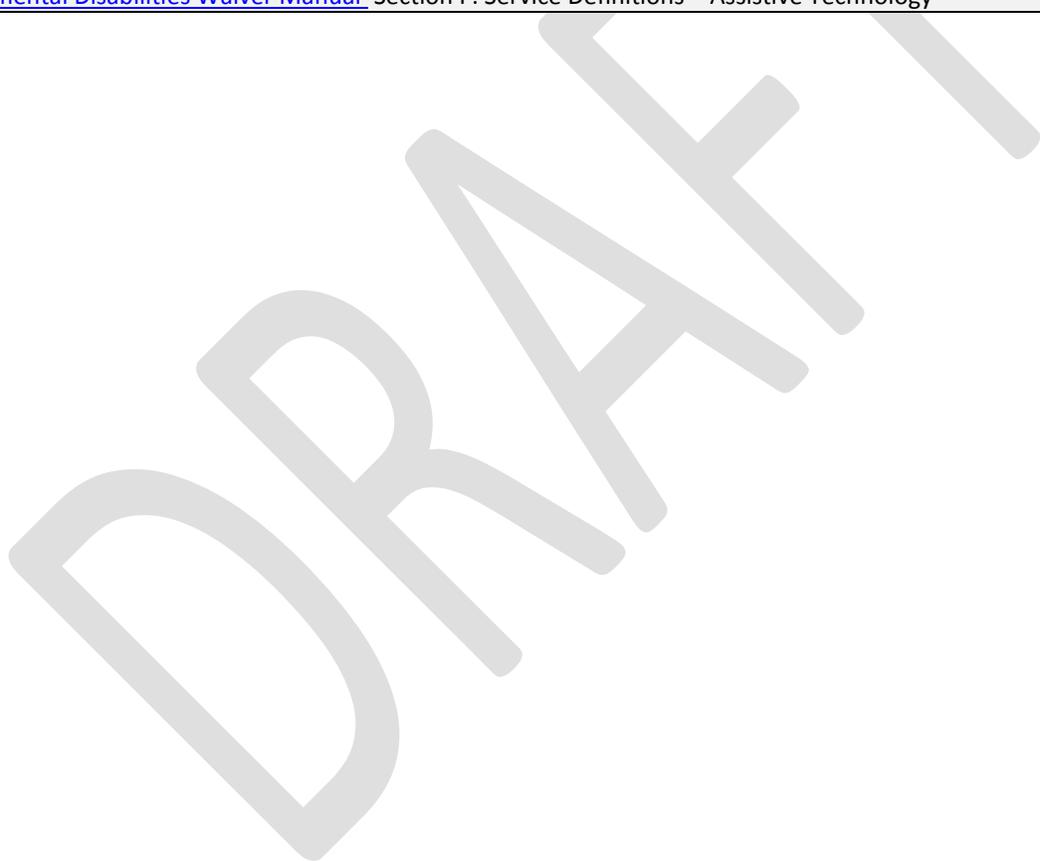
INDIVIDUALS WHO HAVE MODIFICATION (RESTRICTIONS) TO RIGHTS	
Specific restriction(s) to legal rights	Mandatory
<b>Justification - purpose &amp; rationale</b> <ul style="list-style-type: none"> <li><input type="checkbox"/> Describe the restriction</li> <li><input type="checkbox"/> Document less intrusive methods of meeting the need that have been tried but did not work. (HCBS Rule) <b>42 CFR 441.301(c)(2)(xiii)</b></li> <li><input type="checkbox"/> Identify a specific and individualized assessed need</li> <li><input type="checkbox"/> Explain the reason the limitation or restriction is being put in place.</li> <li><input type="checkbox"/> Explain if the restrictions or limitations are necessary to keep the person safe or others safe?</li> <li><input type="checkbox"/> Describe any historical pattern or significant situation which has occurred that would justify a limitation or restriction?</li> </ul>	Mandatory
<b>Conditions - under which the restriction is applied</b> <p>Explain where the restriction or limitation will be imposed (i.e. only at home, in the community, day program, in kitchen, etc.)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Include a clear description of the condition that is directly proportionate to the specific assessed need. <b>42 CFR 441.301(c)(2)(xiii)</b></li> <li><input type="checkbox"/> Explain when the restriction will be imposed (i.e. at all times, in morning, after/before a</li> </ul>	Mandatory

specific event or situation, if family present, only when.....)?	
<p><b>Teaching or Support Strategies</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Outcomes/Strategies that are being taught to help an individual develop skills in order to overcome the need for this restrictive support?</li> <li><input type="checkbox"/> Document the positive interventions and supports used prior to any modifications to the person centered service plan. <b>42 CFR 441.301(c)(2)(xiii)</b></li> <li><input type="checkbox"/> Provide evidence that this type of intervention/teaching has worked in the past and information on why this is the method by which the person learns best.</li> <li><input type="checkbox"/> There may be situations where an individual has multiple restrictions. If a team decides to prioritize/focus teaching outcomes on only a few restrictions at a time, versus all the restrictions at once, the team will need to prioritize.</li> <li><input type="checkbox"/> If there are restrictive supports that are required to keep the person or others safe and teaching strategies have not been identified, then the supports need to be identified in the ISP and the efforts that are being explored to support the person in the least restrictive way.</li> <li><input type="checkbox"/> For teaching and support strategies, document who is responsible for the training of the strategies.</li> </ul>	Mandatory
<p><b>Monitoring methods</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Include an assurance that interventions and supports will cause no harm to the individual. <b>42 CFR 441.301(c)(2)(xiii)</b></li> <li><input type="checkbox"/> Include a regular collection and review of data to measure the ongoing effectiveness of the modification. <b>42 CFR 441.301(c)(2)(xiii)</b></li> <li><input type="checkbox"/> Information on data collection methods should include... <ul style="list-style-type: none"> <li>• Who is documenting</li> <li>• Where data is kept (i.e., daily progress notes, outcome data sheets, MAR, etc)</li> <li>• What is the frequency of documentation (i.e. daily, weekly, monthly, etc)</li> <li>• How often is the data reviewed by team</li> </ul> </li> <li><input type="checkbox"/> If the plan is being referred for annual review, there must be documentation noting the progress or lack of progress from the past year of implementation (i.e. summary of monthly reviews, quarterly reviews, behavioral data results, evaluations about the effectiveness of medications/interventions)</li> </ul>	Mandatory
<p><b>Criteria for restoration</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Describe what will it take for the restriction to be lifted / how will the individual and team know when the restrictive support is no longer needed or could be reduced in intensity/frequency?</li> </ul> <p>The criterion needs to be in specific observable &amp; measurable terms (i.e. if individual has three consecutive months of no attempts to elope, chimes will be removed from the exterior door)</p>	Mandatory
<p><b>Review schedule</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. <b>42 CFR 441.301(c)(2)(xiii)</b></li> <li><input type="checkbox"/> State how often team will submit plan to Due Process Committee for review (minimum is annually)</li> </ul>	Mandatory

<p><b>Notice of right to due process</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Include informed consent of the individual. <b>42 CFR 441.301(c)(2)(xiii)</b></li> <li><input type="checkbox"/> Document that the individual and the guardian are aware of the restrictions, were part of the planning process to develop interventions, know they have a right to due process, and have information on what to do if they do not agree with the restrictions or interventions.</li> <li><input type="checkbox"/> Signed authorization page (can either be signed by guardian only or can be signed by guardian and individual)</li> </ul>	<p>Mandatory</p>
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**Authority and Other References**

CFR – HCBS Rule 42 CFR 430  
 Missouri Revised Statutes Chapter 630 Department of Mental Health *630.110 Patient’s rights--limitations.*  
 630.125. 1 Explanation of rights and entitlements; 9 CSR 45-5.010 (3) (C) 1. D.; 9 CSR 45-5.010 (3) (C) 1. E.; 9 CSR 45-5.010 (3) (C) 1. G.; 9 CSR 45-5.010 (3) (C) 1. M.; 9 CSR 45-5.010 (3) (C) 2. A. 9 CSR 45-5.010 (3) (C) 2. B.; 9 CSR 45-5.010 (3) (C) 2. C.; 9 CSR 45-5.010 (3) (C) 2. D. ; 9 CSR 45-5.010 (3) (C) 2. E.; 9 CSR 45-5.010 (3) (C) 2. O.  
[Contract For Services Contract # ER019914XX Purchase of Services Program for the Division of DD 3.9 Consumer Rights Developmental Disabilities Waiver Manual](#). Section F: Service Definitions – Assistive Technology





**Citizenship & Advocacy**

**People Have Opportunities to Advocate for Themselves, Others and Causes They Believe In, including Personal Goals and Dreams**

*This outcome emphasizes the importance of self-advocacy. Training and ongoing support are often time require to assist an individual in developing their self-advocacy skills.*



**CITIZENSHIP & ADVOCACY: PERSONAL INCOME (Formerly Management of Individual Funds)**

This section addresses the individual’s income and outlines the management of those funds. While this may apply to all individuals receiving supports, it is a mandatory component for individuals receiving residential supports. This section also provides a tool for the payee of benefits to prioritize remaining funds after daily living expenses are paid as directed by the individual within the parameters of [Social Security](#).

**Age 17 – Additional Activities- Social Security and Medicaid Eligibility Determination Recommendation:**

At least six months prior to turning 18 the DD support coordinator should educate the family about Social Security and *MO Health Net* benefits. The support coordinator should, with the family’s permission, assist the family in completing documentation requirements to determine eligibility for social security benefits. In Missouri often individuals who are found eligible for social security benefits may also be found eligible for Medicaid. Beginning the process early helps to ensure a more seamless transition to adult service system. The intent is that eligibility would go into effect on the child’s 18<sup>th</sup> birthday.

**For individual who receive residential services where the Regional Office is the Payee:**

The Division of Developmental Disabilities receives the SSA or SSI benefit checks monthly for those for whom they serve as payee. The Division uses these benefits to pay monthly room and board costs and other necessary living expenses. The Division maintains a NAFs (non-appropriated funds or consumer banking) account balance for any unspent funds. These balances are available to be used for other needs and wants. Per [Social Security guidelines](#) for payees, the funds must be used for basic needs such as food, clothing, shelter, health related expenses or burial plans/life insurance before they are spent on recreational activities.

There are **no restrictions** from Social Security on what recreational activities an individual chooses.

The Division manages an individual’s NAFs account to ensure that their total resources are less than \$999. If resources increase beyond this amount, the individual will no longer be eligible for Medicaid and will no longer qualify for the Home and Community Based Medicaid Waiver or Medicaid State Plan Supports.

All individuals will have identified their needs and wants for the upcoming year during their ISP meeting. This enables the individual, support coordinator, family member or provider to identify what needs and wants to be purchased from their account.

**Assessments and Tools Used in Planning**

<b>Assessment/Tools</b>	<b>Purpose</b>
<a href="#">Personal Income ISP Questions</a>	Tool used for planning to ensure the individual has the support they need to manage their funds.
Summary of benefits	This will give the planning team an idea of excess funds available after all daily living expenses are paid, as well as indicate recurring expenses, including Medicaid Spend down.
<a href="http://www.socialsecurity.gov/pubs/10076.html">http://www.socialsecurity.gov/pubs/10076.html</a>	Outlines the social security guidelines for payee of benefits.

<b>PERSONAL INCOME ISP REQUIREMENTS</b>	
Supports or 'Personal Outcomes' discovered during review the Personal Income ISP Questions	Mandatory
Individuals earned income from employment What support does the individual need to manage these funds?	Mandatory if employed
Supports needed to maintain benefits	Mandatory
Supports needed to manage funds. <ul style="list-style-type: none"> <li>If the individual has a representative payee, provide relevant information.</li> <li>If the individuals serves as their own payee, what, if any, supports (either natural or paid) are needed to assist the individual.</li> </ul>	Mandatory
ISP must document : <ul style="list-style-type: none"> <li>That the individual's resources were considered when given options for residential room and board.</li> <li>What housing resources (e.g., vouchers and other rental assistance options) were explored.</li> <li>That individual was given the information necessary to make an informed choice regarding housing options.</li> </ul>	Mandatory- for those receiving residential supports
Information regarding how the individual wants to spend/save their excess funds after daily living expenses are paid. (i.e. dental insurance, burial plans, leisure activities, etc.).	Mandatory for all residential services
If the individual lives in a residential setting what is the monthly personal spending allowance? What support does the individual need to manage these funds?	Mandatory
Support needed in preparation for application for SSI if individual will require support/services from Division (e.g. needs job preparation or community employment services)	Contingent School Transition Youth at age 17

#### **Authority and Other References**

The person centered service plan documents the (setting) options based on the individual's resources available for room and board. 42 CFR 441.301(4)(ii)  
DD Waiver Manual-  
Support Coordinator Manual  
Division webpage  
Social Security's Guide to Rep Payee: Sets out the roles and responsibilities of a representative payee.



## CITIZENSHIP & ADVOCACY: SELF-DIRECTED SUPPORTS

Self-Directed Supports (SDS) is an option for individuals who live in their own private residence or that of a family member, which enables individuals to exercise more choice, control and authority over supports by allowing both employment and budget authority. SDS includes the services of: Personal Assistance; Medical/**Behavioral** Personal Assistance; Group Collaboration; and Community Specialist.

Assessments and Tools Used in Planning	
Assessment/Tools	Purpose
<a href="#">Support Brokers Assessment</a>	Tool use to ensure individual/Designated Representative receives the information and assistance needed in order to self-direct supports. Helps to determine outcomes goals and duration of supports for agency based support brokers services.
<a href="#">Personal Assistance Assessment with Training Exemptions</a> <b>PDF Document</b>	Tool used to support the Individual/Designated Representative in determining what allowable task they would like for their employees to provide and the training they feel is needed for these employees. This tool helps ensure the ISP provides enough detail in order for the Personal Assistant to understand what supports are required. The tool also helps determine the number of hours of supports needed in order to create the Individual Budget Allocation.
<a href="#">Community Specialist Assessment</a>	Used to determine type of professional, outcomes goals and duration of supports needed when authorized for Community Specialist service.
<a href="#">My Choice!: Guide for Creating your Own Individual Support Plan when Self-Directing Supports</a>	Guide for Individuals and families to prepare for their ISP meeting.
<a href="#">SDS Individual Allocation Tool</a> <b>PDF Document</b>	Tool used to determine the Individual Budget Allocation for which the Individual/Designated Representative has budget and employment authority.

SELF-DIRECTED SUPPORTS ISP REQUIREMENTS	
Identifies the <i>Designated Representative</i> (when appointed)	Mandatory
Supports or 'Personal Outcomes' discovered during review the Support Broker Assessment Questions ( <i>Personal Outcomes must be identified for SB service.</i> )	Mandatory
<b>The services being self-directed are listed and what supports being provided by these services</b> (Personal Assistance, Community Specialist, and Support Broker Assessment is used as the tool) <i>The ISP is used as a training document for employees and must provide enough details in order for all employees to understand what is needed to provide supports. (Personal Outcomes must be identified for SB and CS.)</i>	Mandatory
Justifies any training exemptions on the Personal Assistant "Training Checklist".	Mandatory
Identifies the back-up plan which includes provisions for support in the case of scheduled employees not being able to provide the support. *May refer to separate document(s) to attach to the plan.	Mandatory*
In the case of a paid family member - the plan must reflect that: <ul style="list-style-type: none"> <li>The individual is not opposed to the family member providing the support.</li> <li>The supports to be provided are solely for the individual and not household tasks expected to be shared with people who live in a family unit.</li> <li>The support team agrees that the family member providing the individual assistance will best meet the individual's needs.</li> </ul>	Mandatory

For new individuals to SDS and those with a change in allocation The SDS Budget Allocation tool is complete and matches \$ amount on Authorization Form.	Mandatory
If individual is receiving Medicaid State Plan Personal Care Services through Health and Senior Services. Division of Senior and Disability Services (DSDS) service authorization system has been checked to ensure that these services are not being self-directed. If individual is receiving Medicaid State Plan Personal Care Services through Health and Senior Services (DHSS), service authorization system has been checked to ensure that these services are not being self-directed.	Mandatory

**Authority and Other References**

The ISP "Include those services, the purpose or control of which the individual elects to self-direct." 42 CFR 441.301(c)(2)(xi)  
 DD [Waiver Manual- Section D](#)  
 Support Coordinator Manual [Self Directed Supports](#)  
 SDS Division webpage <http://dmh.mo.gov/dd/progs/selfdirect.htm>

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## **CITIZENSHIP & ADVOCACY: CHOICE OF SERVICE, PROVIDER AND OPTION OF SELF-DIRECTED SUPPORTS**

*“The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State’s 1915(c) HCBS waiver, the written plan must: **42 CFR 441.301(c)(2)**”*

*The ISP must “Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS”. **42 CFR 441.301(c)(2)(i)***

The ISP process: “Offers informed choices to the individual regarding the services and supports they receive and from whom”. 42 CFR 441.301(c)(1)(vii)

[Technical Assistance Manual for Regional Offices, County Senate Bill 40 Boards, and Other Not-for-Profit Agencies](#) States: *“D. Further Discussion of ‘Free Choice: Individuals and their guardians must be given free choice of all waiver and other MO HealthNet providers and services. ISPs for waived services must not restrict choice. This requires the support coordinator to give all pertinent information and not to bias individuals’ free choice.*

*All waiver services have to be necessary to the support of the individual in the community, as determined by a planning team and approved by the Regional Office. The individual (or family or guardian) has to be informed about services available under the waiver.*

*The individual has to be informed about which waiver services are considered necessary to support him or her successfully and why the decision was made. This decision is reached through an assessment and planning process, with consensus (on) the goal. Nonetheless, the individual may appeal the decision if he/she is dissatisfied, and the support coordinator will then need to explain both the informal and formal avenues of appeal.*

*Finally, the individual has the right to reject any or all waiver services. This may result in participation in the waiver not being feasible, but it is a choice. Termination from the waiver, following due process notification is required.”*

<b>Assessments and Tools Used in Planning</b>	
<b>Assessment/Tools</b>	<b>Purpose</b>
<u><a href="#">Choice ISP Questions</a></u>	Tool used for planning to assist in ensuring individuals have the support they need to make choices about services.
<u><a href="#">Provider Profile Directory</a></u>	Used to provide individuals, families and guardians information about potential service providers.
<u><a href="#">“A Guide to Understanding MoHealthNet (Medicaid) Services”</a></u>	A guide to understanding MOHealthNet and Waiver Services.

ISP REQUIREMENTS	
How was the individual educated and informed of the options list in the "Medicaid Waiver, Provider, and Services Choice Statement." <a href="http://dmh.mo.gov/docs/dd/h15wvrchoiceform.doc">http://dmh.mo.gov/docs/dd/h15wvrchoiceform.doc</a>	Mandatory for all waiver recipients
How was the individual educated and informed of the full range of HCBS available to support achievement of personally identified goals.	Mandatory for all waiver recipients
Includes a method for the individual to request updates to the plan as needed. <b>42 CFR 441.301(c)(1)(viii)</b>	Mandatory for all waiver recipients
Records the alternative home and community-based settings that were considered by the individual. <b>42 CFR 441.301(c)(1)(ix)</b>	Mandatory for all waiver recipients

Authority and Other References

42 CFR 441.301(c)(1)(vii)

[Technical Assistance Manual for Regional Offices, County Senate Bill 40 Boards, and Other Not-for-Profit Agencies](#)

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## CITIZENSHIP & ADVOCACY: CONFLICT RESOLUTION

The ISP *“Includes strategies for solving conflict or disagreement within the process, including clear conflict-of interest guidelines for all planning participants.”* 42 CFR 441.301(c)(1)(v)

*“Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.”* 42 CFR 441.301(c)(1)(vi)

### REQUIREMENTS OF FAMILY OF MINOR CHILD OR GUARDIAN

If the individual is a minor child, information from the parent(s) or guardian MUST be included in the plan. If the individual is an adult with a guardian, information must be included if the guardian requests that it be included. The plan (support section or outcome / action steps as applicable) should describe how guardian concerns are being addressed.

It is very important to clearly differentiate what is important to the guardian from what is important to the individual. Information such as this should be included in the plan but it needs to be clear. One way to provide clarity would be to include a section titled “What is important to the guardian” while balancing the needs and preferences of the individual.

<b>ISP REQUIREMENTS</b>	
Provides information regarding who to contact if unhappy with services or supports	Mandatory
Provides information on making an anonymous complaint	Mandatory
Provides a section on dissenting opinions of team members	Mandatory
Individual is provided clear information regarding any potential conflict of interest	Mandatory
<b>FAMILY OF MINOR CHILD OR GUARDIAN</b>	
Parents of Minor Child differentiate what is important to the guardian if different from the Individual	Mandatory
Guardian (per request) differentiate what is important to the guardian if different from the Individual	Mandatory

## **PERSONAL OUTCOMES AND IMPLEMENTATION PLAN**

The ISP must: *“Include individually identified goals and desired outcomes.” 42 CFR 441.301(c)(2)(iv)*  
 Personal outcomes are what drive a person’s ISP. These are personal goals, things that the individual is interested in trying, learning, doing, or achieving in the next year. Personal Outcomes must relate to what is important to the individual—personal outcomes are not simply support needs, although they may contain components of supports a person needs in specific areas or with specific tasks. The Support Coordinator facilitates the development of Personal Outcomes with the person and others in the person’s life if applicable (e.g. guardians, providers, family, friends, and others the person may wish to involve).

Individuals may have “Support Needs” that do not require specific goals or action steps. For example if an individual has a support need for ‘briefs’ an outcome or action plan is not required.

Please note that some services are habilitative in nature and require Outcomes/Goals and Action Planning such as Independent Living Skills Development and Individualized Support Living. See **WAIVER SERVICES REQUIRING PERSONAL OUTCOMES AND IMPLEMENTATION PLANS** (Link to be added) and reference the [Utilization Review Desktop Reference PDF Document](#) for details.

<http://dmh.mo.gov/dd/manuals/docs/urdirectory.pdf>

### **Guidance to Health and Human Services Agencies for Implementation Principles of Section 2402(a) of the Affordable Care Act:**

**Standards for Person -Centered Planning in Home and Community-Based Services Programs** states: *“Goals must be documented in the person’s and/or representative’s own words, with clarity regarding the amount, duration, and scope of HCBS that will be provided to assist the person. Goals will consider the quality of life concepts important to the person.”*

### **Implementation Plan**

The implementation plan is developed by the provider responsible for providing the service(s) used to help the person achieve their outcome(s). See **Appendix B for information on Implementation Plans.**

<b>PERSONAL OUTCOME ISP REQUIREMENTS</b>	
Regardless of whether an individual has funded supports or support coordination only, at least one Personal Outcome must be identified.	Mandatory
List the Specific Personal Outcome.	Mandatory
Information that is important to know about the Personal Outcome: Current situation, things that have been tried or the individual may like to try, why the Outcome is important to the individual (and family). What the outcome means specifically to the individual, in <u>their words</u> if possible. The Outcome is written in <i>“plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.”</i> 42 CFR 441.301(c)(1)(iv)	Mandatory
Time lines and frequency and duration regarding completion of Personal Outcome.	Mandatory
What Personal Strengths and Assets (skills, abilities, knowledge, attributes, passions, hobbies etc....) does the individual have in relation to the Personal Outcome (May be	Mandatory

identified within other sections of the ISP)	
What technology (computer, tablet, apps, smart phone, watch, alarm clock etc....) can be used to achieve the Personal Outcome? (May be identified within other sections of the ISP)	Mandatory
What relationships (friends, family, connections at places of interest etc....) do the individual have which can help achieve the Personal Outcome? (May be identified within other sections of the ISP)	Mandatory
What community resources (clubs, community associations, gyms, library, animal shelter etc....) can be used to achieve the Personal Outcome? (May be identified within other sections of the ISP)	Mandatory
Who is responsible for writing the Implementation Plan? (May be identified within other sections of the ISP)	Mandatory
Scope duration, amount of services	Mandatory

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**BUDGET/AUTHORIZATION PAGE** *(Information about this topic is mandatory)*

The support coordinator will assure that the individual’s budget information is part of the ISP document (the budget shall also be attached) and outlines all services received and costs.

This information is vital for the individual, their family, and all service providers as it creates a picture of all paid supports for the individual.

The budget shall outline the following information:

- Time span of service(s)
- Name of each service
- Name of each service provider
- Number of units to be provided in the time span indicated for each service
- Service rate per unit for each service
- Total cost per time span of each service
- Total budget cost for all combined services

**Note:**

The budget is part of the ISP and the individual/guardian shall receive a copy.

## MONITORING OF ISP

Monitoring of ISP	
Identify the individual and/or entity responsible for monitoring the plan. 42 CFR 441.301(c)(2)(viii)	Mandatory

**AMENDMENTS:** If the individual already has an individual support plan, the plan must be amended within 30 days to reflect any new supports that will be provided to the individual upon entrance into a waiver program.

Note: Any new service / support must be justified and noted in the ISP; therefore, an amendment is necessary to reflect the changes within 30 days of the change.

*Review of the Person-Centered Service Plan.* “The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required by § 441.365(e), at least every 12 months, when the individual’s circumstances or needs change significantly, or at the request of the individual”. **42 CFR 441.301(c)(3)**

The planning process; “Includes a method for the individual to request updates to the plan as needed” **42 CFR 441.301(c)(1)(viii).**

Changing / updating the ISP: Reviews / updates need to occur, not just by reviewing the ISP document, but also through discussions / dialogues with the individual and the circle of support (planning team). ISP’s must be reviewed quarterly and updated as often as necessary. Review and update of the ISP must also occur as often as the individual and/or guardian requests and/or when there is a need for service and support changes as noted above.

Significant changes (for example any change in service / supports, outcomes, legal information, guardianship, limitation of rights, changes in safety / health status) always require dated signatures whereas informational changes (such as clarification to any information already noted in the ISP) do not. Again, the ISP should change as often as there are changes in the individual’s life.

Once the amendment has been completed to justify the service / support, the team must assure the ISP continues as a current document. Therefore, 30 days from implementation of the new service / support, it is best practice for the team to meet to gather any additional information that needs to be conveyed in the ISP. This time period gives the team and the individual an opportunity to assess what is working / not working with the changes in any service / support.

The ISP process should be fluid. The ISP should change as the individual’s life changes to include any transition. This fluidity and the impact of transitions shall be reflected in the support plan.

## **APPENDIX A: ADDITIONAL REFERENCES / RESOURCES**

<b>Person Centered Planning Tools and Resources</b>	
<b><u>Utilization Review Desktop Reference</u></b> PDF Document	<a href="http://dmh.mo.gov/dd/manuals/docs/urdirectory.pdf">http://dmh.mo.gov/dd/manuals/docs/urdirectory.pdf</a>
Waiver Services Requiring Personal Outcomes and Implementation Plans	<i>In development</i>
LifeCours Tools	<a href="http://www.lifecoursetools.com/planning/">http://www.lifecoursetools.com/planning/</a>
Helen Sanderson and Associates	<a href="http://www.helensandersonassociates.co.uk/">http://www.helensandersonassociates.co.uk/</a>
The Learning Community for Person-Centered Practices	<a href="http://www.learningcommunity.us/home.html">http://www.learningcommunity.us/home.html</a>
Person-Centered Thinking	<a href="http://www.thinkandplan.com/person-centred-thinking.html">http://www.thinkandplan.com/person-centred-thinking.html</a>
One page profiles	<a href="http://onepageprofiles.wordpress.com/">http://onepageprofiles.wordpress.com/</a> <a href="http://www.helensandersonassociates.co.uk">http://www.helensandersonassociates.co.uk</a>
Copeland Center for Wellness and Recovery: WRAP for People with Developmental Distinctions	<a href="http://copelandcenter.com/">http://copelandcenter.com/</a>
MAPS: Inclusion Press	<a href="http://www.inclusion.com/maps.html">http://www.inclusion.com/maps.html</a>
Kansas Institute for Positive Behavior Support: facilitating person-centered planning	<a href="http://www.kipbs.org/new_kipbs/fsi/pcp.html">http://www.kipbs.org/new_kipbs/fsi/pcp.html</a>
Beach Center – Planning with families	<a href="http://www.beachcenter.org/default.aspx">http://www.beachcenter.org/default.aspx</a>
Pacer Center – <i>champions for children with disabilities</i>	<a href="http://www.pacer.org/tatra/resources/personal.asp">http://www.pacer.org/tatra/resources/personal.asp</a>
Laurie Markoff – The Institute for Health and Recovery	<a href="http://www.healthrecovery.org">http://www.healthrecovery.org</a>
Person-Centered Career Planning	<a href="http://www.onestops.info/article.php?article_id=284">http://www.onestops.info/article.php?article_id=284</a>
A Manual for Person-Centered Planning Facilitators Angela Novak Amado, Ph.D. and Marijo McBride, M.Ed. Institute on Community Integration UAP	<a href="http://rtc.umn.edu/docs/pcpmanual1.pdf">http://rtc.umn.edu/docs/pcpmanual1.pdf</a>
Families planning Together	<a href="http://learningcommunity.us/documents/FPTGuide.11-03.pdf">http://learningcommunity.us/documents/FPTGuide.11-03.pdf</a>

**APPENDIX B: IMPLEMENTATION PLAN**

*Workgroup Meeting in March of 2016*

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**APPENDIX C: ISP TEMPLATE EXAMPLES**

**ISP Template Examples**

			<a href="#">ISP Template Example</a>
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