Individual Support Plan (ISP) Instruction Manual

Updated 1/10/2014

The following changes are included in this manual	
PD checklist update	**Pg. 33**
Addendum updates	**Pgs. 26, 27, and 34**
CSE goals	**Pg. 20**
MH contract info	**Pgs. 5, 19, and 20**
DDA therapy changes	**Pgs. 4, 5, and 7**
Guardian email contact	**Pgs. 8, 10**
CFH/SL/alone time clarifications	**Pgs. 14, 19, 22, 33**

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Instructions for Completing an Initial or Annual Individual Support Plan

Purpose of the Individual Support Plan (ISP) Manual

The purpose of the Individual Support Plan (ISP) Instruction Manual is to help plan developers complete all of the forms required for an ISP.

Required Forms

Plan developers must complete each of the following required forms and submit them **completed** before an initial or annual ISP can be processed for authorization:

- Supports and Services Authorization form (Excel version)
- Signature Page form
- Personal Summary form - includes Assessed Needs table, Transition Plan (if applicable), Plan Monitoring questions, Safety Concern questions, and Alone Time in a CFH questions
- Supports and Services form(s)
- Exception Review form(s) (only in cases where the plan is requesting High or Intense Supported Living and it is over budget)
- Safety Plan (if applicable, for Supported Living only)
- History and Physical that is current within 365 days **and** Nursing Service and Medication Administration Referral Form **-OR-** Physician's Medical Care Evaluation Form that is current within 365 days (as some doctors are continuing to use these forms)
  Note: Plans will be considered incomplete if not received

For **ISP addendums**, **only** the following documents must be submitted:

- ISP Supports and Services Addendum form (Excel version)
- Additional justification for services (if requested)
- Exception Review form(s) (only in cases where the addendum is requesting High or Intense Supported Living and it is over budget or remains above their budget)

> **Important:** Before submitting the forms listed, a plan developer should ensure the following requirements are met:
> - All forms must be on the current version and typed.
> - All fields within the forms must be completed correctly.
>
> **Note: Plan developers will be notified if the forms do not comply or are filled out incorrectly, and an incomplete notice will be generated, as applicable.**

Assessments and documents initiated by the Idaho Center for Disabilities Evaluation (ICDE) include:

- Physician's letter
- Eligibility Determination Letter with budget amount
- Medical, Social and Developmental Assessment Summary
- SIB-R report

Assessed needs for the ISP can be obtained from:

- History and Physical
- SIB-R (report only)
- Medical, Social, and Developmental Assessment Summary
- Developmental evaluations- including comprehensive and specific skill assessments
- Functional assessments
- Psychological evaluations
- Physical therapy/occupational therapy/speech assessments from independent therapy providers

Supports and Services Authorization Instructions

Note: <u>You can find an example ISP Authorization page on the Adult DD Care Management website</u>

Participant Name: Type the name of the participant exactly as it appears on their Idaho Medicaid card.

Medicaid #: Type the participant's Medicaid identification number as it appears on their Idaho Medicaid card.

Agency Name Column: List in this column all DD waiver and state plan service providers who are delivering services (that need to be costed) to the participant. All routine costs that support a participant in the community, and that are related to their disability, must be listed. Costs can be found at **www.healthandwelfare.idaho.gov**. Select Providers>Medicaid Providers>Medicaid Fee Schedule.

<u>**For plans starting September 1, 2013, Behavioral Health services (formerly known as mental health clinic, psychosocial rehabilitation and substance abuse services) will be managed and paid for by the State's contractor, Optum Idaho and do not need to be costed against the participant's budget. Behavioral Health services must continue to be included in the Supports and Services. For more information on Optum's processes, visit</u> www.OptumIdaho.com

<u>**For medical transportation service provision questions, contact American Medical Response (AMR) at 1-877-503-1261. This service can be included on the Supports and Services page. It is a Per Member Per Month service, so there is no cost to the participant's budget.</u>

<u>**For Residential Habilitation Program Coordination services for Certified Family Home providers, contact Community Partnerships of Idaho at pcdata@mycpid.com.</u>

<u>**For waiver Dental program questions, contact Idaho Smiles at 1-800-936-0978. This service must be included on the Supports and Services page. It is a Per Member Per Month service, so there is no cost to the participant's budget.</u>

** *Service plans with requests for CSE-* all requested services on the plan must remain within the calculated budget including what formerly was "Pended CSE." Requests for CSE do not fall into the updated exception review parameters for plans that are over budget.

Procedure Code Column: List the service code that corresponds with the DD waiver or state plan service. This service code can be found under the "Procedure Code" and "Modifiers" columns of the most current fee schedule (see Web site listed above).

Start Date and End Date Columns: Type the proposed start and end date for each service being delivered.

Units Column:

> Based on the service's unit time value, list the total number of units being requested for a particular service. **Use the most current fee schedule for this information.**
>
> Examples of units and their time value are as follows:
> * 1 unit = 15 minutes/1 day/1 mile/1 visit/1 per year, etc.
>
> **Reminder:** When a service provider is requesting hours and the service unit's time value is 15 minutes, the number of hours requested must be multiplied by 4 to determine the total number of units. For example: 10 hours x 4 units per hour = 40 units

Unit Cost Column: Refer to the "Amount Allowed" column of the fee schedule for the dollar value of each unit. List this dollar value in this column. **Example:** For code H2032: 1 unit = $3.02

Frequency Column:

> Service units being requested must also have a frequency. To determine frequency, list how often the units of service are being delivered.
>
> Examples of frequency to enter are:
> - 365 for daily services (i.e. Supported Living: Daily rate)
> - 52 for weekly services (i.e. Developmental Therapy)
> - 12 for monthly services (i.e. Service Coordination)
> - # of units for yearly services   (i.e. Plan Development)

Annual Cost Column: This column will populate automatically based on a formula. **DOUBLE-CHECK FOR ACCURACY**

Annual Units: This column will populate automatically based on a formula. **DOUBLE-CHECK FOR ACCURACY**

Requires IPA # Column: This column is for Department of Health & Welfare use only. If the box for the "Service Type" contains a number, the service has been prior authorized.

Annual Total: This cell will populate automatically based on a formula. **DOUBLE-CHECK FOR ACCURACY**

Calculated Budget Amount: Type the authorized budget amount from the participant's Eligibility Notice.

+/- Medicaid Annual Total: This cell will populate automatically based on a formula. **DOUBLE-CHECK FOR ACCURACY**

Final Plan Amount: Type the final amount requested. The Care Manager will review, approve or negotiate and update the "final plan amount" as needed.

Instructions to pro-rate plans

When plans are extended due to an appeal/hearing or some other valid reason determined by the IAP or Care Manager (i.e. an initial plan is unable to be submitted and approved prior to the 90 days after the assessment), confirm with the Care Manager the dates needed to complete the pro-ration.

Instructions to pro-rate a plan—Divide the full calculated annual budget (or negotiated budget) by the 12 months in the year and then take that amount multiplied by the number of months left in the plan year

For example: If a $35,000 budget plan should have started 8-1-2014 but was extended to 11-30-14, this is now an 8 month plan. $35,000/12= $2916.67 x 8 months left in the plan year= $23,333

Process for Physical, Occupational, and Speech Therapy Services on the ISP

Therapy services for adults with a developmental disability must be discussed as prioritized needs through the person centered planning process and be included on the ISP as part of the total cost coming out of the participant's annual budget.

Beginning July 1, 2013, PT, OT, Speech therapy, and all related evaluations are unable to be provided in a DDA.   These must be provided by independent therapy providers.

Note: Therapy evaluations completed by independent providers may provide support in developing Developmental Therapy Goals in a DDA.

Effective January 1, 2012, therapy services, when received from an independent therapy provider or outpatient hospital provider, are limited based on the annual Medicare caps below. ***Please see Medicaid Information Release MA11-28 for more information on requests exceeding these caps.***

➢ $1,870 per calendar year for speech language pathologist (speech therapy) services and physical therapy services combined.
➢ $1,870 per calendar year for occupational therapy services.

If these services are required by a participant they need to be included and costed accordingly on the participant's plan; however, Medicaid does not reimburse for services that are duplicative.

For further information on these changes, see rule 16.03.09.732.04.

Signature Page Instructions and Form

Note: This form is provided as an example and can not be used as an actual ISP authorization page.

Participant Name: Type the name of the participant exactly as it appears on their Idaho Medicaid card.

Medicaid #: Type the participant's Medicaid identification number as it appears on their Idaho Medicaid card.

Date of Person Centered Planning Meeting (PCP): Type the month, day, and year the PCP meeting was conducted.

DD Waiver Participant: Check the "Yes" or "No" box according to the participant's waiver status.

Initial or Annual Plan: Check the corresponding box if this is the first state plan or waiver Individual Support Plan (ISP) being submitted for the participant or their annual plan.

Did the participant attend his/her Person Centered Planning (PCP) meeting?: The participant must indicate whether or not they attended their person centered planning meeting by checking the appropriate box. If the participant checks "YES", the plan developer must include a brief summary of how the participant participated in the process on the Personal Summary page of the ISP. If the participant checks "NO", the plan developer must provide information on how the participant participated in the process (e.g., discussion at another time).

Participant Address and Phone #: Type the participant's current physical address with city, state, and ZIP code. Type the telephone number where the participant can be reached. If needed, designate if the number is for a landline, a cell phone, or a message phone.

Participant Date of Birth: Type the participant's date of birth with month, day, and year.

Gender: Check the box for the participant's gender.

Guardian Name (if applicable): Type the first and last name of the participant's legal guardian or "Self" if the participant is their own guardian.
Note: If a participant is committed to the Department of Health and Welfare, indicate that the Department is the guardian.

Guardian Address: Type the guardian's current mailing address with city, state, and ZIP code.

Guardian Phone #: Type the guardian's phone number with the area code.
Note: If a guardian is named, verify that a copy of the guardianship papers is on file with the Idaho Center for Disabilities Evaluation (ICDE). If not, obtain the guardianship papers and submit them to the Idaho Center for Disabilities Evaluation (ICDE).

Guardian Email: Type the email of the guardian.

Emergency Contact (if applicable): If no legal guardian is identified, type the name, address, and telephone number of a family member or friend who can be contacted in the event of an emergency.

Plan Developer: Type the first and last name of the plan developer.

Plan Developer: Type in the name of the Plan Developer.

Plan Developer Agency and Address: Type the agency's name and mailing address where the plan developer is employed with city, state, and ZIP code.

Plan Developer Telephone #: Type the telephone number where the plan developer can be reached.

Plan Developer Email: Type the email address of the Plan Developer.

DD Waiver Participant/Guardian Initials: The participant/guardian must indicate by initialing that they have chosen developmental disability (DD) waiver services over intermediate care facility (ICF/ID) placement.
- If the participant is their own guardian and unable or unwilling to sign due to "individual special circumstances" (e.g., refusal to sign at that time, participant is tactile defensive), the plan developer must document the case specific reason(s) why with the submission of the plan.

Planning Team Members Present for PCP Meeting: Individuals who are physically present at the PCP meeting must sign here.

Relationship to Participant: Each PCP team member must legibly print the nature of their relationship to the participant whether it be a member of the PCP team or a service provider (i.e. mother, developmental specialist, program coordinator, etc.). If the PCP team member is a service provider, have them also indicate their agency name in this section.

Other Planning Team Members Not Present: List the first and last name of individuals whose input was considered when developing the plan but who were not physically present at the PCP meeting.

Relationship to Participant: The plan developer must indicate the nature of the other planning team members' relationship to the participant. If a team member is a service provider, indicate their job title and agency name.

Participant Signature and Date Lines: The participant must sign (or mark or stamp) on this line if the participant is their own guardian. If the participant is unable or unwilling to sign due to "individual special circumstances" (e.g., refusal to sign at that time, participant is tactile defensive), the plan developer must document the case specific reasons why with the submission of the plan. Write the month, day, and year the participant signed their plan.

Guardian Signature and Date Lines: The guardian's signature on the ISP Supports and Services Authorization page indicates the guardian's request for identified services on behalf of the participant. In the event the guardian is not physically present at the person centered planning (PCP) meeting, documentation must exist that verifies the plan developer forwarded a copy of the entire ISP Supports and Services Authorization form to the guardian for review.

If a plan developer is unable to obtain the guardian's signature before submitting the ISP Supports and Services Authorization form for authorization, the plan developer has the option of obtaining confirmation from the guardian by e-mail or telephone that they agree with the plan. The plan developer must then document in the guardian signature section the guardian's approval of the plan, the means by which the plan developer received approval from the guardian (e-mail or telephone), and the date the approval was received.

Although the ISP Supports and Services Authorization form can be submitted for authorization without the guardian's signature when the above mentioned documentation is present, the plan developer must still require the guardian to sign, initial, and forward a copy of the ISP Supports and Services Authorization form to the plan developer by mail or fax to support the request for services. The plan developer must then maintain the ISP Supports and Services Authorization form signed and initialed by the guardian in the participant's file for quality assurance review purposes.

Write the month, day, and year the guardian signed the plan or the month, day, and year the guardian gave confirmation by e-mail or telephone of their agreement with the ISP on this line.

Plan Developer Signature and Date Lines: The plan developer must sign here. Write the month, day, and year the plan developer signed the plan.

Plan Developer Acknowledgement (**): By signing this page, the plan developer acknowledges that any modifications to the Individual Support Plan (ISP) that was initially developed by the person-centered planning team will only be made with the agreement of the participant, guardian, and any applicable providers.

**For participants in a CFH, this ISP, along with current medical information and CFH implementation plans must be kept in the home.

Bureau of Developmental Disability Services
Individual Support Plan

Participant Name: Jonathan Andrews	Medicaid #: XXXXXXX	Date of PCP Meeting: 11/1/2013
DD Waiver Participant? Yes ☒ No ☐	Initial Plan ☐ Annual Plan ☒	Did the participant attend his/her Person Centered Planning meeting? Yes ☒ No ☐

Participant Address and Phone #: 001 Main Street Boise ID 83702 (208) 123-4567 **Participant Date of Birth: 5/5/1955** **Gender: M ☒ F ☐**	**Guardian Name (if applicable), Address and Phone #:** Nancy Doe 002 West St. Boise ID 83702 (208) 000-5555 **Guardian Email:** ndoe@email.com **Emergency Contact (if applicable):** Deena Little (sister) (208) 891-0123	**Plan Developer:** Susan Pike **Plan Developer Agency and Address:** XYZ Service Coordination 1985 Broadway, Boise ID 83706 **Plan Developer telephone#:** 208-891-0123 **Plan Developer email:** sp@tsc.com

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

Person Centered Planning Team Members

Planning Team Members Present for PCP Meeting	Relationship to Participant	Other Planning Team Members Not Present	Relationship to Participant
Susie Planwriter	Plan developer/TSC- XYZ Service Coordination	Barry Bus	Van Driver- LMNOP Trans.
Nancy Doe	Mother/Provider/Guardian	Nelly Needle	Nurse-QRS Services
Shannon Sister	Sister	Billy Banter	CBRS worker- Healthy Steps
Sam Schmidt	Program Coordinator- ABC Agency	Tawny Talker	Therapy, Inc.
Debbie Data	Developmental Specialist- EFG Developmental		
Mark McDonald	Job coach- EFG Developmental		

Authorization is requested for the services listed on the Authorization page by the following people:

_____   _____

PARTICIPANT SIGNATURE

_____

_____   _____

GUARDIAN SIGNATURE (if applicable)

_____

_____   _____

PLAN DEVELOPER SIGNATURE

_____

**By signing this page, I am acknowledging as the plan developer that any modifications to the Individual Support Plan (ISP) that was initially developed by the person-centered planning team will only be made with the agreement of the participant/guardian and/or any applicable providers.

For individuals living in Certified Family Homes, this ISP, accompanied by current medical information and CFH Implementation Plan(s) must be maintained in the home.

Personal Summary Instructions and Form

Participant Name: Type the name of the participant exactly as it appears on their Idaho Medicaid card.

Medicaid #: Type the participant's Medicaid identification number as it appears on their Idaho Medicaid card.

Participant Involvement in the Person Centered Planning (PCP) Process: Describe how the participant participated in the PCP process. Include a brief summary of statements and choices made regarding their services.

Assessed Needs:

An assessed need is identified through documented, professional, objective observation and testing. It is relevant to the participant's current situation and is determined by identifying which assessed deficits are necessities based on information that they impact or are barriers to the participant's independence. Assessed needs can be addressed through the use of available supports and services. They are skills the participant needs help with, not services they are to receive. A deficit may not necessarily be a need.

During an ISP meeting, the following categories should be discussed and information updated yearly. On the form, indicate "Yes" or "No" if an assessed need(s) exists in that area. There may be more than one assessed need in each area. If there is a need in an area based on assessment information, and the team would like to defer that need, indicate such.

- **Physical/Mental Health:** Consider the primary and co-occurring diagnoses and health conditions of the participant (e.g., high blood pressure, allergies, specialized medical equipment, bipolar disorder, treatments).
- **Living Situation:** Consider the participant's current living situation (e.g., in own home/apartment with or without roommates, certified family home with or without relative providers, residential assisted living facilities (RALF), activities of daily living, housekeeping skills).
- **Family/Social Relationships:** Consider family members or natural supports which are involved in the participant's personal life and any family needs.
- **Behavioral Issues:** Consider behaviors that impact the participant's health and safety and the safety of others in the community.
- **Employment:** Consider where the participant works, what the participant does, and whether it is paid or unpaid employment. Consider if the participant is interested in employment.
- **Legal Status:** Consider whether or not the participant is their own guardian or has a guardian.
- **Communication:** Consider the participant's primary method of communication (e.g., verbal, sign language, communication devices, interpretive services) and skills in expressive/receptive language.
- **Ambulation/Mobility:** Consider what adaptive equipment is necessary for mobility and what methods the participant uses to navigate through the community (e.g., bicycle, public transportation, drives own car, motorized wheelchair).
- **Financial Status:** Consider if the participant has a representative payee or conservatorship, trusts, personal checking and/or savings account(s), sources of income, and the participant's ability to manage funds or if assistance is required.
- **Community Access and Other:** Consider where the participant accesses the community, their educational needs, interests, etc.
- **Long Range Goals:** These are not deferred needs but goals that the participant would like to achieve over time (not within the current plan year). These could include marriage, children, getting a driver's license, changing living environments, pre-planning for end of life issues, etc. The current year's assessed needs and objectives may contribute to achievement of these goals in the future.

Correlate Assessed Needs to Goals to be Addressed Within the Plan Year: After identifying the assessed needs of the participant as identified during the PCP team meeting and in looking at other assessment tools, a direct relationship must always exist between each of them and the short-term participant goals and provider based goals listed on the Individual Support Plan (ISP) Supports and Services page(s).

Additional Information Related to the Personal Summary Form

Transition Planning - The transition plan is the process that is anticipated to meet the transition goal. It must facilitate independence, personal goals, and personal interests while helping the participant move toward fewer paid services and greater natural supports in community environments. The transition plan must include a transition into one or more of the following environments:

- An alternative setting
- Vocational training
- Supported or independent employment
- Volunteer opportunities
- Community based organizations and activities
- Less restrictive settings

There are **two instances** when a transition plan is required for a participant:
- A transition plan must be developed and included on the ISP when a participant has been notified that they are borderline eligible for waiver or state services at the beginning of the plan year on their eligibility notice.
- A transition plan must be developed when a participant is anticipated to transition to a lower intensity or frequency of any service they receive during the upcoming plan year.

The transition plan is incorporated on the Personal Summary page of the ISP. The criteria in which a transition plan is required are stated on the form, as are the accepted transition areas.
- For **all** participants, mark the appropriate box indicating if a transition plan is needed.
- If a transition plan is required:
    - As a PCP team, discuss and write in the first column which transition area(s) are anticipated for the participant.
    - Assign each area with a number for purposes of tracking across the table.
    - In the second column, write the transition goal and planning steps for the identified transition area within the plan year. These goals and planning steps should be structured and progressive
    Examples: a reduction in the amount of hours of a more restrictive service, increase in time alone or with natural supports for supervision, use of other non-Medicaid funded resources, etc.
    - In the third column, write who is going to ensure the goal and steps are accomplished for each transition area.
    - In the fourth column, write the expected completion date for each transition area.
    Note: Service Coordination notes should document the progress made toward each transition area.
    - For those transition steps where a service is decreased or discontinued and the annual budget is affected, **submit an addendum.**
- If the PCP team determines the participant needs a behavior/safety plan for one of the goals and planning steps, write "Refer to attached _____ plan".
- For participants who are moving out on their own or getting off probation, they still need to meet the criteria to have a transition plan.
- If the participant is expected to move between hubs or regions during the plan year, refer to the Transfer Protocol on the Developmental Disability (DD) Care Management website.
- Unexpected transitions throughout the year can be handled with an addendum, if necessary.

Plan Monitoring-

- Answer the 3 questions in this section using "Yes" or "No". For those questions with a "No" answer, the Plan Monitor/TSC (PM) should give an explanation. Provider Status Reviews are required to be submitted to the PM at 6 month and annual intervals, but do not need to be submitted with the plan. Care Managers may request this information if they feel it is necessary during plan review.

<u>Safety Concerns and Alone Time -</u>

- Answer the 6 questions in this section using "Yes" or "No". Give an explanation for all answers, as needed.
- **<u>Safety Plans for participants who are in Supported Living are submitted with the ISP</u>**
- **<u>For Alone Time in a CFH, please see the "Home Alone Guidelines for Adults with Developmental Disabilities" on the DD Care Management website</u>**

<u>Safety Plan Information -</u> A safety plan should be in place in the event that the participant requires immediate help at a time when a paid support is normally in place and is not available. A safety plan is needed when any of the following criteria are met:

- A "YES" answer for the following Safety Concern question is identified **and** the participant lives in a supported living environment:
  - "Within the last plan year have there been any situations that could re-occur that would put the participant or others in danger?" If a 'yes' response, a safety plan is required.
- **<u>Any</u>** requests for home alone time on an ISP for participants accessing High Supported Living services
- There is a transition to fewer paid supports indicated by a 'yes' for either situation on the transition section of the ISP. (i.e. a participant moving from 'Intense' to 'Hourly')

A safety plan generally includes the participant's own knowledge of what to do in emergency situations, and the availability of natural supports and/or other paid supports or devices such as:
- Co-workers at a job site
- Roommate or neighbors at home
- Family, friends and good community acquaintances
- A Personal Emergency Response System (PERS)

A safety plan would need to include the following information:
- What support is in the plan to reduce risk?
- What will be done to resolve a risk due to loss of support?
- How has the participant demonstrated their ability to implement any part of the identified safety plan?
- How would the participant evacuate their residence?
- What mobility, functional and communication skills does the participant have to protect themselves?
- What back-up supports are in place?
- What ability does the participant have to recognize the need for and seek emergency help?

Supporting documentation, including but not limited to, staffing and activity schedules, progress notes, and incident reports may be necessary to determine if the safety plan is adequate. These can be requested by the Care Manager during plan review.

Idaho Department of Health and Welfare
PERSONAL SUMMARY
(Including Assessed Needs, Transition Planning, Plan Monitoring, Safety Concerns)

Participant Name: Jonathan Andrews	MID: XXXXXXX	Plan Start Date: 1/1/2014

Participant Involvement in the PCP process: Jonathan identified who he wanted at his PCP meeting. While at the meeting, Jonathan stated that he wants to keep his job at Taco Bell but not have a job coach all the time. Jonathan stated he enjoyed his DDA and the activities he does there. He agreed that he needs some work on not injuring himself and stated he wants to work harder on that this year. Jonathan also stated he wanted to go camping with his friend, George, this year.

Assessed Needs - Review ICDE assessments and provider evaluation tools to identify the participant's assessed needs.	*Is there an assessed need(s) in this area?*		*If yes, give a brief description of the assessed need(s)- (a service, support, and or goal on the Supports and Services pages should correlate to the assessed need(s) identified)*
	Yes	*No*	
Physical/Mental Health	☒	☐	Jonathan has been diagnosed with Bipolar Disorder which he also takes medication for and accesses CBR services to help address coping skills. He uses adult Attends for nighttime incontinence.
Living Situation	☒	☐	Jonathan needs assistance in learning ADLs, personal care skills
Family/Social Relationships	☐	☒	
Behavioral Issues	☒	☐	Jonathan will sometimes hit others when asked to do something he does not want to do. Jonathan does engage in self-injurious behaviors such as biting and scratching himself when he is upset. He may also display repetitive behaviors such as rocking. He could benefit from training in replacement behaviors.
Employment	☒	☐	Jonathan needs a job coach to help him maintain his employment.
Legal Status	☐	☒	
Communication	☒	☐	Jonathan is verbal but currently has difficulty with receptive and expressive communication skills.
Ambulation/Mobility	☒	☐	Jonathan is ambulatory, however, he does have decreased mobility on his right side due to seizure activity. This is an assessed need but is being deferred at this time as Jonathan will ask for assistance if needed.
Financial	☒	☐	Jonathan needs to work toward assisting in managing his own money.
Community Access	☒	☐	Jonathan needs to work on using appropriate social skills in different environments.
Long Range Goals	☒	☐	Jonathan would like to be able to live in an apartment with roommates when his mother is no longer living. He could benefit from training in independent living skills.

Participant Name: Jonathan Andrews	**MID:** XXXXXXX	**Plan Start Date: 1/1/2014**

Transition Planning- A transition plan must facilitate independence, personal goals and personal interests. The transition plan must also meet the health and safety needs of the participant.	
Based on the eligibility notice, is this a participant who may no longer qualify for DD waiver services at the end of the plan year?	**Yes** ☒ **No** ☐
Based on the PCP team discussion, is this a participant who will need to transition to a lower intensity/frequency of any services they receive during the current plan year?	**Yes** ☐ **No** ☒

If either question is marked "Yes", describe the transition plan below in terms of where and how the transition will take place: It must be a transition into one or more of the following: An alternative setting, vocational training, Supported or independent employment, volunteer opportunities, community based organizations and activities and/or less restrictive setting

Transition Area	Goal & Planning Steps (reduction of services)	Responsible Party	Expected Completion Date
1. Less restrictive setting	1. Reduce use of Supported living: A. Allow alone time beginning now for 4 hours during night. B. Increase activities with George C. Add visiting mom 2 weekends a month	1.Jonathan, RH, TSC, George, mom	1. 6-1-14
2. Community based organizations and activities	2. Increase community activities alone: A. Get/learn to use a bus pass to go to work, Idaho Youth Ranch, Bowling, SO, ARC, and grocery store. B. Set up time to go alone to the ARC where planned activities are taking place 2 hours a day 4 days a week	2. Jonathan, TSC, RH, mom	2. 4-1-14
3. Volunteer opportunities	3. Increase volunteer opportunities A. Volunteer at Idaho Youth Ranch(work up to 3 mornings/week, 2 hours each) *See attached safety plan	3. Jonathan, TSC, Idaho Youth Ranch, RH	3. 9-1-14
4. Supported/ind. Emp.	4. Increase hours at work. A. Use a checklist & timer for independent guidance B. Ask co-workers for feedback on quality	4. Jonathan, job coach, Taco Bell supervisor, TSC	4. 8-1-14

Plan Monitoring	Yes	No	
Over the last plan year, were services provided to the participant according to the authorized plan?	☒	☐	*If no, what action was taken?*
Did you receive completed Provider Status Reviews for required services that show progression, regression, and/or maintenance of skills?	☐	☒	*If no, please list the agency and the action taken* EFG Developmental. Plan Monitor contacted the agency at the 6 month time frame for this document. Agency did not respond, but did submit the document at the PCP meeting.
In the past year, was/is the participant satisfied with the quality and quantity of services received from all providers?	☒	☐	*If no, what action was taken?*

Safety Concerns	Yes	No	
Within the last plan year have there been any situations that could re-occur that would put the participant or others in danger?	☐	☒	*If yes, describe the situation(s) in detail, how this is being addressed and by whom? Include a safety plan for SL participants only*
Are there structural, physical, emotional, or environmental risks (i.e., evacuation during an emergency, etc.) that would present concerns related to the well being of the participant?	☒	☐	*If yes, describe the risks in detail, how this need will be addressed and by whom?* If there was a fire, Jonathan is able to evacuate on his own. Jonathan does not like loud noises. For him to access the community, those with him should prepare him for any unexpected noise he may encounter and offer him options to work through the situation.
Are there significant health and well being issues not addressed on the ISP?	☐	☒	*If yes, describe them in detail and, in detail, how these needs are addressed and by whom?*

Alone Time in a CFH	Yes	No	
Does the participant/guardian want to utilize alone time?	☒	☐	*If yes, describe how much alone time is desired by the participant, when the participant would like to be alone, where the alone time will likely occur. If no, then do not answer further questions.* Jonathan would like to be alone for an hour a day when he returns home from the DDA (5 hours per week).
Does the PCP team agree the participant's functional age and cognitive skills would allow the participant to follow a home alone	☒	☐	*If no, describe the risks or issues that the PCP team has identified that prevent the participant from utilizing alone time.*

safety plan to reduce risk and address health and safety concerns?			
Does the PCP team agree there are no issues (e.g. behavioral issues or impulse control) which would impact the participant's ability to follow a home alone safety plan to reduce risk and address health and safety concerns?	☒	☐	*If no, describe the risks or issues the PCP team has identified that prevent the participant from utilizing alone time.*

Supports and Services Instructions and Form

Note: This form is provided as an example and is not representative of actual ISP Support and Services pages. The services below are not intended to be a comprehensive list. For services not listed here, refer to the fee schedule.

Participant Name: Type the name of the participant exactly as it appears on their Idaho Medicaid card.

Medicaid #: Type the participant's Medicaid identification number as it appears on their Idaho Medicaid card.

Supports and Services column: List in this column all of the supports and services that will be delivered to the participant during the plan year.

Some of the services listed in this column provide supports that have the participant's responsibilities and expectations listed in IDAPA code or their Provider Agreement and do not need to be copied here. These services include (see example Individual Support Plan (ISP) pages):
- Residential habilitation - supported living agency - include emergency number
- Plan development

Some of the services below have goals that may correlate to an assessed need and/or do not have measurable participant objectives associated with them. These supports are accomplished by the provider. If the participant receives any of the following services, please include a list of the supports being provided (see example ISP pages):

Service	Support to be listed
Residential Habilitation Program Coordination	Program Coordination Plan and Program implementation Plans (PIPs): Develop, implement and monitor **Indicate the number of hours of home alone time being requested per week (if applicable)
Residential Habilitation Certified Family Home	Supports of the home, frequency of doctor and dentist visits, and if substitute care/alternate care/alone time is being requested
Adult Day Health	Supports of the provider
Non- Medical Transportation	Pick up site and ending destination (including address and city for both)
Medical Transportation	Refer to AMR as the support for this service to/from DDA services.
Behavioral Consultation	Supports of the provider
DD Waiver Nursing services	Goals of the provider from their care plan-submit care plan
Durable Medical Equipment (DME)	Supplies/items
Service Coordination and Emergency Plan	Specific goals of the provider, frequency/mode of contact/who is being contacted, emergency and non-emergency situations, how to coordinate services after an emergency
Behavioral Health Services (psychotherapy, CBRS (formerly PSR), med management, etc.)	Behavioral health goals are identified on provider treatment plan - double check there is no duplication with other services (16.03.10.513.04)
Natural Supports	Locations in the community that are accessed
OT/PT/Speech Therapy- Independent Providers	Goals to be addressed during the plan year

Dental services- this can be the only waiver service on the plan	Needs addressed by the dentist and the name of dental clinic as the provider

Lesser used services such as chore services, respite, home modifications, specialized medical equipment, personal emergency response systems (PERS), home delivered meals, and interpretation can be listed in the Supports and Services column, along with the frequency and provider in the appropriate columns.

Goals to be Addressed Within the Plan Year column: Based on assessed needs, include in this column any short-term goals that the participant will work to accomplish within the plan year for the following service types:
- Residential Habilitation Certified Family Home (CFH)
- Residential Habilitation Supported Living
- Developmental Therapy
- Community Supported Employment (if an annual plan and has already been receiving the service)

Accessing Behavioral Health Services: The plan developer must obtain behavioral health assessments and/or treatment plans for use during the person centered planning process. When the initial/annual plan is written, assessed needs related to the participant's behavioral health should be identified within the Personal Summary and goals should be included in the Supports and Services. Behavioral health services are not costed on the cost page. Regional Care Managers will review the ISP has no duplication of services, addresses health and safety and provides for the right care, in the right place, at the right price with the right outcomes. If through this clinical review, the care manager believes that developmental disability and behavioral health goals on the Supports and Services page are duplicative, the care manager may request behavioral health assessments and/or treatment plans can be requested from the Developmental Disability (DD) plan developer for more detailed information.

Requests for CSE: There is no longer a process for "Pended CSE."   If a participant has not utilized CSE before, the initial or annual plan will need to identify the intent for the participant to obtain a job and use waiver CSE by including the following language on the plan. This assessed need should be addressed within the Personal Summary and the statement below should be added to the Supports and Services page.

- **"I have identified employment as a priority for my plan. When an employment opportunity has been identified, an addendum to my Individual Support Plan will immediately be submitted by my Plan Developer.   The addendum will identify the necessary units per week needed for CSE and decrease my other support services to allow for CSE and stay within my assigned budget"**

During plan review, Regional Care Managers may request other documentation to see data or for clarification if the goals on the Supports and Services page appear to be too broad and/or duplicative.

Frequency Column: Identify how often each service or support is being delivered (e.g., 20 hours/week, 1 time/year, etc.) This frequency should correlate with what is on the authorization page.

- For durable medical equipment (DME), identify the quantity of the product (e.g., 3 boxes). If the product is also being requested on a regular basis (e.g., weekly, monthly), this information must also be included (e.g., 3 boxes per month, etc.). Refer to the DME fee schedule for pricing.
- For developmental therapy, identify whether it is home and community-based individual, home and community-based group, center-based individual, or center-based group developmental therapy.
- For non-medical transportation, include the miles per trip, trips per day, and the number of days per week it is occurring (e.g., 4 miles/ trip x 2 trips/day x 3days /wk).
- For natural supports, include the frequency the activities are completed.

- For the emergency plan, include the frequency, as needed.

Agency or Provider Column:
- Type the name of the CFH provider, if the participant receives CFH services.
- Type the agency responsible for providing the service and/or support. Do not include the staff names from the agency. However, Residential Habilitation Program Coordination must include the name and contact information of the Program Coordinator.
- Type the name of the person or organization responsible for helping the participant during an emergency or for natural supports.

Idaho Department of Health and Welfare
Supports and Services Form
EXAMPLE FORM

Participant Name: Jonathan Andrews   **MID#: XXXXXXX**   **Plan Start Date:** 9/1/2014

Supports and Services	Goals to be Addressed Within Plan Year	Frequency	Agency or Provider
Residential Habilitation Program Coordination If an "Alone Time" request to the right is approved, a Home Alone Time Program Implementation Plan (PIP) will be developed by the PC	Program Coordination Plan and Program implementation Plans (PIPs): Develop, implement and monitor **Participant will be safe for __7__ hours of Alone Time a week.	365 days/year 52 weeks/year	Community Partnerships of Idaho Program Coordinator- Julie Long 208-999-9999
Residential Habilitation (CFH) -See Dr. Johnson (physician) 1x/ year -See Dr. White (dentist) 2x/ year -Assist with medications -Assist with scheduling appointments and transportation -Assist with daily living skills -Assist with finances -Assist with recreational opportunities Alternate Care: None	Jonathan: Will initiate taking medications Will increase independence with bathing skills Will increase social skills during meals Will increase shopping skills Will increase opportunities for community integration Will pick up own place and setting after meals	365 days/year	Nancy Doe, Provider
Residential Habilitation- Supported Living Emergency contact number: 111-1111	Jonathan: Will increase independence with bathing skills Will increase shopping skills Will increase budgeting skills Will increase opportunities for community integration Will pick up own place and setting after meals	40 hours/week	ABC Agency
Adult Day Health Assist with ADLs Monitor social opportunities Provide recreational activities		4 hours/week	EFG Developmental
Non-Medical Transportation From home (001 Main Street Boise) to Adult Day Health at EFG Developmental		1 mi/one way 2 miles/day 4 days/wk	LMNOP Transportation

Supports and Services	Goals to be Addressed Within Plan Year	Frequency	Agency or Provider
(234 Foothill St. Boise) and back			
Community Supported Employment I have identified employment as a priority for my plan. When an employment opportunity has been identified, an addendum to my Individual Support Plan will immediately be submitted by my Plan Developer. The addendum will identify the necessary units per week needed for CSE and decrease my other support services to allow for CSE and stay within my assigned budget.		TBD	TBD
Behavioral Consultation Provide staff training Provide emergency back-up as needed Consult with direct care staff regarding behavior management techniques		30 min./month	QRS Services
Nursing Monitor prescription needs Monitor dietary needs Monitor blood pressure		1 visit/month	QRS Services
DME-gloves		2 boxes/ month	QRS Services
Plan Development		6 hours/year	XYZ Service Coordination
Service Coordination and Emergency Plan By phone or in person the para-professional will: -Link to Special Olympics events in the area -Explore the guardianship process -Assist in locating appropriate transportation to DDA services By phone or in person the professional will: -Explore alternate care when Deborah is		Para- 1 hour/month Pro- 3 ½ hours/month	XYZ Service Coordination

Supports and Services	Goals to be Addressed Within Plan Year	Frequency	Agency or Provider
on vacation - Link to energy assistance -Conduct a face to face meeting with Jonathan at least every 90 days to review the plan -Monitor Jonathan's satisfaction in the DDA and at his job every 90 days -Identify an emergency plan in the case of Jonathan injuring himself during a behavior -Complete 180 day review of TSC goals - By phone or in person the professional or paraprofressional will contact: Jonathan, mom, relevant providers, etc. **-In the event of a medical emergency:** Contact 911, and call Jonathan's mother Deborah at 123-4567. **-In the event of a non-medical emergency:** Contact Deborah at 123-4567, sister Deena at 891-0213. Susan Pike can be contacted at 987-6543 -In the event of an emergency, Susan will assist in contacting any applicable service providers if Jonathan is unable to attend services. Susan will also contact applicable members of the PCP team to discuss prevention and resolution of recurring emergencies.		As needed As needed As needed As needed	Nancy Doe Shannon Sister XYZ Service Coordination

Supports and Services	Goals to be Addressed Within Plan Year	Frequency	Agency or Provider
DDA	Jonathan: Will increase communication by using full sentences Will request assistance from store employees Will stay on topic in conversations Will follow multiple part instructions Will learn to make change using bills and coins Will learn to write a complete check Will learn to maintain an accurate check book Will tell time on a clock	Ind Center 2 hours/ week Group Center 2 hours/week Ind community 2 hours/week Group community 2 hours/week	EFG Developmental
Community Based Rehabilitative Services Provide training to build and maintain stabilization in mood, behavior Provide training to use medical resources appropriately		1 hour/week	Healthy Steps
Natural Supports **-**Church -Spend time with family -Special Olympics bowling		Every Sunday 1 wknd a mo. Weekly	Nancy Doe Shannon Sister Shannon Sister, George
Speech Therapy Improving speech production when asked a question Speaking clearly Enunciation		40 units/year	Therapy, Inc.
Medical Transportation To and from XYZ Agency for DT		5 days a week	AMR
Dental services (waiver participants only) -Dental exams, xrays, and cleanings -Dental hygiene education -Discuss oral hygiene concerns in relation to participant medical conditions		2x a year	White Dental Clinic

Supports and Services Addendum Instructions

**Note: <u>You can find an example addendum page on the
Adult DD Care Management website</u>**

Participant Name and Address: Type the name of the participant exactly as it appears on their Idaho Medicaid card. Type the participant's name current physical address with city, state, and ZIP code.

Medicaid#: Type the participant's Medicaid identification number as it appears on their Idaho Medicaid card.

Plan Developer Name, Agency Address, and Phone: Type the Plan Developer's name, agency name and mailing address where the plan developer is employed with city, state, and ZIP code, and phone number.

ISP Start Date: Type the month, day, and year the current Individual Support Plan (ISP) was authorized for which an addendum is being submitted.

Provider Requesting Addendum: Type the name of the individual/agency who is requesting the addendum on this line, if it is someone other than the plan developer.

Date Requested: Type the month, day, and year the ISP Supports and Services Addendum form is completed.

Reason for Addendum Request: Identify which of the options listed below is the reason for submitting the addendum. **Note:** The reason must be based on the participant's need or want and must be clearly identified. More than one option can be listed. **Additional pages can be attached when justification is needed. ** An addendum is not needed for goal changes.**

- Adding or deleting services (e.g., supported living, community supported employment, DDA).
- Changing the type of service (e.g., home and community DT to center DT).
- Changing the amount of service.
- Changing the agency identified on the ISP Supports and Services form.
- Change of participant address

For demographic changes for a participant (i.e. address, phone number, etc.)- the participant will also need to send an email to Self Reliance at <u>MyBenefits@dhw.idaho.gov</u>. This information will then be updated with Molina.

Adding CSE with an addendum: All requested services must remain within the assigned budget including CSE. CSE requests do not fall into the updated exception review parameters for plans that are over budget.

- Once a job has been identified, the Idaho Division of Vocational Rehabilitation (IDVR) will e-mail the Regional Care Manager and the Participant's Plan Developer the following information

     o Stop date of the IDVR funding (includes the training phase) identified by a work specification sheet sent to IDVR by the vocational provider

     o Waiver CSE provider

- o   Number of hours of CSE

- o   Frequency of CSE

- Using the information provided by IDVR, the Plan Developer must develop an addendum to add CSE onto the plan and decrease other services to stay within the assigned budget.

Important:

- **This information must be sent and received timely enough for an addendum to be submitted and authorized prior to the start date of the CSE and end date of IDVR funding (Plan review and authorization requires at least 15 days in advance of start date).**
- **If additional CSE units are required, or there is a change in the CSE provider, an addendum must be submitted requesting these changes.**
- **A list of the "Goals to be Addressed Within the Plan Year" for the participant under CSE should accompany the addendum.**
- **If non-medical transportation is required to get the person to and from the job it must also be identified on the plan, costed, and be within the assigned budget.**
- **An addendum cannot be used to add CSE as an initial waiver service.**

Agency Name Column: Type the name of the provider or agency responsible for delivering the service.

Procedure Code Column: List the service code that corresponds with the DD waiver or state plan service. This service code can be found under the "Procedure Code" and "Modifiers" columns of the most current fee schedule (see Web site listed above).

Start Date and End Date Columns: Type the stop date for the service that is being ended. Type both the start and end date for the service that is being added/modified. **Submission should allow for plan review and authorization requires at least 15 days in advance of the start date being requested.**

Units Column: See page 6 for how to list the Units in this column.

Units Cost Column: Refer to the "Amount Allowed" column of the fee schedule for the dollar value of each unit. List this dollar value in this column. **Example:** For code H2032: 1 unit = $3.02.

Frequency Column: See page 6 for how to list the Frequency in this column.

Annual Cost Column: Multiply the "Unit column" by the "Unit Cost column" and "Frequency column" to get the annual cost. If you are decreasing or discontinuing the service, make sure this total is indicated by a (-) sign.

Annual Units: This column will populate automatically based on a formula. **DOUBLE- CHECK FOR ACCURACY**

IPA # Column: This column is for Department of Health & Welfare use only. If the box for the "Service Type" contains a number, the service has been prior authorized.

Addendum Sub-Total: This cell will populate automatically based on a formula. **DOUBLE- CHECK FOR ACCURACY**

Previous Annual Plan Total: Type this amount here.

Calculated Budget Amount: Type the authorized budget amount from the participant's Eligibility Notice.

New Medicaid Annual Total Line: Type this new amount here.

Participant Signature and Date Line: The participant must sign (or mark or stamp) here if the participant is their own guardian. If the participant is unwilling or unable to sign due to "special circumstances" (e.g., refusal to sign at that time, participant is tactile defensive), the plan developer must document the case specific reasons why with the submission of the plan. Write the month, day, and year the participant signed the ISP Supports and Services Addendum.

Guardian Signature and Date Line: Refer to page 11 of this manual for directions on how to get a guardian signature. Write the month, day, and year the guardian signed the ISP Supports and Services Addendum or the month, day, and year the guardian gave confirmation by e-mail or telephone of their agreement with the ISP Supports and Services Addendum.

Plan Developer Acknowledgment Signature and Date Line: The plan developer must sign here. Write the month, day, and year the plan developer signed the ISP Supports and Services Addendum.

Plan Developer Acknowledgement (**): By signing this page, the plan developer is acknowledging that any modifications to the Individual Support Plan (ISP) that was initially developed by the person-centered planning team will only be made with the agreement of the participant/guardian and/or any applicable providers.

Plan Development Authorization Cover Sheet

Date	Assessor	Participant
Prior Authorization Start Date (Date provided by the plan developer)	**Prior Authorization End Date**	**MID #**
Plan Developer and Agency Name: (*please print or type*)		**Provider Number (preferable):**

Agency Notes (if needed):

_____
_____
_____
_____

Plan Development Services Have Been Authorized:
(*for regional office use only*)

Service	Frequency	Prior Authorization #
G9007 Plan Development	**hours / year**	

Department Notes (if needed):

_____
_____
_____

Instructions: The Plan Development Authorization Cover sheet can be completed at the time of the person centered planning meeting or after. It can be turned in directly to the Regional Support Staff for prior authorization. **Note: The Prior Authorization Start Date should not be a day/month (date) earlier than last year's prior authorization date.**

Exception Review Instructions and Form
DO NOT TURN THE INSTRUCTIONS IN WITH THE ISP

The Department will complete an exception review and negotiate additional funding in the following circumstances **ONLY**:

I. A participant and the person centered planning team may request an exception review for individuals when they require ***Intense Supported Living***. The participant's plan must include a request for Intense Supported Living services and supporting documentation must verify that the participant requires a type, frequency or intensity of support that is not addressed by the Inventory of Individual Needs. To qualify for additional funding there must be documentation submitted to support one or more of the following:

   a. The participant has recent felony convictions or charges for offenses related to serious injury or harm of another person*. **These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration.***

   b. The participant has a history of predatory sexual offenses and is at a high risk to re-offend based on sexual offender risk assessments completed by appropriate professional.

   c. The participant has a sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes that person fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring and regular and routine intervention to prevent injury to themselves or others.

   d. The participant has chronic or acute medical conditions that are so complex or unstable that one-to one staffing is required to provide frequent interventions and constant monitoring. Without this intervention and monitoring, the participant would require placement in a nursing facility, hospital or ICF/ID with twenty-four (24) hour on-site nursing. Verification of the complex medical condition and the need for this level of service requires medical documentation.

II. Participants and Person Centered Planning teams may request an Exception Review for individuals when they request ***High Supported Living.*** The participants plan must include a request for High Supported Living services and supporting documentation must verify that the service is required for health and safety and meets Medical Necessity criteria below from IDAPA 16.03.10.012.14a.-c.

   a. It is reasonably calculated to prevent, diagnose or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunctions; and
   b. There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly.
   c. Medical services shall be of a quality that meets professionally recognized standards of health care and shall be substantiated by records including evidence of such medical necessity and quality.

*** All other participants requesting additional funding must do so as part of a budget appeal when they do not believe their assigned budget meets their assessed needs.***

*** Care Managers may request additional information if they feel it is necessary during plan review.***

EXCEPTION REVIEW REQUEST FORM

Established Standards and documentation requirements identified below:

This process is supported by the following rules:
IDAPA 16.03.10.515.03 Exception Review and 16.03.10.513.08 Plan Negotiation

Intense Supported Living:

The need to provide exceptional support to address health and safety issues associated with the following circumstances will be considered for additional funding. Please check all that apply and provide documentation to support each.

☐   The participant has recent felony convictions or charges for offenses related to serious injury or harm of another person.

> **Documentation:**   The documentation must describe the incident(s) and outcome.   The documentation must support that as a result of the incident(s), the participant will access Intense Supported Living directly from incarceration or directly after being diverted from incarceration. Information must be provided by the Supported Living agency indicating the reasons why additional funding is required to maintain the participant's health and safety, what type of additional support will be provided and the anticipated cost of providing the support.

☐   The participant has a history of sexual offenses and is at high risk to re-offend.

> **Documentation:**   The documentation must identify the type and   frequency of the offenses. If there are current issues, data and incident reports must be provided to describe the status of the individual in relation to these offenses.   There must also be a recent psychosexual risk assessment completed by a qualified professional that identifies the person's propensity to re-offend, why this level of support is required to maintain health and safety, and a treatment and supervision plan to manage or address any identified risk(s).

☐   The participant has a sustained history of serious aggressive behavior that shows a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes the person fear bodily harm and the participant has the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring and regular and routine interventions to prevent injury to themselves or others.
.

> **Documentation:** The documentation must include the data and incident reports to support frequency and intensity of the aggressive behavior(s).   The Supported Living agency must include a current psychological evaluation and behavior management plan developed by a professional to address and manage the identified behaviors and the agency's plan for implementing this level of support in order to maintain the participant's health and safety.

☐   The participant has chronic conditions that are so complex or unstable that requires frequent interventions and constant monitoring and/or the participant has an acute medical condition that is so complex or unstable they require frequent interventions and constant monitoring.

Documentation: The documentation must include a current physician's order that supports the chronic or acute condition and any medical, behavior or psychiatric assessments and notes. The documentation must also include a physician plan or nursing plan for intervention. The professional's plan must indicate whether there is a need for around the clock up and awake monitoring, and if not, what frequency, intensity and type of support is required to maintain participant's health and safety.

PROJECTED TIME PERIOD the over budget plan costs will be needed:

Start Date: _____   End Date: _____

High Supported Living:

I.   Persons accessing High Supported Living and requesting additional funding must provide documentation to support that the service is required for health and safety and meets the following Medical Necessity criteria identified at IDAPA 16.03.10.012.14a. "The service is medically necessary if it is reasonably calculated to prevent, diagnose or treat conditions in the participant that endanger life, cause pain, or cause functionally significant deformity or malfunctions."

PROJECTED TIME PERIOD the over budget plan costs will be needed:

Start Date: _____   End Date: _____

Plan Developer ISP Checklist

Participant Name: Plan Developer Name:

Plan Due Date (30 days for initials/45 days before the expiration of the existing annual plan):

Date Submitted:

☐ ISP forms: Authorization Page, Signature Page, Personal Summary Page(s), Supports and Services Page(s)

☐ Double-check History and Physical/Nursing Form or MCE was received by ICDE or submitted with plan

☐ Check for participant/guardian/plan developer signatures

☐ Waiver box initialed (*) on Signature Page

☐ Goals are consistent with participant's assessed needs identified from Personal Summary/assessments

- Participants who have serious general maladaptive behavior index scores (below -22) and/or are requesting Intense Supported Living Services based on IDAPA 16.03.10.514.02.b.i., ii., or iii. should have at least 1 formal behavioral goal to be addressed within the plan year
- Participants who have a GMI of -17 in combination with their age equivalency of 8-8y6m should have goals to address any behavioral issues
- Participants who take prescription psycho-active drugs and who have Axis I diagnoses should have services or supports which address any behavioral and/or medication assistance or medication administration issues

☐ Transition plan on Personal Summary for participants who are borderline waiver plan eligible as noted on their annual eligibility notice or are expected to need less intensity/frequency of supports during the year

☐ Goals for Certified Family Home, Supported Living, Developmental Therapy, CSE are listed under "Goals to be Addressed with the Plan Year" on the Supports and Services page

- Goals are specific enough to adequately determine what is being worked on and ensure there is no duplication of services, however, they are not so specific as to list individual objectives

☐ CFH Provider enrollment letter is attached to initial plans and addendums requesting Res Hab- CFH Services

☐ Plans indicating an intent to receive CSE show statements to this effect

☐ Goals for Adult Day Health, Behavioral Consultation, DD Waiver Nursing, Service Coordination are listed under "Supports and Services" on the Supports and Services Page

☐ Goals for PT, OT, Speech when provided by an independent provider and cost caps do not exceed Medicare amounts

☐ Assessment requests in a DDA do not exceed *4 hours for the year*

☐ Behavioral Health services are identified in the Supports and Services page and do not duplicate other services on the ISP

☐ Frequency of services and programs are consistent with the participant's needs and current situation

☐ Documentation of unmet needs and service gaps including goals to address these needs or gaps

☐ Emergency Contacts listed on plan

☐ Exception Review (*) form(s) to justify a request for plan cost above the authorized budget for High or Intense Supported Living only

☐ Risk Assessment (*)

☐ Safety Plan for participants in Supported Living-needs to match Supports and Services. 'Safety Concerns' and 'Alone Time in a CFH' sections of the Personal Summary must be completed for a participant requesting alone time in a CFH. Frequency of alone time being requested must be listed on Supports and Services Page

☐ Nursing Plan of Care (*)

☐ Provider Status Reviews are received by the TSC/Plan Monitor for required services **(DO NOT TURN IN WITH THE PLAN-KEEP IN FILE AND SEND IF REQUESTED BY THE CARE MANAGER)**

- Participant is making progress or maintaining skills or new ISP indicates adjustment

☐ Implementation plans for CBRS and DT/RES HAB (*) **NO DUPLICATION**

☐ There is no duplication of services and services do not exceed 168 hours per week

☐ Services are listed and costed accurately in units using the correct codes on the Authorization Page and correlate to the Supports & Services page(s)

☐ DME/SME is identified on Authorization Page and Supports and Services page with the correct code and cost (*)

☐ Non-medical transportation is identified on Authorization Page and Supports and Services page (*)- verify type (i.e. commercial, agency, or individual) and rate with transportation provider prior to costing

☐ Waiver dental services are identified in the Supports and Services

 (*) = if applicable

How to Initiate an Addendum

When a situation arises that requires a current service or support provider to request a modification to the existing Individual Support Plan (ISP) based on participant preference or assessed need, an ISP Supports and Services Addendum form must be submitted for authorization. The process for initiating an ISP Supports and Services Addendum for submission is as follows:

Step 1.   A plan developer and/or service or support provider may initiate an addition, deletion, or modification to the existing ISP.

Step 2.   The requesting provider then completes the ISP Supports and Services Addendum form according to the ISP Instruction Manual.

Step 3.   The requesting provider reviews the completed ISP Supports and Services Addendum form with the participant or guardian (if applicable).

Step 4.   The requesting provider (if not the plan developer) forwards the ISP Supports and Services Addendum to the plan developer.

           If two or more service and/or support providers submit separate ISP Supports and Services Addendums for the same participant at the same time, the plan developer can create one overall ISP Supports and Services Addendum to encompass all requests for change, if the service and support providers agree with this arrangement. The plan developer will then be responsible for obtaining all required signatures on the one overall ISP Supports and Services Addendum.

Step 6.   Once the plan developer receives an ISP Supports and Services Addendum from a service or support provider, the plan developer evaluates whether it is necessary to convene a person centered planning (PCP) meeting to discuss the proposed request and verify the participant's or guardian's (if applicable) agreement with the request as stated in the ISP Supports and Services Addendum.

Step 7.   Once it has been verified by the plan developer that the participant/guardian is in agreement with the ISP Supports and Services Addendum request, the plan developer determines the financial impact of the request relative to the participant's annual budget.

           If the ISP Supports and Services Addendum request puts the plan over the participant's assigned budget, the plan developer should collaborate with the PCP team to discuss alternatives to bring the plan within budget. If the PCP team is requesting High or Intense Supported Living and the plan is over budget, the plan developer, together with the PCP team, must complete an Exception Review form.

Step 8.   The plan developer will then submit the ISP Supports and Services Addendum form along with the Exception Review form (if applicable) to the Information Coordinator (IC) who then forwards it on to the appropriate regional Care Manager for review and authorization. The requested start date of the plan should allow for 15 days to review, approve, and PA the addendum.

PLAN DEVELOPERS AND DEPARTMENT STAFF

Plan Developers are responsible for assisting individuals requesting developmental disability services to obtain needed medical equipment and supplies and to submit Individual Support Plan (ISP) service authorization requests and addendums for costing as needed.

> It is important to remember that if the participant you are providing services to is enrolled with Healthy Connections, a primary care provider referral is necessary for Medicaid reimbursement of Durable Medical Equipment and Supplies (DME) or Specialized Medical Equipment and Supplies (SME). You are responsible for assuring that this referral is obtained prior to requesting Medicaid reimbursement for DME or SME.

Durable Medical Equipment and Supplies (DME)

- Copies of DME rules are available through the IDAPA rules at 16.03.09.752

- If it has been determined that a participant needs any medical equipment or supplies during their Person Centered Planning (PCP) meeting or at any other time, the Plan Developer will need to consult with a chosen medical equipment vendor to determine whether or not the requested equipment/supplies are covered under Medicaid's DME limits and require prior authorization.

- If the DME does not require prior authorization the item and the cost will be included on the Individual Support Plan or addendum and reviewed by Regional Care Managers as part of their clinical review for cost and meeting assessed needs.

- If the DME requires a prior authorization, the plan developer works with the vendor to provide a copy of the final authorization to be submitted with the plan or addendum. The item and cost of the item will be indentified on the plan or addendum. When DME has been authorized by the Medical Care Unit, the Regional Care Manager must negotiate other services to bring the plan within budget if applicable.

- If the equipment/supplies are not covered under the State Plan and the individual is either receiving or applying for waiver services, follow the procedure for Specialized Medical Equipment and Supplies (SME) listed below. The Medical Care Unit is currently reviewing SME, using CMS criteria and medical necessity. The Medical Care Unit will contact the vendor and request the Prior Authorization request form to follow the SME process below.

- When requests for non-covered equipment and/or supplies are submitted to the Medical Care unit, they will automatically consider any equipment/supplies under SME.

- If a participant is currently living in an ICF/MR or is applying for waiver services and will need either DME or SME immediately upon discharge onto the DD waiver, the vendor will need to provide the discharge order along with the PA request to the Medical Care Unit. The date of the PA may not be sooner than the date of the discharge.

- The authorization of the plan and/or the discharge from the facility should not be delayed waiting for authorization of DME or SME, unless the item is required to maintain health and safety for that participant in a community setting.

Specialized Medical Equipment and Supplies (SME) - DD Waiver

- Specialized medical equipment and supplies include devices, controls, or appliances, specified in the ISP. The equipment and supplies must enhance the participants' daily living, and enable them to control and communicate within their environment. This also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the State Plan.

- Items covered under the DD waiver are in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items that are of no direct medical, adaptive, or remedial benefit to the participant. All items must meet applicable standards of manufacture, design, and installation, including Underwriter's Laboratory (UL), Federal Drug Administration (FDA), and Federal Communication Commission (FCC) standards. Items available under the Medicaid program may only be billed by a medical vendor provider.

- Prior to requesting SME, the Plan Developer or Service Coordinator must first attempt to access these services through all other resources including State Plan Medicaid coverage.

- SME does not include convenience items or devices to assist the provider in fulfilling their responsibilities as outlined in rule due to a disability or deficit of the provider.

- The code for SME can not be used to bill for DME or for participants that are not eligible for services on the DD waiver.

- If there are questions in regards to SME on the ISP, contact the Regional Care Manager.

- Vendors must have the appropriate Medicaid provider agreement in order to bill for the DME or SME types and specialties.

- The vendor submits a request for SME using the Specialized Medical Equipment Prior Authorization Request Form to the Idaho Medicaid Medical Care Unit.

- The Medical Care Unit will review the request and determine if it meets medical necessity criteria.

- If they approve the request, the Medical Care unit will fax a copy of the authorized vendor request to the vendor. The Plan Developer works with the vendor to get a copy of the authorized vendor request to submit with the plan or addendum. The request form includes information attempts to use natural supports and all efforts to find other funding.

- The Regional Care Manager uses the Medical Care unit authorization when reviewing addendums and plans to verify the plan cost request is within the assigned budget including the costs for SME.

- The Regional Care Manager will negotiate budget discrepancies as needed with the Plan Developer. Since the SME has already been authorized in MMIS, the Care Manager will need to negotiate other services to bring the plan within budget.

- If the Medical Care unit denies the request, they will send a denial notice to the vendor. The Plan Developer works with the vendor to determine which requests have been approved for inclusion on the plan or addendum.

Idaho Medicaid Specialized Medical Equipment Prior Authorization Request Form - Developmental Disability Waiver

Return to: Idaho Medicaid Medical Care Unit
Fax: (800) 352-6044 Phone: (866) 205-7403 Mail: PO Box 83720, Boise, ID 83720-0036

Please complete entire form and submit all required documentation

Medicaid Provider Information			
Provider Name:	Provider Number:	Phone:	Fax:
Contact Person:			

Medicaid Participant Information			
Last Name:	First Name:	Initial:	Medicaid ID:
Date of Birth:	Phone Number:	Healthy Connections Referral Number:	

Physician Information		
Physician Name:	Phone:	Fax:
Diagnosis:		ICD-9:

Requested Equipment		
HCPCS Code(s) Requested:	Start Date:	End Date:
Monthly Rental Price: (Ten month rental to equal purchase)	☐ Required for hospital discharge, date:	

Required Documentation for Initial Request (please provide all required documentation for review)
☐ Current, signed and dated physician order with diagnosis and length of need. **Note:** Verbal orders, signature stamps, or electronic signatures are not accepted.
☐ For mobility equipment, a seating and mobility evaluation completed by a physical or occupational therapist. See www.dme.idaho.gov for the mobility evaluation form.
☐ Documentation that shows that the equipment will enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.
☐ Documentation that shows all natural supports have been exhausted and all efforts to find other funding. Attach documentation to this request or use comment section below.
Notes or Comments:

(Department Use Only) Do not Write in Area Below				
Received Date:	Eligibility:	LTC:	TPOI:	Urgent:
Authorized: Yes No	Denied: Yes No	PA Number:		
Reviewer:	Date:	Keyed By:	Date:	

Guidelines for Developing Person Centered Plans that Encourage Independence

Every effort must be made to develop services and supports that meet the participant's identified assessed needs in the most independent manner. Participants should be encouraged and helped to find activities and develop relationships in their community. In considering the questions below, you succeed in helping the participant realize independence, identify natural supports, and reduce dependence on services. This in turn helps provide the paid services they need within their approved budget.

Here are some questions you can ask:
- Are the activities on the plan based on the participant's choice?
    - Do they support their life goals or slow them down?
- Do they need to learn skills to succeed in the activities, or do they just need assistance to access the activity?
    - Do they need training or just assistance in finding/accessing transportation?
    - Are the goals achievable?
- How much time are they able to focus on what is being taught?
- How often do they need to practice the skill in order to learn the skill?
- Is the skill being taught in the setting where they need to use it to be successful independently?
    - Should it be taught in a community activity of interest?
    - Should it be taught with a group of individuals instead of individually?
- Are there duplicative services? If so, eliminate all duplications.
- How much supervision is required for the participant to be safe and the services effective?
    - Do they need a job coach through their entire working shift?
    - Do they need night supervision?
    - Do staff need to be up and awake?
    - Do they need supervision during all waking hours or could they be left alone for periods of the day?
    - Could they share a staff that could supervise both of them at the same time?
- Would services such as personal emergency response systems and home delivered meals make them more independent yet still provide for their safety and needs?
- What natural (unpaid) supports or goods can take the place of paid supports?

Adding Waiver Services When There is an Existing "State Plan Only" ISP

If a participant is on a state plan only ISP and wants to access DD waiver services before the next annual ISP, they must submit an application to the Regional Medicaid Services office. If the participant has been seen within 120 days, the assessor does not need to see them. If it is over 120 days, they will need to be seen and the SIB-R re-administered if it falls within the guidelines requiring a more current SIB-R. Following the determination for waiver, the assessor will send out a new eligibility letter which may have a new calculated budget. If the participant is determined eligible for waiver services, the plan developer must then convene a person-centered planning (PCP) team meeting to initiate a new initial waiver ISP. **An addendum cannot be used to add initial waiver services. The date of the new initial waiver ISP becomes the new annual re-determination date.**

Each of the following forms must be submitted before an initial waiver ISP can be processed for authorization:
- Supports and Services Authorization form, Signature Page form, Personal Summary form (includes Assessed Needs, Transition Plan- if applicable, Plan Monitoring, Safety Concerns, Alone Time), Supports and Services form(s)
- Exception Review form(s) (only in cases where the plan is requesting High or Intense Supported Living and it is over budget)
- H&P and Nursing Form or MCE (if over 365 days)
- Safety Plan (if applicable, for Supported Living only)

Change in Plan Developer Within the Plan Year

If a participant chooses to change their plan developer within the current plan year and the new plan developer is employed by a different service coordination agency, the request for the change in plan developer and plan development hours (if there are any within the 6 hours left) must be submitted on an Individual Support Plan (ISP) Supports and Services Addendum form by the new plan developer.

The following questions should be taken into consideration by the new plan developer when generating the addendum:

- Does the new plan developer need to develop an ISP Supports and Services Addendum to change participant goal(s)?
- Does the new plan developer need to develop an ISP Supports and Services Addendum to add or delete services?

Statewide Bureau of Developmental Disabilities Phone List

Regional Medicaid Services	
For assistance not found in this manual, review of crisis requests, application for services, and the plan submission process	
Region 1	(208) 769-1567 Select Regional Medicaid
Region 2	(208) 799-4430 or (877) 799-4430 Select Adult Developmental Disabilities Program
Region 3	(208) 455-7150
Region 4	(208) 334-0960
Region 5	(208) 736-3024 or (800) 826-1206
Region 6	(208) 239-6260
Region 7	(208) 528-5750

Independent Assessment Providers	
For eligibility determination and assessment	
Region 1	(208) 772-8502
Region 2	(208) 799-5044
Regions 3 and 4	(208) 373-1730
Region 5	(208) 736-5711
Region 6	(208) 282-5465
Region 7	(208) 525-7050

Adult Protection Services	
For reporting of suspected abuse, neglect or exploitation	
Area 1 (Region1)	(208) 667-3179 or 1-800-786-5536
Area 2 (Region 2)	(208) 743-5580 or 1-800-877-3206
Area 3 (Regions 3 and 4)	(208) 322-7033 or 1-800-859-0321
Area 4 (Region 5)	(208) 736-2122 or 1-800-574-8656
Area 5 (Region 6)	(208) 233-4032 or 1-800-526-8129
Area 6 (Region 7)	(208) 522-5391 or 1-800-632-4813

Web Site Links

General Health and Welfare information:
http://healthandwelfare.idaho.gov/Home/tabid/55/Default.aspx

Adult DD Care Management: Forms, DD Application information, etc:
http://healthandwelfare.idaho.gov/Medical/DevelopmentalDisabilities/AdultDDCareManagement/tabid/211/Default.aspx

Self-Direction information:
www.selfdirection.idaho.gov

Administrative Rules:
http://www.adm.idaho.gov/adminrules/

Idaho Statute:
http://www3.state.id.us/idstat/TOC/idstTOC.html

Federal Regulations:
http://www.gpoaccess.gov/cfr/

Medicaid Provider Handbook
https://www.idmedicaid.com/Provider%20Guide/Forms/AllItems.aspx

DME Information
www.dme.idaho.gov

Medicaid Fee Schedule:
http://healthandwelfare.idaho.gov/Providers/MedicaidProviders/MedicaidFeeSchedule/tabid/268/Default.aspx

Empowerment Project:
http://healthandwelfare.idaho.gov/Medical/DevelopmentalDisabilities/Empowerment/tabid/210/Default.aspx

Molina:
https://www.idmedicaid.com/Default.aspx