

# **Individual Support Plan (ISP) Instruction Manual**

**Updated for ISPs submitted beginning 1/1/2019**

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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 submit THE FOLLOWING required forms **complete** before an initial or annual ISP can be processed for authorization:

- Individual Support Plan- Prior Authorization Worksheet (Excel)
- Signature Page
- Personal Summary/Assessed Needs page
- ISP Supplemental Information Page- includes the Transition Plan (if applicable), Plan Monitoring questions, Safety Concern questions, and Alone Time in a CFH questions
- Supports and Services pages
- Supported Employment form (and Supported Employment Exception Review Request Form, if applicable)
- Health Risk or Safety Risk form to request additional budget dollars to address a health or safety concern (also known as Exception Review) (if applicable)
- Safety Plan (if applicable, for High or Intense Supported Living only)
- Intense Blended Staffing Request (if applicable)
- Order form from a health care professional for Specialized Medical Equipment (SME) (if applicable)
- Medical Care form that is current within 365 days of submission (this form may indicate the participant was last seen on a previous date)

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

- Individual Support Plan Addendum Worksheet (Excel)
- Safety Plan (if applicable) and the new provider will be responsible for implementing the Safety Plan (if applicable)
- Health Risk or Safety Risk form to request additional budget dollars to address a health or safety concern (also known as Exception Review) (if applicable)
- Intense Blended Staffing Request (if applicable)
- Updated Supports and Services pages if there is a change in provider and the new provider is;
  - Required to develop an implementation plan; and,
  - Assuming or changing the supports provided by the previous provider (listed in the 1<sup>st</sup> column)
- A Care Manager may request additional information, if necessary, to support a service request

**Important:** Before submitting the forms listed, a plan developer should ensure the following requirements are met:

- All forms must be on the current Department approved template and typed. **Please do not change formatting or formulas.**
- All required forms must be submitted.
- 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.**

**ISPs and addendums should be submitted to the Information Coordinator by the following methods:**

**Email to [BDDACM@dhw.idaho.gov](mailto:BDDACM@dhw.idaho.gov) or Fax at (208) 332-7297**

**Assessments and documents initiated by the assessment provider include:**

- Medical Care Form (sent to the participant for them to take to their physician)
- Eligibility Determination letter
- Medical, Social and Developmental Assessment Summary
- Eligibility Assessment Tool report

**Supports and services to assist the participant may be identified by reviewing:**

- History and Physical
- Eligibility Assessment Tool report
- Medical, Social, and Developmental Assessment Summary
- Developmental evaluations- including comprehensive and specific skill assessments
- Functional assessments
- Psychological evaluations
- Physical therapy/occupational therapy/speech assessments

## Supports and Services Authorization Instructions

Note: **You can find an example ISP Prior Authorization worksheet on the Adult DD Care Management website**

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

**Services:** Check the corresponding circle for the services the participant receives.

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

**Initial or Annual Plan:** Check the *initial* plan box if this is the first DD state plan and/or DD waiver plan being submitted for the participant or check the *annual* plan box if the participant will continue to receive DD services in the coming plan year.

This form is broken down into two (2) areas:

- DD services—includes requests for any Developmental Disability (DD) Waiver services and DD state plan services
  - With the exception of: OT/PT/Speech/DME/interpretive services- these should be reflected on the Supports and Services page only
- DD Service Coordination services—includes Plan Development and DD Service Coordination

As service cost information is entered into each of these areas, each service will have an auto-populated annual cost total.

*NOTE: If additional budget dollars are being requested through the Exception Review process to address a health or safety concern, a Health or Safety Risk form and supporting documentation must also be submitted as part of the service plan. The Health or Safety Risk form must identify the type and frequency of the identified service(s) and their cost. These service(s) and their cost(s) should be included as part of the service cost information on the PA Worksheet.*

*Participants requesting additional budget dollars to purchase **Supported Employment** services only do not need to submit an Exception Review request with a Health or Safety Risk form and supporting documentation. These requests should be submitted using the SE Exception Review Request Form. The cost of these SE services should be included as part of the service cost information on the PA Worksheet.*

**Provider Name Column:** List in this column the names of service providers who are delivering services (that need to be costed) to the participant. All routine costs that support a participant in their home and/or community, and that are related to their developmental disability, must be listed.

**Procedure Code Column:** List the service code that corresponds with the DD waiver or DD state plan service.

**Start Date and Stop Date Columns:** Type the start and stop date for each service being delivered.

**Units Column:** List the total number of units being requested for a particular service, as it relates to the frequency identified for the service (e.g. 40 units/week, 1 unit/52 weeks, 1 unit/365 days).

**How to figure units:**

**Only use numbers in this column.** Use the most current reimbursement rate chart to identify the unit value for a particular service.

**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

**To request plan development units, please submit all *Plan Development Authorization Coversheets* to the email address that corresponds with the participant's last name. The alphabet has been divided as follows:**

<b>A – Gon</b>	<a href="mailto:BDDSR1CMDocs@dhw.idaho.gov">BDDSR1CMDocs@dhw.idaho.gov</a> Questions? Phone: 208-769-1567 option #2
<b>Goo – Oh</b>	<a href="mailto:BDDSR4CMDocs@dhw.idaho.gov">BDDSR4CMDocs@dhw.idaho.gov</a> Questions: Phone: 208-334-0940 option #3
<b>Oi – Z</b>	<a href="mailto:BDDSR5CMDocs@dhw.idaho.gov">BDDSR5CMDocs@dhw.idaho.gov</a> Questions? Phone: 208-736-3024 option #2

**Link to the Plan Development Cover Sheet:**

<https://healthandwelfare.idaho.gov/Medical/DevelopmentalDisabilities/AdultDDCareManagement/AdultDDInformationforProviders/tabid/2310/Default.aspx>

**Unit Cost Column:** Refer to the “Allowed Amount” column of the reimbursement rate chart for the cost value of each unit. List the cost value in this column. **Example:** For code H2032: 1 unit = \$3.02

**Frequency Column:** Enter how often the units of service are being delivered.

**How to figure frequency:**

Examples of frequency to enter are:

- 365 for daily services, as applicable (or 366 for leap years) (e.g. Residential Habilitation—Intense or High Supported Living/CFH)
- 52 for weekly services, as applicable (e.g. Residential Habilitation- Hourly supported living, developmental therapy (DT), adult day health, supported employment, nursing)
- 12 for monthly services, as applicable (e.g. service coordination, nursing)
- # of units for yearly services, as applicable (e.g. plan development, developmental evaluations)

**Annual Cost Column:** The annual cost column will populate automatically for each section.

**Annual Units:** The annual unit column will populate automatically.

**Annual Plan Total:** The annual plan total box will populate automatically and will calculate the combined total of the two (2) areas at the top of the form.

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

## **Instructions to pro-rate plans**

When plans are extended, Plan Developers should confirm with the Care Manager the start date needed for the pro-rated plan.

**To pro-rate a plan**— Subtract the Plan Development amount for the year (\$290.16) and divide the rest of the calculated annual budget by the 12 months in the year. This amount is then multiplied by the number of months left in the plan year to get the new pro-rated budget and the PD (\$290.16) is then added back in.

For example: If a \$35,000 budget plan should have started 1-1-2019 but was extended to 2-28-2019, this is now a 10 month plan, starting on 3-1-2019.  $\$35,000 - \$290.16 = \$34,709.84$  divided by 12 =  $\$2892.49$  x 10 months left in the plan year =  $\$28,924.87$ . After adding the PD back in, the new pro-rated total is  $\$29,215.03$ .

## Signature Page Instructions and Example Form

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

**Service boxes:** Check the corresponding box(es) for the services the participant receives.

**Initial or Annual Plan:** Check the corresponding box if this is the initial 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?:** Indicate whether or not the participant attended their person centered planning meeting by checking the appropriate box. If the "YES" box is checked, the plan developer must include a brief summary of how the participant participated in the process on the Personal Summary page. If the "NO" box is checked, the plan developer must provide information on how the participant participated in the process (e.g., discussion at another time) on the Personal Summary page.

**Participant Mailing and Physical Address and Phone #:** Type the participant's current mailing and physical addresses 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 assessment provider. If not, obtain the guardianship papers and submit them to the assessment provider.

**Guardian Email:** Type the email address 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 Agency and Address:** Type the agency's name and mailing address where the plan developer is employed with the 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.

**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/information 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.

**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.

- The participant/guardian does not need to initial this area if they are not eligible to receive DD waiver services or are requesting only adult DD state plan benefit option services (e.g. developmental therapy, plan development, service coordination, community crisis supports)

**Participant Signature and Date:** The participant must sign (or mark or stamp) on this line if they are their own guardian. Write the month, day, and year the participant signed their plan.

- If the participant is unable or unwilling to initial/sign their name 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.

**Guardian Signature and Date:** 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 worksheet 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 worksheet 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.

**Plan Developer Signature and Date:** 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.



Participant Name: Sally Jones	Medicaid #: XXXXXXXX	Date of PCP Meeting: 3/1/2019
DD Waiver: <input checked="" type="checkbox"/> A&D/DD: <input type="checkbox"/> DD State Plan: <input type="checkbox"/>	Initial Plan <input type="checkbox"/> Annual Plan <input checked="" type="checkbox"/>	Did the participant attend his/her Person Centered Planning meeting? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

<b>Participant Mailing Address and Phone #:</b> 001 Main Street Anytown, ID 80000 (208) 123-4567  <b>Participant Physical Address: same</b>  <b>Participant Date of Birth:</b> 1/1/2001 <b>Gender:</b> M <input type="checkbox"/> F <input checked="" type="checkbox"/>	<b>Guardian Name (if applicable), Address and Phone #:</b> Nancy Jones 002 West St. Anytown, ID 80000  (208) 000-5555 <b>E-mail:</b> nancy@email.com  <b>Emergency Contact (if applicable):</b> Deena Little (sister) (280) 891-0123	<b>Plan Developer:</b> Susie Planwriter <b>Plan Developer Agency and Address:</b> XYZ Service Coordination 003 North St. Anytown, ID 80000  <b>Plan Developer telephone#:</b> (208) 901-2345 <b>Plan Developer email:</b> sp@tsc.com <b>Agency Administrator e-mail:</b> ab@tsc.com
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**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	Nelly Needle	Nurse- QRS Services
Nancy Jones	Mother/Guardian	Billy Banter	CBRS worker – Healthy Steps
Shannon Jones	Sister	Tawny Talker	Therapy, Inc.
Debbie Data	DS- EFG Developmental		
Gary Goal	PC- ABC Agency		
Wendy Work	Job coach- EFG Developmental		

**DD Waiver Participant/Guardian Initials:**     NJ     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.

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

_____	<u>    Nancy Jones    </u>	<u>    Susie Planwriter    </u>
PARTICIPANT SIGNATURE	GUARDIAN SIGNATURE (if applicable)	PLAN DEVELOPER SIGNATURE
_____	<u>    3/10/19    </u>	<u>    3/10/19    </u>
DATE	DATE	DATE

**\*\*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 Form Instructions

**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.

**Additional information that has occurred since the eligibility assessment:** Provide any further information related to the participant that was not captured in the eligibility assessment and/or has occurred since the assessment meeting. This could be in relation to assessed needs, medical issues, critical incidents, etc. This can give the plan reviewer a more complete picture of what has happened in that time with the participant.

### Assessed Needs:

An assessed need is identified through documented, professional, objective observation and testing. Assessed needs are relevant to the participant's current situation and the PCP team should consider how they 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. If there is a need in an area based on assessment information, and the team would like to **defer** that need for the current plan year, indicate it as "*deferred*".

During an ISP meeting, the following categories should be discussed and information **updated yearly**. Indicate "**Yes**" or "**No**" if an assessed need(s) exists in that area. There may be more than one assessed need in each area.

- **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, diabetes). Do they need DME items to address their DD needs? Therapies?
- **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). Do they want to make any changes in this situation? What skills do they need to maintain their living situation?
- **Family/Social Relationships:** Consider family members or natural supports which are involved in the participant's personal life and any family needs. Do they need to build these relationships and their social skills?
- **Behavioral Issues:** Consider behaviors that impact the participant's health and safety and the safety of others in the community. What types of services would best address their behaviors (med mgmt., counseling, CBRS, etc.) \*\*See the PD Checklist for situations when a formal behavior goal is required based on the assessed needs of the participant
- **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. What skills do they need to maintain or get employment?
- **Legal Status:** Consider whether or not the participant is their own guardian or has a guardian. Do they need a guardian? Are they involved in the legal system in any way? Do they have probatory guidelines?
- **Communication:** Consider the participant's primary method of communication (e.g., verbal, sign language, communication devices, interpretive services) What skills do they need 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). What skills do they need to be more independent and safe in their community/home?

- **Financial:** 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. What types of skills do they need to handle financial transactions or decisions?
- **Community Access:** Consider where/how often the participant accesses the community, their educational needs, interests, religious preferences, etc. What activities would they like to be involved in to enhance their skills?
- **Long Range Goals:** These are goals that the participant would like to achieve over time (not within the current plan year) with the help of their PCP team. These could include marriage, children, getting a driver’s license, moving out of mom and dad’s house in 10 years, 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.
- **Personal Goals:** Consider the goals of the participant based on their preferences, choices, and interests. Review the Medical, Social Developmental Assessment Summary for related responses. How is the team able to facilitate movement towards these goals during the current plan year, if possible?

**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 assessed need and the current plan year’s participant goals and provider based goals/supports listed on the Individual Support Plan (ISP) Supports and Services page(s).

- For each area that is checked “Yes”, give a brief description of the assessed need and list the corresponding goal/support on the Supports and Service page(s).
- For each area that does not have an assessed need or is not being addressed this current plan year, check “No” or “Deferred”. There is no further response needed.

# Supplemental Information **Form** Instructions (including transition planning, plan monitoring, safety concerns, and alone time)

**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.

**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 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 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 enter 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, enter 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 with natural supports for supervision, use of other non-Medicaid funded resources, etc.
  - In the third column, enter who is going to ensure the goal and steps are accomplished for each transition area.
  - In the fourth column, enter 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 safety plan based on responses to the safety concern questions, write "Refer to attached safety 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.
- 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.

## **Safety Concerns and Alone Time -**

- Answer the 6 questions in this section using “Yes” or “No”. Provide an explanation for all answers, if applicable.
  - For Safety Concern question 1, the response should only provide information **within the last year**
  - For Safety Concern question 2, provide information on general risks to the participant. Supports identified on the plan should address these risks and providers should work to develop measures to mitigate the risk, as well as back-up plans and strategies when needed.

### **For Alone Time requests in a CFH:**

- **On the annual ISP- the request should be indicated on the Supports and Services- CFH section. CFH implementation plans for alone time are not submitted with the ISP.**
- **Mid-year- see the guidance on the Adult DD Care Management webpage**

**Safety Plan Information** - 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.
- **Any** requests for 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?

**During plan review, a Care Manager may request 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.**

A safety plan should only be submitted with an initial/annual service plan or with an addendum adding a new service or requesting a change in provider when the new provider will be responsible for implementing the safety plan. Safety plans should not be submitted as standalone documents or with an addendum that does not comply with IDAPA

16.03.10.513.11.

## **Supported Employment Form Instructions**

Include the participant name and Medicaid number. Add the start and stop dates of the supported employment services that will be provided.

This form should come in with an ISP with questions 1-3 answered for participants that ARE NOT currently employed and questions 4-6 answered for participants that ARE currently employed.

This form should also come in with an addendum adding supported employment services, with only questions 4-6 answered.

If the cost of DD services on the ISP/addendum is over budget due to supported employment costs, the Exception Review Request for Supported Employment form must also be submitted. See page 36 for this form.



**Idaho Department of Health and Welfare  
PERSONAL SUMMARY/ASSESSED NEEDS EXAMPLE**

<b>Participant Name: Sally Jones</b>		<b>MID: XXXXXXX</b>		
<b>Participant Involvement in the PCP process:</b> Sally identified who she wanted at her PCP meeting. While at the meeting, Sally stated what goals she wanted to work on at the center and that she wanted to do more job tasks independently. She agreed that she needs some work on her behavior and wants to work harder on that this year.				
<b>Additional information that has occurred since the eligibility assessment:</b> Since the assessment, Sally was hospitalized for 5 days with pneumonia. The PCP team is monitoring her health and may evaluate having her stay indoors more in winter and not go out in the community with the DDA group due to her susceptibility. Sally also has elected to try a new center closer to her home.				
<b><i>Assessed Needs</i></b> - Review the eligibility assessments and provider evaluation tools to identify the participant's assessed needs.	<b><i>Is there an assessed need(s) in this area?</i></b>			<b><i>If yes, give a brief description of the assessed need(s)- below your description list the corresponding goal(s)/support(s) from the Supports and Services page (a service, support(s), and or goal(s) on the Supports and Services pages should correlate to the assessed need(s) identified).</i></b>
	<b><i>Yes</i></b>	<b><i>No</i></b>	<b><i>Deferred</i></b>	
Physical/Mental Health	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Sally has been diagnosed with Mild MR and Bipolar Disorder. She takes medication to help with her cycling. Sally also has nighttime incontinence on occasion. She is able to us the restroom during the day.</p> <p><b>Goal(s)/Support(s): symptom management, incontinence supplies</b></p>
Living Situation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Sally lives with 2 roommates who she gets along with. Sally needs cues throughout her day to maintain a clean home. Sally needs assistance in learning ADLs, personal care skills</p> <p><b>Goal(s)/Support(s): make bed, take meds on time, complete a load of laundry, load dishwasher, cook a simple recipe, brush hair after showering</b></p>
Family/Social Relationships	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Sally is close with her family. Sally needs assistance in not interrupting others. Sally also would like assistance to meet new friends.</p> <p><b>Goal(s)/Support(s): wait turn when speaking, asking questions of others, plan new community activity 2 times a month</b></p>
Behavioral Issues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Sally will sometimes hit others when asked to do something she does not want to do. Sally does engage in self-injurious behaviors such as scratching herself when she is upset. She could benefit from training in replacement behaviors.</p> <p><b>Goal(s)/Support(s): med mgmt., talking with staff when upset</b></p>

Employment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sally just got a new job cleaning an office a few nights a week so will need a job coach to help her maintain her employment.
				<b>Goal(s)/Support(s): following list of items to clean, refilling window spray, cleaning bathroom items, asking for help when she can't locate a cleaning item</b>
Legal Status	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
				<b>Goal(s)/Support(s):</b>
Communication	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sally is verbal but currently has difficulty with expressive communication skills due to slurring her speech.
				<b>Goal(s)/Support(s): speech evaluation</b>
Ambulation/Mobility	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sally is ambulatory, however, she does have decreased mobility on her right side due to seizure activity. Sally could benefit from PT to strengthen her right side.
				<b>Goal(s)/Support(s): PT</b>
Financial	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
				<b>Goal(s)Support(s):</b>
Community Access	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sally needs to work on using appropriate social skills in different environments and how to access different locations near her home.
				<b>Goal(s)/Support(s): ordering in a restaurant, learning to ride the bus</b>
Long Range Goals	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sally would like to be able to live alone in an apartment in 5-10 years. Sally's family would also like to do some planning for when they are no longer living.
				<b>Goal(s)Support(s): link to funeral home to discuss burial planning, link to classes that discuss independent living</b>
Personal Goals				Sally would like to take a trip to San Diego, learn how to ride horses, and take swimming lessons.
				<b>Goal(s)Support(s): natural supports</b>

Idaho Department of Health and Welfare  
Supplemental Information Form EXAMPLE

<b>Participant Name:</b> Sally Jones	<b>MID:</b> XXXXXXXX
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***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 <input checked="" type="checkbox"/> No <input type="checkbox"/>
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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 <input type="checkbox"/> No <input checked="" type="checkbox"/>
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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 the night. B. Increase activities with natural support, Julie C. Add visiting mom 2 weekends a month	1. Sally, RH, TSC, Julie, mom	1. 6-1-2019
2. Community based organizations and activities	2. Increase community activities alone: A. Get/learn to use a bus pass to go to work, bowling, SO, ARC, and grocery store. B. Set up time to go alone to the community center where planned activities are taking place 2 hours a day 4 days a week	2. Sally, TSC, RH, mom	2. 7-1-2019
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	3. Sally, TSC, Idaho Youth Ranch, RH	3. 9-1-2019

4. Supported/ind. Emp.	plan 4. Increase hours at work. A. Use a checklist & timer for independent guidance B. Ask co-workers for feedback on quality	4. Sally, job coach, McDonald's supervisor, TSC	4. 6-1-2019
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<b><i>Plan Monitoring</i></b>	<b><i>Yes</i></b>	<b><i>No</i></b>	
Over the last plan year, were services provided to the participant according to the authorized plan?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<b><i>If no, what action was taken?</i></b>
Did you receive completed Provider Status Reviews for required services that show progression, regression, and/or maintenance of skills?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<b><i>If no, please list the agency and the action taken</i></b> 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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<b><i>If no, what action was taken?</i></b>

<b><i>Safety Concerns</i></b>	<b><i>Yes</i></b>	<b><i>No</i></b>	
Within the last plan year have there been any situations that could re-occur that would put the participant or others in danger?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<b><i>If yes, describe the situation(s) in detail, how this is being addressed and by whom? <u>Include a safety plan for SL participants only</u></i></b>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<b><i>If yes, describe the risks in detail, how this need will be addressed and by whom?</i></b> If there was a fire, Sally is able to evacuate on her own. Sally does not like loud noises. For her to access the community, those with her should prepare her for any unexpected noise she may encounter and offer her options to work through the situation.
Are there significant health and well being issues not addressed on the ISP?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<b><i>If yes, describe them in detail and, in detail, how these needs are addressed and by whom?</i></b>

<b><i>Alone Time in a CFH</i></b>	<b><i>Yes</i></b>	<b><i>No</i></b>	
Does the participant/guardian want to utilize alone time?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<b><i>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.</i></b>

			Sally would like to be alone for an hour a day when she returns home from the DDA (5 hours per week). She uses this time to listen to music.
Does the PCP team agree the participant's functional age and cognitive skills would allow the participant to follow a home alone safety plan to reduce risk and address health and safety concerns?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>If no, describe the risks or issues that the PCP team has identified that prevent the participant from utilizing alone time.</i>
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?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>If no, describe the risks or issues the PCP team has identified that prevent the participant from utilizing alone time.</i>

Idaho Department of Health and Welfare  
Supported Employment Form EXAMPLE

<b>Participant Name:</b> Sally Jones	<b>MID:</b> XXXXXXXX	<b>Start Date:</b>	<b>Stop Date:</b>
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<i>Supported Employment</i>	<i>Yes</i>	<i>No</i>	
<b>Please fill out this section if the participant is not currently employed</b>			
1. Has the participant considered work as a goal?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>If no, give reason for not considering work as a goal:</i>
2. Has the participant gone through the Vocational Rehabilitation process?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If no, please explain:</i>  Sally is working on pre-vocational skills in DT prior to applying with VR.
3. What are the current goals that would increase the participant's ability to work?			<i>List goals here:</i> staying on task, following directions, personal hygiene, asking clarification questions
<b>Please fill out this section if the participant is currently employed</b>			
4. Does the participant require support on the job?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, describe the type of Supported Employment supports needed for the participant to be successful at work (such as number of hours per week, if supports are needed for part of the work day or throughout the work day).</i>
5. Is it anticipated that Supported Employment Services will be accessed this year?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If no, please explain:</i>
6. Describe the plan to transition the participant to greater independence while at work (such as a decrease in the number of Supported Employment hours, coordination with the job site supervisor)			<i>Describe here:</i>

## Supports and Services Instructions and Example Form

**Note:** This form is provided as an example and is not representative of actual ISP Support and Services pages.

**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 the supports and services that will be delivered to the participant during the plan year.

Since IDAPA rules state that service plans must reflect paid and unpaid services and supports that will assist the participant to achieve identified goals, this column should include information regarding the type of supports and services the participant will receive from each provider **as they were discussed, and agreed to, at the initial/annual PCP meeting, or when an addendum is completed.**

Service	Support to be listed
Residential Habilitation Program Coordination for Certified Family Homes (CFH)	“Develop, implement, and monitor Program Coordination Plans and Program Implementation Plans (PIPs)”
Residential Habilitation CFH	Details related to personal assistance (16.03.19.011.04.) and standards of care (16.03.19.170.) provided by the home, and if substitute care/alternate care/alone time is being requested
Residential Habilitation Supported Living	Any informal supports this service will provide
Adult Day Health	Any informal supports this service will provide
Non- Medical Transportation	Pick up site and ending destination (including address and city for both)
Medical Transportation	Refer to MTM as the support for this service to/from DDA services.
Behavioral Consultation	Any informal supports this service will provide
DD Waiver Nursing	Nursing goals from the plan of care
Durable Medical Equipment (DME)	Supplies/items requested
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, etc.
Developmental Therapy	Any informal supports this service will provide
Supported Employment	Any informal supports this service will provide
Behavioral Health Services (psychotherapy, CBRS, med management, etc.)	Behavioral health goals - 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 from Independent Providers	Provider goals

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

For the services below, the following information should also be considered when completing the supports and services page(s) for an ISP/addendum:

Service	Contractor/Partner	Contact information	Costed?
Behavioral health	Optum	<a href="http://www.OptumIdaho.com">www.OptumIdaho.com</a> 1-855-202-0973	No
Non-emergent Medical Transportation	Medical Transportation Management, Inc. (MTM)	<a href="http://www.mtm-inc.net">www.mtm-inc.net</a> 1-877-503-1261	No
CFH Program Coordination-DD	Community Partnerships of Idaho	<a href="mailto:pcdata@mycpid.com">pcdata@mycpid.com</a> 208-376-4999	No
Interpretation, translation, sign language	NA	NA	No

**Goals to be Addressed Within the Plan Year column:** Based on assessed needs, include in this column any short-term goals the participant will work to accomplish within the plan year for the following service types. **These goals should be discussed, and agreed to, at the initial/annual PCP meeting, or when an addendum is completed.**

- Residential Habilitation Certified Family Home (CFH)- also indicate the number of hours of alone time being requested per week (if applicable)
- Residential Habilitation Supported Living
- Developmental Therapy
- 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. Care Managers will ensure 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 service goals 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 Plan Developer for more detailed information.

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.).



- 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 High Supported Living, include the breakdown of how many hours of group and individual support the participant is receiving each week

**Agency or Provider Column:**

- Type the name of the agency or provider responsible for providing the service and/or support.
  - Do not include specific staff names, with the following exceptions:
    - For Residential Habilitation CFH Program Coordination services, include the name and contact information for the Program Coordinator.
    - Enter the name of the CFH provider, if the participant receives CFH services.

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

**Participant Name: Sally Jones**

**MID#: XXXXXXXX**

\*These are examples below- goals, supports, emergency objectives, etc. need to be specific to the participant the plan is being written for

<b>Supports and Services</b>	<b>Goals to be Addressed Within Plan Year</b>	<b>Frequency</b>	<b>Agency or Provider</b>
<p><b>Residential Habilitation Program Coordination</b></p> <p>Develop, implement, and monitor Program Coordination Plans and Program Implementation Plans (PIPs)</p> <p>-Provide 6 month and annual status review to TSC</p>		<p>365 days/year 52 weeks/year</p>	<p>Community Partnerships of Idaho</p> <p>Program Coordinator- Gary Goal 208-999-9999</p>
<p><b>Residential Habilitation (CFH)</b></p> <p>-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</p>	<ul style="list-style-type: none"> <li>• Safety scenarios</li> <li>• Use a washcloth when bathing</li> <li>• Ask for food to be passed during meals</li> <li>• Pick up own place setting after meals</li> </ul> <p>**Participant will be safe for <u>7</u> hours of alone time a week.</p>	<p>365 days/year</p>	<p>Nancy Jones, Provider</p>
<p><b>Residential Habilitation Supported Living- Hourly example</b></p> <p>-Provide assistance with hygiene -Implement risk mitigation goals and strategies -Provide risk mitigation assistance -Assist with transportation to ___'s job</p>	<ul style="list-style-type: none"> <li>• Choose between 2 community activities</li> <li>• Budget spending money for an activity</li> <li>• Complete a load of laundry</li> <li>• Fill out a job application</li> <li>• Complete a household chore</li> <li>• Pick up after cat</li> <li>• Greet someone before entering their</li> </ul>	<p>40 hours/week</p>	<p>ABC Agency</p>

Supports and Services	Goals to be Addressed Within Plan Year	Frequency	Agency or Provider
-Assistance with medications -Attend ISP meeting -Provide emergency contact -Provide 6 month and annual status review to TSC	personal space		
<b>Residential Habilitation Supported Living- High example</b>  -Provide assistance with daily living skills -Home maintenance checks -Follow health and safety plan -Implement risk mitigation goals and strategies -Provide risk mitigation assistance -Assist with transportation to ___'s job -Assistance with medications -Attend ISP meeting -Provide emergency contact -Provide 6 month and annual status review to TSC	<ul style="list-style-type: none"> <li>• Use a calendar for appts.</li> <li>• Follow a simple recipe</li> <li>• Choose a community activity each week</li> <li>• Daily exercise</li> <li>• SAM program</li> <li>• Ask for a break when upset</li> </ul>	148 hours group  20 hrs of 1:1  No alone time	ABC Agency
<b>Residential Habilitation Supported Living- Intense example</b>  -Provide assistance with daily living skills -Assist with home cleaning as needed -Maintain contact with guardian -Implement risk mitigation goals and strategies -Provide risk mitigation assistance -Assist with scheduling MH treatment appointments -Assistance with medications -Attend ISP meeting -Provide emergency contact	<ul style="list-style-type: none"> <li>• Morning routine</li> <li>• Follow a shopping list</li> <li>• Express self with "I" statement when mad</li> <li>• Make bed</li> <li>• Daily exercise</li> <li>• Make a simple recipe</li> <li>• Grab soft item instead of punching walls, hitting others</li> </ul>	168 hours of 1:1  No blended staffing	ABC Agency

Supports and Services	Goals to be Addressed Within Plan Year	Frequency	Agency or Provider
-Provide 6 month and annual status review to TSC			
<b>Adult Day Health</b> -Assist with ADLs -Monitor social opportunities -Provide recreational activities -Provide 6 month and annual status review to TSC		4 hours/week	EFG Developmental
<b>Non-Medical Transportation</b> From home (001 Main Street Boise) to Adult Day Health at EFG Developmental (234 Foothill St. Boise) and back		1 mi/one way 2 miles/day 4 days/week	LMNOP Transportation
<b>Behavioral Consultation</b> -Provide staff training -Provide emergency back-up, if needed -Consult with direct care staff regarding behavior management techniques		30 min./month	QRS Services
<b>Nursing</b> -Monitor medication compliance -Monitor nutrition -Assess and monitor hydration -Assess and monitor skin integrity		1 visit/month	QRS Services
<b>DME-gloves</b>		2 boxes/month	QRS Services
<b>Service Coordination and Emergency Plan</b> By phone or in person the para- professional will: -Link to Special Olympics events in the area -Explore the guardianship process By phone or in person the professional will: -Explore alternate care when Nancy is on vacation - Link to energy assistance -Conduct a face to face meeting with Sally at least every 90 days to review the plan		Para- 1 hour/month  Pro- 3.5 hours/month  As needed	XYZ Service Coordination

Supports and Services	Goals to be Addressed Within Plan Year	Frequency	Agency or Provider
<p>-Monitor Sally’s satisfaction in the DDA and at her job every 90 days</p> <p>-Identify an emergency plan in the case of Sally injuring herself during a behavior</p> <p>-Complete 180 day review of TSC goals</p> <p>- By phone or in person the professional or paraprofessional will contact: Sally, mom, relevant providers, etc.</p> <p>-Discuss barriers to service provision</p> <p><b>-In the event of a medical emergency:</b> Contact 911, and call Sally’s mother Nancy at 123-4567.</p> <p><b>-In the event of a non-medical emergency:</b> Contact Nancy at 123-4567, sister Shannon at 891-0213. Susie can be contacted at 901-2345</p> <p>-In the event of an emergency and unable to attend services, Susie will assist in contacting any applicable service providers. Susie will also contact applicable members of the PCP team to discuss prevention and resolution of recurring emergencies.</p>		<p>As needed</p> <p>As needed</p> <p>Every 90 days</p> <p>Every 90 days</p> <p>As needed</p> <p>Every 180 days</p> <p>Monthly</p> <p>As needed</p>	<p>Nancy Jones</p> <p>Shannon Jones</p> <p>XYZ Service Coordination</p>
<p><b>Developmental Therapy</b></p> <p>-Complete a developmental evaluation</p> <p>-Assist with bathroom needs</p> <p>-Attend ISP meeting</p> <p>-Develop, implement, and monitor PIPS</p> <p>-Provide 6 month and annual status review to TSC</p>	<ul style="list-style-type: none"> <li>• Use a full sentence when responding to a question</li> <li>• Request assistance from a store employee</li> <li>• Follow a 2-step instruction</li> <li>• Make change using bills and coins</li> <li>• Tell time on a face clock</li> <li>• Prepare a sandwich for lunch</li> </ul>	<p>Ind Center 2 hours/week</p> <p>Group Center 18 hours/week</p> <p>Group community 2 hours/week</p>	<p>EFG Developmental</p>
<p><b>Supported Employment</b></p> <p>-Attend ISP meeting</p> <p>-Develop, implement, and monitor PIPS</p>	<ul style="list-style-type: none"> <li>• Bring in trays from the lobby</li> <li>• Wipe down drink station</li> <li>• Ask supervisor for clarification</li> <li>• Come back from break on time</li> </ul>	<p>4 hours/week</p>	<p>EFG Deve;</p>

Supports and Services	Goals to be Addressed Within Plan Year	Frequency	Agency or Provider
-Provide 6 month and annual status review to TSC			
<b>Community Based Rehabilitative Services</b> Provide training to build and maintain stabilization in mood, behavior Provide training to use medical resources appropriately		1 hour/week	Healthy Steps
<b>Natural Supports</b> -Church -Spend time with family -Special Olympics bowling		Every Sunday 1 wknd a mo. Weekly	Nancy Doe Shannon Sister George
<b>Speech Therapy</b> Improving speech production when asked a question Speaking clearly Enunciation		40 units/year	Therapy, Inc.
<b>Medical Transportation</b> To and from XYZ Agency for DT		5 days a week	MTM

## Individual Support Plan Addendum Worksheet Instructions

Note: **You can find an example addendum on the Adult DD Care Management website**

**Participant Name/Mailing and Physical Address/Phone:** Type the name of the participant exactly as it appears on their Idaho Medicaid card. Type the participant's name current mailing and physical address with city, state, and ZIP code and their phone number.

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

**Guardian Name/Address/Phone Number/Email (if applicable):** Type the first and last name of the participant's legal guardian or "NA" if the participant is their own guardian. Type the guardian's current mailing address with city, state, and ZIP code. Type the guardian's phone number with the area code. Type the guardian's email address.

**ISP Start Date:** Type the month, day, and year the current ISP was authorized for which an addendum is being submitted.

**Plan Developer (PD) Agency/Name/Phone/Email:** Type the PD's agency name where they are employed, name, phone number with area code, and email address.

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

**Date Requested:** Type the month, day, and year the Addendum Prior Authorization Worksheet is submitted.

**Reason for Addendum Request:** Specifically identify the reason for submitting the addendum from the following categories:

- Change in cost
- Addition of a service or increase to a service
- Change of provider
- 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 MyBenefits@dhw.idaho.gov. This information will then be updated with DXC Technology (formerly Molina).**

**Service boxes:** Check the corresponding box(es) for the services the participant receives. Be sure to also check CFH, as applicable.

**Provider Name Column:** Type the name of the provider of the service that a change is being requested for.

**Procedure Code Column:** List the procedure 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 reimbursement rate chart.

**Start Date and Stop Date Columns:** Type ONLY THE STOP DATE for any 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 at least fifteen (15) days in advance of the start date being requested.

**Units Column:** List the total number of units being requested for a particular service as it relates to the frequency identified for the service (e.g. 40 units/week, 1 unit/52 weeks, 1 unit/365 days). For service(s) that are being decreased/ended, include a minus sign (-) in this column only.

**How to figure units:**

**Only use numbers in this column.** Use the most current reimbursement rate chart to identify the unit value for a particular service.

**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 Cost Column:** Refer to the "Allowed Amount" column of the reimbursement rate chart for the cost value of each unit. List this cost value in this column. **Example:** For code H2032: 1 unit = \$3.02

**Frequency Column:** Enter how often the units of service are being delivered.

**How to figure frequency:**

Examples of frequency to enter are:

- 365 for daily services, as applicable (or 366 for leap years) (e.g. Residential Habilitation—Intense or High Supported Living/CFH)
- 52 for weekly services, as applicable (e.g. Residential Habilitation—Hourly supported living, developmental therapy (DT), adult day health, supported employment, nursing)
- 12 for monthly services, as applicable (e.g. service coordination, nursing)
- # of units for yearly services, as applicable (e.g. plan development, developmental evaluations)

*NOTE: If additional budget dollars are being requested through the Exception Review process to address a health or safety concern, a Health or Safety Risk form and supporting documentation must also be submitted as part of the service plan. The Health or Safety Risk form must identify the type and frequency of the identified service(s) and their cost. These service(s) and their cost(s) should be included as part of the service cost information on the PA Worksheet.*

*Participants requesting additional budget dollars to purchase **Supported Employment** services only do not need to submit an Exception Review request with a Health or Safety Risk form and supporting documentation. These requests should be submitted using the SE Exception Review Request Form. The cost of these SE services should be included as part of the service cost information on the PA Worksheet.*

**Annual Cost Column:** The annual cost column will populate automatically.

**Annual Units:** The annual unit column will populate automatically.

**Addendum Sub-Total:** The addendum sub-total box will populate automatically.



**Previous Plan Amount:** Type the total amount previously approved on the ISP or last addendum here.

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

**New Medicaid Annual Total:** The New Medicaid Annual will populate automatically.

**For addendums that indicate a change in provider(s) the PD should coordinate with the new DD Service providers to ensure services are delivered according to the existing initial/annual ISP, as applicable.**

**Participant Signature and Date:** 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:** Refer to page 9 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:** 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.

## Health Risk and Safety Risk Form Instructions (also known as Exception Review)

For a participant to request additional budget dollars to purchase supports or services to address a health or safety concern, a Health Risk or Safety Risk form needs to be filled out and submitted with the ISP/addendum. These forms are located on the Adult DD Care Management website here:

<https://healthandwelfare.idaho.gov/Medical/DevelopmentalDisabilities/AdultDDCareManagement/AdultDDInformationforProviders/tabid/2310/Default.aspx>

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

**Date of Request:** Type the date the request form is completed.

**Current Living Situation:** Check the box for the current living situation of the participant.

**Service/Support Request:** In the grid on each form, type in the service/support description that is being requested, including the type, frequency, and cost. The service/support request(s) on the Health Risk form should be to address a health concern. The service/support request(s) on the Safety Risk form should be to address a safety concern.

### Check all that apply:

On the Health Risk form, check the corresponding box(es) for what the service/support request will achieve:

- Prevent my physical health from deteriorating
- Prevent my mental health condition from deteriorating
- Prevent my cognitive functioning from deteriorating
- Prevent an increase in my maladaptive behavior

On the Safety Risk form, check the corresponding box(es) for what the service/support will achieve:

- Prevent criminal behavior
- Prevent the destruction of property
- Prevent harm to me or others

**Please describe the risk:** On either form, type in specific details/information describing what the health risk/safety risk is for the participant. The definition of Health and Safety is provided on the Adult DD Care Management website above.

### Additional documentation to support the request:

For a Health Risk request, additional documentation submitted must meet the following criteria:

- Health risks must be established through written documentation and current treatment recommendations from a licensed practitioner of the healing arts as defined by [IDAPA 16.03.10.521.14](#) or other professional licensed by the State of Idaho whose recommendation for the specific support or services that are being requested is within the scope of his or her license.

- Such documentation must establish: (1) the current physical or mental condition or cognitive functioning that will likely deteriorate, or the current maladaptive behavior(s) that will likely increase; and (2) the specific supports or services being requested that will address the identified need and how those supports or services will prevent the health risk.

For a Safety Risk request, additional documentation submitted must meet the following criteria:

- Safety risks must be documented by the following: (1) current incident reports; (2) police reports; (3) assessments from a licensed practitioner of the healing arts as defined by IDAPA 16.03.10.521.14 or a professional licensed by the State of Idaho and whose assessment is within the scope of his or her license; or (4) status reports and implementation plans that reflect the type and frequency of intervention(s) in place to prevent the risk and the participant's progress under such intervention(s).
- Such documentation must establish: (1) an imminent or likely safety risk; and (2) the specific supports or services that are being requested (including the type and frequency, if applicable) that are likely to prevent that risk, and how those supports or services will likely prevent this risk.

**Documentation:** Indicate what documentation will be submitted for the Health Risk or Safety Risk form to support the service/support request.

**Participant/Guardian Name/Signature/Date:** Provide the name of the participant/guardian, their signature and the date they signed the form.

**Authorized Representative of Participant Name/Signature/Date:** Provide the name of the authorized representative of the participant, their signature, and the date they signed the form.

## EXCEPTION REVIEW REQUEST FORM FOR SUPPORTED EMPLOYMENT

Participant Name: _____	Proposed Start Date: _____
Supported Employment Agency: _____	
Request submitted by: _____	Job title: _____
The frequency of the additional Supported Employment being requested: _____	
Additional budget dollars requested: _____	

Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (IDAPA 16.03.10.703.04)

The Department will complete an exception review of plans or addendums requesting services that exceed the assigned budget authorized by the assessor. The process for Exception Review Requests for Supported Employment is supported in IDAPA 16.03.10.515.03.b.

***Check (X) each of the criteria below has been met and supporting documentation is attached to the request:***

<input type="checkbox"/>	A Supported Employment service recommendation completed by the Idaho Division of Vocational Rehabilitation (IDVR) when the participant is transitioning from IDVR services or, when the participant is in an established job, by the Supported Employment Agency identified on the plan of service or addendum. <b>Documentation:</b> The documentation must include a service recommendation which includes the recommended amount of service, level of support needed, employment goals and a transition plan.
<input type="checkbox"/>	A comprehensive review of all services of the participant's plan has taken place. <b>Documentation:</b> The documentation must include a copy of the participant's plan that includes a goal for supported employment. Additionally, for exception reviews submitted with an addendum, the plan developer should indicate that a review of services has taken place in the "Reason for Addendum Request" section. The combination of supports and services on the participant's plan and the addendum must support the increase or addition of supported employment services.
<input type="checkbox"/>	Acknowledgement that additional budget dollars approved to purchase Supported Employment services may not be reallocated to purchase any other Medicaid service. <b>Documentation:</b> Participant and Guardian signature is included in the <i>Person-Centered Planning Team Endorsement</i> below.

**Person-Centered Planning Team Endorsement:**

By signing below, I acknowledge that additional budget dollars approved to purchase Supported Employment services may not be reallocated to purchase any other Medicaid service. I am also indicating that I believe the additional hours requested meet the Supported Employment needs of the participant and represent the participant's choice.

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employment Agency Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Plan Developer/TSC: \_\_\_\_\_ Date: \_\_\_\_\_

Other: \_\_\_\_\_ Date: \_\_\_\_\_

Other: \_\_\_\_\_ Date: \_\_\_\_\_

**Supported Employment  
Employment Agency Exception Review recommendation SAMPLE**

**Date:**

**Client:**

**Referral Source:**

**Employment Specialist/Employment Agency:**

**Employer/Location:**

**Client's Scheduled Hours:**

**Client's Current Wage:**

**Client's Employment Benefits:**

**Progress Summary:**

(Support hours have been used to maintain the following performance/discuss client's progress on the job detailing successes and limitations)

**Employment Goals/Objectives:**

(List client's goals and discuss the client progress on the goals)

**Recommended Amount of Service/Level of Support:**

The client has learned the position and the job tasks and is meeting the employer's expectations with the support of a job coach. From the Employment Specialist observation and evaluations made during this training period the following level of support is recommended:

The client is currently working \_\_\_\_ hours per week

The client will require \_\_\_\_ (full, moderate low) level of support for \_\_\_\_ hours per week of Supported Employment to maintain employment.

**Examples:**

- The client is currently working 20 hours per week and will require full support for 20 hours per week of Supported Employment to maintain employment.
- The client is currently working 20 hours per week and will require moderate level of support for 12 hours per week of Supported Employment to maintain employment.
- The client is currently working 20 hours per week and will require a low level of support for 8 hours per week of Supported Employment to maintain employment.

**Rational:**

(Discuss the rational to justify the number of hours recommending)

**Transition Plan:**

(Discuss plan to transition the client to fewer hours of Supported Employment or to a different level of support during the upcoming year. If the participant is unable to transition to fewer hours or level of support, discuss why a transition plan is not feasible.)

Thank you,

\_\_\_\_\_  
ES name

Employment Specialist

## Plan Developer ISP Checklist

Participant Name:

Plan Developer Name:

Date Submitted:

Plan Due Date (30 days prior to the requested start date for initials/45 days before the expiration of the existing annual plan)

- ISP forms filled out completely: Authorization Worksheet, Signature Page, Personal Summary/Assessed Needs page, Supplemental Information page(s), Supported Employment form, Supports and Services Page(s)
  - Double-check Medical Care form was received by the assessment provider or submitted with plan
  - Waiver box initialed (\*) on Signature Page
  - Goals and supports are consistent with participant's assessed needs identified from 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 at least 1 goal 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 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 next plan year
  - Goals (formal) for Certified Family Home, Supported Living, Developmental Therapy, Supported Employment are listed on the Supports and Services page and link to an assessed need
    - 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 from DXC Technology is attached to a plan or addendum requesting to start services with a CFH for the first time
  - Services/supports (informal) for Adult Day Health, Behavioral Consultation, DD Waiver Nursing, Service Coordination, transportation, DME, behavioral health, and PT/OT/Speech therapies, etc. are listed on the Supports and Services Page
  - Assessment requests in a DDA consistent with Medicaid Information Release 10-22
  - Behavioral Health services do not duplicate other services on the ISP
  - Frequency of services and programs are consistent with the participant's needs and current situation
  - Emergency contacts/objective listed on plan
  - Health Risk or Safety Risk forms and documentation for service requests over the approved budget (also known as Exception Review) (\*)
  - Safety Plan for participants in High or Intense Supported Living (\*)
  - '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.
  - 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)**
  - 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 ISP Authorization Worksheet
  - SME is identified on ISP Authorization Worksheet with the correct code and cost (\*)
  - Non-medical transportation is identified on ISP Authorization Worksheet (\*)- verify type (i.e. commercial, agency, or individual) and rate with transportation provider prior to costing
- (\*) = if applicable

## 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. The Medical Care Unit webpage provides additional information on this:  
<https://healthandwelfare.idaho.gov/Medical/Medicaid/MedicalCare/tabid/217/Default.aspx>
- 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 regarding SME on the ISP, contact the Care Manager.
- Vendors must have the appropriate Medicaid provider agreement in order to bill for SME.
- SME requests must be ordered by a health care professional working within their scope of practice. A copy of the order must be submitted with the ISP/addendum.



## Guidelines for Developing Person Centered Plans that Encourage Independence

Every effort must be made to develop a plan that meets 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. By considering the questions below, you succeed in helping the participant realize further independence, identify natural supports, and reduce dependence on services. Some questions to ask:

- Are the activities on the plan based on the participant's choice?
  - Do they support their life goals or slow them down?
- Does the participant 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 is the participant able to focus on what is being taught?
- How often does the participant need to practice the skill in order to learn the skill?
- Is the skill being taught in the setting where the participant needs to use it to be successful independently?
  - Should it be taught during a community activity of interest?
  - Should it be taught individually instead of with a group of other people?
- 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 alone for periods of the day?
  - Could participants share a staff that could supervise both of them at the same time?
- Would services such as a personal emergency response system or home delivered meals make the participant 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 Bureau of Developmental Disability Services office. If the participant has been seen within 120 days, the assessor does not need to see them. 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.**

## Change in Plan Developer/TSC Agency 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 ISP Addendum Worksheet by the new plan developer.

## Reference Phone Lists

<b>Bureau of Developmental Disability Services</b> For assistance in applying for BDDS services, or other general DD questions	
Region 1	(208) 769-1567 or (855) 769-1567 Select Regional Medicaid
Region 4	(208) 334-0940
Region 5	(208) 736-3024 or (800) 826-1206

<b>Independent Assessment Provider</b> For eligibility determination and assessment	
Statewide	(208) 258-7980, toll free 1-877-305-3469

<b>Adult Protection Services</b> 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) 898-7060 or 1-844-850-2883
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

## Website Links

### **Adult DD Care Management- forms, DD application information, etc.**

<http://healthandwelfare.idaho.gov/Medical/DevelopmentalDisabilities/AdultDDCareManagement/tabid/211/Default.aspx>

### **DME Information**

[www.dme.idaho.gov](http://www.dme.idaho.gov)

### **Idaho Administrative Rules**

<https://adminrules.idaho.gov/rules/current/>

### **Idaho Health and Welfare- general information, fee schedules, etc.**

<http://healthandwelfare.idaho.gov/Home/tabid/55/Default.aspx>

### **Idaho Statute**

<https://legislature.idaho.gov/statutesrules/idstat/>

### **Idaho Medicaid Provider Handbook**

<https://www.idmedicaid.com/Provider%20Guide/Forms/AllItems.aspx>

### **DXC Technology**

<https://www.idmedicaid.com/Default.aspx>

### **Self-Direction- My Voice My Choice waiver option**

[www.selfdirection.idaho.gov](http://www.selfdirection.idaho.gov)