Support Plan

Commented [SL1]: The module document is a reference for automation. If the CCM tool provides a different method to improve user efficiency (e.g. navigation, workflow, layout) this should be reviewed with the Department for optimization within the CCM platform. This document is a not intended to be automated as is.

Key
Bold Blue Highlight: Module narrative and directions- assessment level instructions and/or help
Orange: Items, responses, and other language specifically for participants 0-17 unless otherwise indicated
Green: Skip patterns
Red: Additional instructions for assessors- item level help
Purple: Section level help
Light Blue: Notes for automation and/or configuration
S **Denotes a shared question with another module (one way only unless otherwise indicated)**
Gray Highlight: Responses/Text Boxes to pull forward to Assessment Output
Yellow Highlight: populate and/or pull forward to the support plan from another module or section within the support plan itself
Green Highlight: Populate and/or pull forward from the member record to an assessment or from an assessment to the member record
Denotes mandatory section/item
Item populates forward for Reassessment
Teal Highlight: Items only for Revision and CSR -Support Plan only
Italics: Items from FASI (CARE) -Department use only

Throughout the Support Plan, items that pull forward from the assessment should be locked and not able to be updated in the Support Plan. Case managers should be directed to update the member record/assessment if changes need to be made. Changes made to the assessment after the Support Plan is created, should be updated with this new information.

The Support Plan uses information captured in the Comprehensive or Basic assessment to develop a person-centered plan for meeting a participant's LTSS needs. While the Support Plan authorizes Home and Community Based Services (HCBS), it is also used to identify a participant's personal goals and supports to help achieve those goals. The plans for achieving these goals may include HCBS Waiver services and other supports, such as unpaid help, help paid by another support, and referrals.

The support planning process is intended to be a collaborative effort in which the participant leads the process to the best of her or his abilities and preferences. The assessor can support this by taking the following actions:

- **Educate the participant about the process and answer any questions that come up.**

- **Write the Support Plan in a manner that reflects the participant's own words wherever possible.**
- **Allow the participant to see documents and computer screens so that he or she can better understand what is being entered.**

1. PARTICIPANT'S IDENTIFYING INFORMATION

Commented [SL2]: Within the CCM tool numbering for sections and questions does not need to match document, however format needs to be determined by the Department based on CCM design.

This section will populate the participant's identifying information from the member record. The purpose of this section is to review and update the member record, as necessary, the participant's location and contact information within the Support Plan and to ensure that the assessor understands how best to communicate with the participant.

1. **Case Manager reviewed all of the following information below with participant and information is current?**
   - ❍ No- Update Member Record to reflect changes
   - ❍ Yes (Skip to Section 2- Support Plan Administrative Information)

a) Name of Individual:_____
b) Current Mailing Address:_____
c) City:_____ e) County:_____
d) State:_____ f) Zip Code:_____
g) Cell phone number:_____ i) Work phone number:_____
h) Home phone number:_____ j) Email:_____
k) Preferred method of contact:
❍ Email ❍Cell phone ❍Work phone ❍Home phone ❍Text Message
l) Date of Birth:_____ m) Age:_____
n) What gender do you identify as?
❍Male ❍Female ❍Transgender ❍Nonbinary/Gender-nonconforming

2. **Participant has someone who assists with or is legally authorized to make decisions (e.g., POA, DPOA, legal guardian, etc.):**
   ❍ No ❍ Yes
3. **Name of individual(s) or agency(ies) assisting or authorized in making decisions:** _____
4. **Decision making capacity:**

☐ Guardian (Non Parental)
☐ Guardian (Parental)
☐ Parent- Non-guardian
☐ Trustee
☐ Representative Payee
☐ Legally Authorized Representative
☐ Responsible Party
☐ Conservator
☐ Power of Attorney (POA)
☐ Surrogate Decision-maker for health care decisions (DPOA)
☐ Partner of parent
☐ Stepparent
☐ Other Relative
☐ Friend
☐ Advocate
☐ Other,
Identify decision making capacity:_____

5. Type of Legal Guardianship

❍ Limited guardianship. Describe:_____
❍ Full guardianship

6. Method(s) participant likes to use to communicate with others:

☐ Verbal English
☐ Verbal Spanish
☐ Verbal Other Language, identify other :_____
☐ Sign Language/Expressive Communication
☐ Writing/Braille
☐ Texting/Email/Social Media
☐ Electronic Device
☐ Other, Identify method of communication:_____

6A. Type of sign language and/or expressive communication participant uses:
(Only show if response to item 6 is "Sign Language/Expressive Communication.")

☐ American Sign Language
☐ Baby Sign
☐ Cued Speech
☐ Emoticon + Bodycon (facial expression + body language)
☐ Home Signs, Gestures
☐ International Sign Language
☐ Limited or Close Vision Signing
☐ Manual alphabet (finger spelling)
☐ Signed English
☐ Tactile (hand in hand) Signing
☐ Other, Describe type of sign language:_____

7. Method(s) participant likes others to use to communicate with him/her:

☐ Verbal English
☐ Verbal Spanish
☐ Verbal Other Language, identify:_____
☐ Sign Language
☐ Writing/Braille
☐ Gestures
☐ Facial Expression
☐ Texting/Email/Social Media
☐ Electronic Device
☐ Other, Identify method of communication:-_____

2. SUPPORT PLAN ADMINISTRATIVE INFORMATION

This section is used to collect information about the development of the Support Plan and the individuals involved in the support planning process. It also provides participants with contact information for their assessor if they have questions after the development of the Support Plan.

1. **Support Plan Type:**
   - ❍ Initial/Enrollment
   - ❍ Continued Stay Review **(Selection of CSR will copy previous Support Plan to review and update)**
   - ❍ Revision **(Selection of Revision will copy current version of Support Plan to update)**

Commented [SL4]: Support Plan Type will populate to the Member record

2. **Location of Support Plan meeting:**
   - ❍ Alternative Care Facility (ACF)
   - ❍ Assisted living facility
   - ❍ Day Program
   - ❍ Participant's home
   - ❍ Other family member's home
   - ❍ Case Management Agency office
   - ❍ Hospital
   - ❍ Nursing Facility
   - ❍ ICF/IID
   - ❍ Other, describe location of support plan meeting:_____

3. **Date of Support Plan Meeting:**_____

4. **Support Plan Certification Period** **(Dates pull from the Program level and correlating LOC Screen Certification Dates)**

   A. Start Date:_____ B. End Date:_____

(Case Manager Information pulls from user profile of the case manager who created the Support Plan)

5. **Case Manager name:**_____
6. **Case Management Agency:**_____
7. **Case Manager phone:**_____

8. **Member is present at the Support Plan meeting**
   - ❍ No:
     Member should be present at the meeting. Describe why member was not present in the Support Plan meeting:_____
   - ❍ Yes

9. Are other individuals contributing to the Support Plan?
   - ❍ No **(Skip to Section 3- Explanation of the Support Planning Process)**
   - ❍ Yes

9A. Other individuals contributing to the plan:

A. Individual 1
   i. Name:_____

ii. Relationship to participant
- ❍ Spouse
- ❍ Child or Child-in-law
- ❍ Parent/Guardian
- ❍ Parent/Non-guardian
- ❍ Guardian (Non-Parental)
- ❍ Partner/Significant Other
- ❍ Other relative:_____
- ❍ Friend
- ❍ Neighbor
- ❍ Advocate
- ❍ Service/Provider Agency:_____
- ❍ Other, describe relationship to participant:_____

iii. Individual invited to Support Plan meeting by:
- ☐ Participant
- ☐ Participant's legally recognized representative

iv. If "Participant" was not selected in Item iii: Because this individual was not invited to the Support Plan meeting by you, identify the reason they were included in the meeting.

Additional individuals can be added.

3. EXPLANATION OF THE SUPPORT PLANNING PROCESS

This section is used to ensure that the participant understands his/her rights and responsibilities and the contents of the Participant Handbook.

1. **I and/or my representative have received the Participant Handbook explaining the Assessment and Support Planning processes prior to my Support Plan meeting.**
❍ No- Provide and review Participant Handbook with the participant/representative prior to proceeding
❍Yes

1a. Notes/Comments related to the Participant Handbook review:

2. **Support Planning Process**: (Prior to proceeding with the Support Plan meeting, the assessor should ensure that the participant understands the support planning process.)

- ☐ What person-centered goals are and how they will be developed
- ☐ What supports are available for making decisions and whether I would like this support
- ☐ Service options, including opportunities for participant-direction

- ☐ Differences in supports available for children transitioning to adult services (Age 16-20)
- ☐ Rights modifications for children transitioning to adult services (Age 16-20)
- ☐ What to expect and not expect from the development of my Support Plan
- ☐ Next steps after my Support Plan is developed
- ☐ How to report mistreatment (including abuse, neglect, exploitation) and other critical incidents

3. The Case Manager discussed the following information regarding the support planning process with me and I understand:

- ☐ Yes **(Yes will populate when all Support Planning Process responses are selected in item 2).**

4. Additional rights and responsibilities:

- ☐ The rights and responsibilities of the participant, legally recognized representative, and Case Manager when developing my Support Plan
- ☐ The responsibility of my team (myself, family, and others I've invited to participate) to provide accurate information throughout the Assessment and Support Planning process
- ☐ Complaint procedures
- ☐ My rights to appeal the contents/results of the Assessment and Support Plan
- ☐ My choice of providers
- ☐ My options for changing my Case Manager
- ☐ My options for changing my Case Management Agency
- ☐ My choice of where I live
- ☐ My choice of programs and services
- ☐ My responsibility to follow and cooperate with program requirements

Commented [SL6]: Note to Department: All Roles and Responsibilities in Introduction to Assessment & Support Planning module and listed here should be documented on the signature page.

5. The Case Manager discussed the additional rights and responsibilities with me and I understand

- ☐ Yes **(Yes will populate when all Rights and Responsibilities responses are selected in item 4).**

4. TRANSITION TO ADULT SERVICES (ONLY SHOW FOR AGES 14-21)

Discussions and activities may be necessary when a participant is transitioning from child to adult services. Discussion and/or the development of activities to meet these needs should be included within the Support Plan as identified by participant or legally recognized representative.

Transition to Adult Services – Goals and/or activities that should be included to address transition to adult services.

- ☐ Apply for Adult SSI/LTC Medicaid (Discuss if participant will turn 18 in next 18 months)
- ☐ Develop replacement activities that will become active after the transition to an adult waiver (Discuss if participant is older than 14 years and/or:
  - 18 if enrolled in CHCBS or CES
  - 21 if enrolled in CHRP or not currently enrolled in a waiver
  - 19 if enrolled in CLLI)
- ☐ Discuss replacement activities that will become active after the child is no longer eligible for EPSDT services, including Private Duty Nursing (Discuss if participant is enrolled in EPSDT and will turn 18 within the Support Plan year)
- ☐ Develop replacement activities that will become active after the child is no longer eligible for EPSDT services, including Private Duty Nursing (Discuss if participant is enrolled in EPSDT and will turn 20 within the Support Plan year

5. FOR CSR OR REVISION ONLY - PROGRESS TOWARDS GOALS FROM PREVIOUS SUPPORT PLAN

This section is used with participants during the reassessment and renewal of the Support Plan to determine the progress that has been made for the established goals from the previous support plan meetings and whether additional steps need to be taken to meet and/or maintain the goals. Goals that are discussed within Section 5 and have not yet been met should be included under Personal Goals section, and next steps for those goals should be discussed.

(The pull forward items should not be able to be updated in this Section and new goals should not be able to be added in this Section.)

Goal	How Progress Towards Goal Will be Measured	Timeframe for Achieving Goal (S)= Short term, Accomplish Within Support Plan Year (O)= Long Term, Ongoing Goal (F)= Future Goal	Progress Made Towards Goal- Use measures identified in previous Support Plan	Score of Progress Towards Goal	Systemic Barriers
Autofill from previous Support Plan	Autofill from previous Support Plan	Autofill from previous Support Plan	Text	❍Goal achieved, can remove Do not pull forward to Personal Goals Table in Section 6 ❍Goal being achieved, need assistance to continue to meet ❍Goal is on target to be accomplished ❍Goal relevant, barriers to overcome:__ ❍Goal no longer relevant Explain:____ Do not pull forward to Personal Goals Table in Section 6 ❍Revision to Support Plan, no progress at this time	Text

Automation will include all goals from previous Support Plan.

6. PERSONAL GOALS

Goal Number	Description of Goal	Participant Rating of How Meaningful Goal Is	Legally Recognized Representative Rating of How Meaningful Goal Is (Only show if Section 1, Item 2 response is "Yes")	How Progress Towards Goal Will be Measured	Timeframe for Achieving Goal (S)= Short term, Accomplish Within Support Plan Year (O)= Long Term, Ongoing Goal (F)= Future Goal
1 (Each goal should have a unique identifier used to pull forward into the Support Plan)	***Text***	❍ Extremely Meaningful ❍ Very Meaningful ❍ Meaningful ❍ Somewhat Meaningful ❍ Not Meaningful ❍ Unable to respond	❍ Extremely Meaningful ❍ Very Meaningful ❍ Meaningful ❍ Somewhat Meaningful ❍ Not Meaningful	**Text Field**	☐ **(S)=** Short term, Accomplish Within Support Plan Year ☐ **(O)=** Long Term, Ongoing Goal ☐ **(F)=** Future Goal

Activities for Goal #1: (Pull Description of Goal for each goal identified)					
Activities to fulfill goal	**Start Date**	**End Date**	**Increasing Independence Through Skills Building**	**Increasing Participant Direction of Activity**	**Additional Notes About the Activity**
Text field	Date field	Date field	☐	☐	

Additional goals & activities can be added within the automated system.

7. FOR REASSESSMENT ONLY- UTILIZATION OF SERVICES

1. Underutilization of services

Services for which utilization is less than 80% of what was authorized	Reason for under-use of services	Description of issue	Changes to my plan to prevent this from happening again	System changes needed to prevent this from happening again
Autopopulate if from claims data	❍ Authorized more than I needed ❍ I was not able to get all of the services that I needed	Text	Text	Text

8. DIRECTING MY SERVICES

Have brief discussion with participant and representative about participant directed services, including an overview of the programs and services (e.g., IHSS and CDASS) that are available and the pros/cons of each based on interest of participant. Participant direction is only available in certain waivers which includes the option to authorize direct services or have an authorized representative authorize direct services if participant does not wish to or is not able to.

1. **I am interested in discussing participant-directed services**.
   ❍ No **(Skip to Section 9- Choosing Medicaid Home and Community-Based Services)**
   ❍ Yes, already enrolled in participant directed services **(Skip to Item 6- Continue participant directed services)**
   ❍ Yes, not currently enrolled in participant directed services

2. **I want to be able to select, dismiss, and manage the people I want to help me, including family members or friends.**
   ❍Strongly Agree ❍Agree ❍Neither Agree nor Disagree ❍Disagree ❍Strongly Disagree

3. **I want to be able to choose how much I pay the people who work for me.**
   ❍Strongly Agree ❍Agree ❍Neither Agree nor Disagree ❍Disagree ❍Strongly Disagree

4. **I want to be able to manage a budget for my services.**
   ❍Strongly Agree ❍Agree ❍Neither Agree nor Disagree ❍Disagree ❍Strongly Disagree

5. **I am interested in receiving participant-directed services.**

❍ No **(Skip to Skip to Section 9- Choosing Medicaid Home and Community-Based Services)** ❍Yes

Show items 6- 10 only if "Yes, already enrolled in participant directed services" is selected in item 1- Interested in discussing participant-directed services

6. **I/My child will continue participant-directed services during the service period identified within this Support Plan.**
❍ No **(Skip to Section 9- Choosing Medicaid Home and Community-Based Services)**
❍Yes

7. **I/my authorized representative have had challenges managing my budget- Only ask if CDASS has been previously authorized**
❍ No ❍Yes ❍N/A

8. **I/my authorized representative have had challenges finding help or managing people who work for me/my child.**
❍ No ❍Yes ❍N/A

9. **Description of challenges**

10. **I/my authorized representative would like to make the following changes to address the challenges I have with my/my child's self-directed services**

☐ Change programs
Describe changes to programs:_____
☐ Get more support in managing my services, including training
Describe support needed managing services:_____
☐ Select someone to be my authorized representative
Identify person to be authorized representative: _____
☐ Make other changes
Describe any other changes needed to address challenges with self-directed services: _____
☐ No challenges

9. CHOOSING MEDICAID HOME AND COMMUNITY-BASED SERVICES

1. **I would like to have a discussion about the pros and cons of the waivers that I am eligible for.**
   ❍ No - Select waiver option in last column in item -2 ❍ Yes

2. **I am eligible for the following Medicaid programs:**

Medicaid HCBS Waivers	Services	Has Waiting List Auto-populate from crosswalk	Allows Participant Direction Auto-populate from crosswalk	Pros	Cons	Select Option
Auto-populate all waivers identified in waiver crosswalk	Fixed field with service options from iC for Waiver/ in Column 1	☐	☐			☐
		☐	☐			☐
		☐	☐			☐

3. **The DD Waiver Status Review- My case manager reviewed my waiting list status for the DD Waiver (Show only if the participant has a DD Determination on file and is age 14+)**
   ❍ No- Must review waiting list status prior to proceeding with Support Plan
   ❍ Yes, briefly describe the result of this review:_____
   ❍ Not applicable, do not wish to be placed on the DD waiting list

10. IDENTIFYING MY SUPPORTS

1. Identify Caregiver Supports- For each complete the information set below. Use age appropriate guidelines to identify support provided that is beyond what is expected of a caregiver of a child of a similar age without disability related issues. Caregivers will pull from Caregiver Module. If none were identified in the Caregiver Module, assessors can enter caregivers within the Support Plan.

Caregiver Information	Distance from Participant	Caregiver Help- Paid [Check all that apply]	Caregiver Help- Unpaid [Check all that apply]	Frequency: How Often is Assistance Provided	Will Support Continue in the Future?	Back-up Planning
Name:_____ Preferred Phone #:___ Preferred Email:___ Caregiver Is: ☐ Regular support ☐ Back-up support	❍ Lives with ❍ Within 5-10 minutes ❍ 15-20 minutes ❍ Longer than 20 minutes	☐ Self-care assistance (for example, bathing, dressing, toileting, or eating/feeding) ☐ Mobility assistance (for example, bed mobility, transfers, ambulating, or wheeling) ☐ IADL assistance (for example, making meals, housekeeping, telephone, shopping, or finances) ☐ Medication administration (for example, oral, inhaled, or injectable medications). ☐ Medical procedures/ treatments (for example, changing wound dressing, or home exercise program). ☐ Management of equipment (for example, oxygen, IV/infusion equipment, enteral/parenteral nutrition, or ventilator therapy equipment and supplies). ☐ Supervision (for example, due to safety concerns). ☐ Advocacy or facilitation of person's participation in appropriate medical care (for example, transportation to or from appointments). ☐ Other advocacy not related to medical care ☐ Assistance with daily (or routine) problem solving ☐ Non-medical transportation ☐ Social opportunities ☐ Other, describe paid caregiver help:____	☐ Self-care assistance (for example, bathing, dressing, toileting, or eating/feeding) ☐ Mobility assistance (for example, bed mobility, transfers, ambulating, or wheeling) ☐ IADL assistance (for example, making meals, housekeeping, telephone, shopping, or finances) ☐ Medication administration (for example, oral, inhaled, or injectable medications). ☐ Medical procedures/ treatments (for example, changing wound dressing, or home exercise program). ☐ Management of equipment (for example, oxygen, IV/infusion equipment, enteral/parenteral nutrition, or ventilator therapy equipment and supplies). ☐ Supervision (for example, due to safety concerns). ☐ Advocacy or facilitation of person's participation in appropriate medical care (for example, transportation to or from appointments). ☐ Other advocacy not related to medical care ☐ Assistance with daily (or routine) problem solving ☐ Non-medical transportation ☐ Social opportunities ☐ Other, describe unpaid caregiver help:____	❍ As needed ❍ Less than once a month ❍ About once a month ❍ About once a week ❍ 3-4 times a week ❍ Once a day ❍ 2 or more times per day, less than continuously ❍ Continuously (ongoing basis or 24hrs/day)	❍ No, Cannot continue providing ❍ Yes, Can continue providing ❍ Yes, Can increase amount of assistance ❍ Yes, Need to decrease amount of assistance ❍ Do not know Does a transition plan need to be developed for the caregiver? ❍ No ❍ Yes	Support source is responsible for arraigning back-up ❍ No ❍ Yes What should I do if the support does not show up? Who else can help and how they can help? *Text field* Any other concerns I have if my other supports are not available? *Text field*
Payment Source	Relationship to Participant			Would the Participant Prefer a Different Caregiver?	Does the Caregiver Need Support Services/Training?	
☐ Unpaid ☐ Self-paid ☐ Paid by other family member/ friend ☐ Medicare ☐ Medicaid ☐ Private LTC Insurance ☐ Private Health Insurance ☐ VA ☐ DVR	❍ Spouse ❍ Parent ❍ Adult Child ❍ Other family member:___ ❍ Friend ❍ Neighbor ❍ Other, specify relationship to participant:_			❍ No ❍ Yes, describe different caregiver preferred:_____	❍ No ❍ Yes, describe support services/training:_____	

☐ Other, describe payment source:__						

Additional caregivers can be added to the table, even if Caregivers were not identified in the Caregiver module.

2. **Voluntary Support Calendar-** The Support Calendar is a voluntary spreadsheet that will allow me to plan the type and amount of support that I will need during different weeks. For example, I may need a different level of support during a work week than I do during a holiday or vacation week.

Support Calendar was completed:
❍ No ❍Yes

11. AUTHORIZING MY SERVICES

1a.Medicaid HCBS waiver services to be Authorized- The following services will be authorized to help me achieve my goals. If service(s) caps are reached alternative services should be explored if participant has unmet needs.

Commented [SL9]: In the system, likely outside of the Support Plan, would like to have the ability to model different service scenarios to determine the impact on the overall budget

Funding Stream HCBS Waiver	Service	Service Start Date	Service End Date	Service Frequency	# of Units	Unit Rate	Total Cost of Service	Service Justified By	Description of Assessed Need Service Helps Address	Guidance to workers	Incr ing Indepe ndence Throug h Skills Buildin g	Provider Agency (pull from iC)
Populate from Waiver selected in Section 10	Dropdown tailored to funding stream selected	Date field	Date field	❍ __Hours/Day __Days/Week __Weeks/Year ❍ __Hours/Week __Weeks/Year ❍ __Hours/Month __Months/Year ❍ Other, describe:_____ _ If selected, # of units become manual entry	Autocalculate based off of Service Frequency & Service Start/End Date	Fixed field based on service option selected in Column 2	Auto-calculated based on # of Units and Unit Rate	☐Assessed Need- Multi-select of all Comprehensive Assessment module names ☐Goal- Multi-select of goal names from Section 6	*Text* Field should only show if "Assessed Need" is selected in previous column	Text	☐	Searchable provider field
Total Cost of Waivers:	Auto-calculated											

Allow for additional services to be added.

Service authorization and total cost of waivers is dependent on business and/or program rules, such as those related to SPAL, daily average cost, waiver caps, and/or Person-Centered Budget Algorithms (Resource Allocation.)

1b. State Plan Benefits – I receive the following services to help me achieve my goals. Note: LTHH and PDN must be included in this table for cost containment considerations.

Funding Stream	Service	Service Start Date	Service End Date	Service Frequency	# of Units	Unit Rate	Total Cost of Service	Service Justified By	Description of Assessed Need Service Helps Address	Guidance to workers	Increasing Independence Through Skills Building	Provider Agency (pull from iC)
State Plan	Dropdown	Start Date Field	End Date Field	❍ __Hours/ Day __Days/Week __Weeks/ Year ❍ __Hours/ Week __Weeks/ Year ❍ __Hours/ Month __Months /Year ❍ Other, describe:_____ If selected, # of units become manual entry	Autocalculate based off of Service Frequency & Service Start/End Date	Fixed field based on service option selected in Column 2	Auto-calculated	☐Assessed Need- Multi-select of all Comprehensive Assessment module names ☐Goal- Multi-select of goal names from Section 6	*Text* Field should only show if "Assessed Need" is selected in previous column	*Text*	☐	*Searchable provider field*
Total Cost of Waivers:				Auto-calculated								

Allow for additional services can be added.
Service authorization and total cost of waivers is dependent on business and/or program rules, such as those related to SPAL, daily average cost, waiver caps, and/or Person-Centered Budget Algorithms (Resource Allocation.)

Average Daily Cost	Auto-calculated
Total Cost for Cost Containment Review	Auto-calculated

Total Cost for Cost Containment Review = Total Cost of Waiver Services + Total Cost of Long-Term Home Health (if applicable) + Total Cost of Private Duty Nursing (if applicable)

2. **Summary of the assessed needs and risks addressed by a non-Medicaid support source.**

3. **Are there challenges with obtaining all services and supports to address the assessed needs, including unmet needs, systematic issues, or other issues?**
   - ☐ Unmet needs,
     Describe unmet needs:_____
   - ☐ Systemic issues,
     Describe systemic issues:_____
   - ☐ Other issues,
     Describe other issues related to challenges with obtaining services and supports:_____
   - ☐ None

4. **I have been informed that: (All responses must be checked prior to proceeding with the Support Plan)**
   a. I have a choice of available long-term services and supports;
      ❍ No ❍Yes
   b. I have the right to select among qualified providers;
      ❍ No ❍Yes
   c. I can change providers at any time;
      ❍ No ❍Yes
   d. A provider has the right to accept or deny my request for services;
      ❍ No ❍Yes

5. **I have been given a list of qualified providers or provided with directions on how to access this list.**
   ❍ No (Skip to Item 7- I want to change providers if CSR or Revision or Item 11- I have selected CDASS/IHSS for Initial)

❍ Yes, given a list of providers during the meeting
❍ Yes, provided directions on how to access a list of providers. How to access this list (e.g., website, mail):_____ (Skip to Item 7- I want to change providers if CSR or Revision or Item 11- I have selected CDASS/IHSS for Initial)

6. I had enough providers to choose from.
❍Strongly Agree ❍Agree ❍Neither Agree nor Disagree ❍Disagree ❍Strongly Disagree

Items 7-10 are for CSR or Revision Only

7. I want to change providers.
❍ No (Skip to Item 11- I have selected CDASS or IHSS) ❍Yes

I want to change the following providers:

8. I have selected a new provider during this meeting.
❍ No
❍ Yes for all providers I want to change (Skip to Item 11- I have selected CDASS or IHSS)
❍ Yes for some providers I want to change,
Identify providers I want to change:_____

9. My Case Manager's plan for helping me find new provider(s):

10. Target date for finding a new provider: (Date field)

11. I have selected CDASS or IHSS as one of my services.
❍ No **(Skip to Section 12- Support Sources to Fulfill Goals)**
❍ Yes, and this is my initial enrollment in participant directed programs

❍ Yes, and I have previously been enrolled in participant directed programs **(Skip to Item 15- Change or update provider)**

12. When I manage people who are paid to help me, this is how I would do the following: [Ask authorized representative if one has been identified. Record brief summary in the boxes below. Emphasize that it is okay to be uncertain about how to address these tasks – the individual and/or authorized representative will receive training on how to perform tasks.]

A. Find/select workers to hire

B. Train workers

C. Give workers directions

D. Deal with a worker who is not doing her/his job well

E. Dismiss a worker who is not meeting my needs

F. Manage my service budget (Ask only if CDASS is selected as service authorized in Item 1a, Section 11)

13. I can self-direct my services:

- ❍ With very little or no support
- ❍ With support, describe: _____
- ❍ If another person acts as an authorized representative:
  - Representative name:_____
  - Relationship to me:_____
- ❍ I have decided not to self-direct my services

14. I would like the following training to help me direct my supports and/or manage my budget (if applicable):

15. For CSR or Revision Only- I need to change or update the provider who helps me with my participant directed program.

❍No (Skip to Section 12- Support Sources to Fulfill Activities)

❍ Yes, identify change/update needed:_____

16. I would like to select the following FMS agency (ask only if CDASS selected as service authorized in Item 1a, Section 11)
Searchable provider field, same as final column in Section 11, Item 1a

17. I would like to select the following IHSS agency (ask only if IHSS selected as service authorized in Item 1a, Section 11)
Searchable provider field, same as final column in Section 11, Item 1a

12. SUPPORT SOURCES TO FULFILL ACTIVITIES

1. Supports and challenges for completing the activities to fulfill my goals.

Goal 1: Autofill Goal Description from Section 6		
Activities to fulfill goal	Support Sources	Challenges
Populate from Section 6	*Text field*	☐ Unmet Need ☐ Systemic Challenges: Text Field ☐Other Challenges: Text Field

13. REFERRALS

Type of Referral	Referral Agency	Reason for referral	Who will follow-up	Contact Information for Referral
Pull selected referral				

categories from assessment				

Additional referrals can be added within the automated system.

14. BACK-UP PLANS

1. **Planning back-up supports-** What should occur if my support source does not show up.

Support Source	Support source responsible for arranging back-up	What should I do if the support does not show up? Who else can help and how they can help?	Any other concerns I have if my other supports are not available.
Caregiver Supports			
Auto-populate from 10.1	Auto-populate from 10.1	Auto-populate from 10.1	Auto-populate from 10.1
Auto-populate from 10.1	Auto-populate from 10.1	Auto-populate from 10.1	Auto-populate from 10.1
Medicaid Waiver/State Plan Supports			
Auto-populate from provider name in item 1a and 1b in Section 11	❍No ❍Yes	*Text*	*Text*
	❍No ❍Yes	*Text*	*Text*

2. **Contact Information for My Back-up Supports-** Contact information for people and agencies listed above:

Name	Phone Number to Call	Email Address
Auto-populate from supports identified as "back-up" in Section 10.1	Auto-populate from supports identified as "back-up" in Section 10.1	Auto-populate from supports identified as "back-up" in Section 10.1

15. DISASTER RELOCATION PLANNING (PULL FORWARD FROM SECTION 1 OF SAFETY AND SELF PRESERVATION MODULE IN THE ASSESSMENT)

1. What do you consider an emergency?

2. How would you get help in an emergency?

3. Do you need help in an emergency?

❍ No
❍ Yes

Describe help needed in an emergency: _____

4. Can get out of the home easily in an emergency

❍ Yes
❍ No

5. Emergency exit plan is in place

❍ Yes
❍ No

6. Emergency kit available (flashlight, candle, water, etc.)

❍ Yes
❍ No

7. Emergency phone numbers easily available

❍ Yes
❍ No

8. Do you have a Disaster Relocation Plan?

❍ No (Skip to Section 16- Minimizing My Risks) ❍Yes

9. My provider has or will develop a Safety Plan for me and/or my information has been entered into or will be entered into an online system for safety and disaster response used by first responders in my area, such as Smart911:

☐ Have not developed a Disaster Relocation Plan **(This response should be mutually exclusive; if this is selected no other responses should be able to be selected.)**
☐ Developed and maintained by provider, briefly describe the provider plan:_____
☐ Has been entered into a response system, date of last update:_____
☐ Will be entered into response system, date information will be entered:_____

9a. Name of system:_____
9b. Weblink for system:_____

Only show 9a and 9b if the following responses are selected in item 9 "Has been entered into a response system, date of last update" and/or Will be entered into response system, date information will be entered

(Skip to Section 16- Minimizing My Risks if response other than "Have not developed a Disaster Relocation Plan" was selected)

10. Emergency Contacts and Relocation Sites- If I need to move to another location in an emergency, these individuals/organizations should be contacted. I have also ranked my preferences for where I should be relocated.

	Name/ Organization (Order should reflect priority of individuals to contact)	**Relationship**	**Primary Phone Number**	**Secondary Phone Number**	**Options for Relocation** (Rank your preference)	**Address** (Enter only if site is a relocation option)
1	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.
2	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Choose an item.	Click or tap here to enter text.

Allow for additional emergency contracts and relocation sites to be added

11. If I need to relocate because of an emergency, this is what I will need to take:

Medication & Equipment to Take	**Information to Take**	**Special Instructions to Share**
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

16. MINIMIZING MY RISKS

This section is to identify, discuss, and mitigate risks. It has four primary areas: 1) Risks related to medical dependency on electricity 2) Risks identified within the Assessment and Support Plan 3) Plans to reduce risk and 4) Identification and acceptance of remaining risks

1. **I depend on medical devices that require electricity.**
   - ❍ No **(Skip to Item 4- Activities for which there are unmet needs)**
   - ❍ Yes

2. **I have applied for an energy assistance program.**
   - ❍ No- Discuss whether participant would like more information
   - ❍ Yes

3. **I have a back-up generator**.
   - ❍ No
   - ❍ Yes, my residential provider is responsible for making sure I have a back-up plan for electricity (Skip to Item 4- Activities for which there are unmet needs)
   - ❍ Yes, I have a back-up generator (Skip to Item 3b- Generator activated by)

   a. I need to get a back-up generator.
      - ❍ No, do not want one. Why not:_____ (Skip to Item 4- Activities for which there are unmet needs)
      - ❍ Yes, but cannot get one due to systemic barriers or other issues:_____ (Skip to Item 4- Activities for which there are unmet needs)
      - ❍ Yes, plan for obtaining back-up generator:_____ (Skip to Item 3e-plan if back-up generator not available)

   b. The back-up generator is activated by:_____
   c. The last time the generator was tested to see if it was working:___/___/_____ **date field**
   d. My primary and back-up caregivers are trained on how to activate the back-up generator.
      - ❍ No, plans for training and/or reasons why some people will not be trained:_____ ❍ Yes

e. Plan if back-up generator is not available or cannot be used:

4. **Activities for which there are unmet needs:**

Activities to Fulfill Goals- Populate from Section 6	**Challenges to Fulfilling Goals-** Populate from Section 6
Assessed Needs- Populate with narrative descriptions from Section 11, Items 2 & 3	

5. **Summary of remaining risks, including medical, behavioral, environmental, and other risks, not addressed by a goal, assessed need, service, and/or referral:**

6. **Plans for reducing remaining risks:**

7. **Have changes been made to services or guidance to workers to reduce risks?**
   - ❍ No
   - ❍ Yes, describe changes:

8. ☐ **I understand and am willing to accept my identified risks** This item must be checked to authorize services

9. ☐ **My legal representative understands and is willing to accept the identified risks (if applicable)** This item must be checked to authorize services

10. **If the participant and/or legally recognized representative have concerns about the remaining risks, such as those around an unmet need, document concerns here:** _____

17. MODIFICATION OF RIGHTS

1. Were emergency control procedures used since the last assessment?
- ❍ No **(Skip to Item 3- Setting in which certain actions must be taken)**
- ❍ Yes

2. Are actions being taken to prevent the need for continued use of emergency control procedures?
- ❍ No, describe why not:
- ❍ Yes, describe actions:

3. I will be subject to a rights modification:
- ❍ No (Skip to Section 18- Advance directives)
- ❍ Yes

4. Reasons for the modification: **4-6 should be dynamic tables, with 5-6 mirroring the number of modifications entered in 4.**

Modification #	Observable and measurable description of behavior or other issue to be changed or improved	Assessment item(s) that demonstrate why issue has been targeted	Efforts to use positive interventions and less intrusive alternatives prior to use of Rights Modification
1	Text	Text box	Text box
2	☐ Same text As Above (Pull text from row above)	☐ Same text As Above (Pull text from row above)	☐ Same text As Above (Pull text from row above)

Commented [SL18]: Help for column 2: Describe the behavioral or other issue that presented a risk to health and/or safety of the individual and/or others and resulted in a modification to the participant's rights. Include enough detail to meet the federal requirement of identifying a specific and individualized assessed need for the rights modification

Commented [SL19]: Help for column 3: Identify assessed need(s) that inform the behavioral or other issue that is being targeted by the rights modifications.

Commented [SL20]: Help for column 4: Describe the po
sitive interventions and supports used prior to any rights modifications and the less intrusive methods of meeting the need that have been tried but did not work.

	If not checked, Text Field	If not checked, Text Field	If not checked, Text Field

Additional rows may be added in the automated system

5. Types of modifications:

Modification #	Classification of modification:	Description of rights modification	Informed consent has been documented for mod.	Staff training on proper implementation	Providers to implement modification	Start Date	End Date
1	☐ Ability to lock bathroom door ☐ Ability to lock room/unit ☐ Access to dangerous objects or hazardous materials ☐ Access to food at any time ☐ Access to media and internet ☐ Access to personal possessions ☐ Access to specific areas in living space	Text box	☐	Text box	Checkboxes for all providers identified in authorized services in items 11.1a and 11.1b	Date-Calendar Picker	Date-Calendar Picker

Commented [SL28]: Help for column 7: Date on which theis rights modification goes into effect.

Commented [SL29]: Help for column 7: Date on which this rights modification ends

Commented [SL31R29]: Leah I think this validation meets your needs. Please confirm.

Commented [SL21]: Help for column 2: Check all apply to this rights modification.

Commented [SL22]: Help for column 3: Describe what right will be modified and provide a brief description of how it will be modified, with enough detail to show that the rights modification is directly proportionate to the specific assessed need (no more restrictive than needed to protect the identified health/safety/wellbeing interests of the individual or others).

Commented [SL24]: Help for column 5: Describe the method for informing staff about the rights modification, including training on how and when the modification should be implemented, and how and where staff will complete documentation of the use of the modification. If the modification has already been enacted, describe how it was enacted, when it is being utilized, and any changes that need to occur. In this section, include an assurance that the rights modification will cause no harm to the individual, as well as an explanation of the basis for this assurance. The explanation should address the provider's plan to support the individual in learning skills so that the modification becomes unnecessary, as well as documentation of any ways in which the modification is paired with additional supports to prevent harm or discomfort.

Commented [SL26]: Help for column 6: Identify the provider(s) that will enact the modification.

Commented [SL23]: Help for column 4: Check the box to indicate that this informed consent, with the signature of the individual (or, if authorized, their guardian or other legal representative), is on file.

	☐ Access to the greater community ☐ Cameras or audio monitors ☐ Chimes or other alerts ☐ Choice of roommates ☐ Choice of services and who provides them ☐ Choice of setting ☐ Choice of visitors at any time ☐ Freedom and support to control own schedules and activities ☐ Freedom to furnish or decorate sleeping or living unit ☐ Independent access to and use of a phone						

	☐ Independent decision-making, initiative, or autonomy ☐ Key to the home ☐ Right to privacy ☐ Restraints ☐ Other, describe classification of modification:_ _____ _____						
2	☐ Ability to lock bathroom door ☐ Ability to lock room/unit ☐ Access to dangerous objects or hazardous materials ☐ Access to food at any time ☐ Access to media and internet	Text box	☐	Text box	Checkboxes for all providers identified in authorized services in items 11.1a and 11.1b	Date-Calendar Picker	Date-Calendar Picker

	☐ Access to personal possessions ☐ Access to specific areas in living space ☐ Access to the greater community ☐ Cameras or audio monitors ☐ Chimes or other alerts ☐ Choice of roommates ☐ Choice of services and who provides them ☐ Choice of setting ☐ Choice of visitors at any time ☐ Freedom and support to control own schedules and activities ☐ Freedom to furnish or decorate						

	sleeping or living unit ☐ Independent access to and use of a phone ☐ Independent decision-making, initiative, or autonomy ☐ Key to the home ☐ Right to privacy ☐ Restraints ☐ Other, describe classification of modification:_ _____ _____						

6. Plans for monitoring and removing modifications:

Modifications #	Who will monitor	Changes necessary to remove Modification	Timeline for reviewing whether modification is still necessary
1	*Text box*	*Text box*	*Text box*

Commented [SL34]: Help for column 2: Identify who monitors the effectiveness of the modification. This may be staff or a supervisor at the provider agency.

Commented [SL35]: Help for column 3: Document the positive behaviors and objective results the individual can work toward to demonstrate that the rights modification is no longer needed, so that the participant can know what he/she needs to do to allow the modification to be removed. Include what kind of concrete data or information will be collected and what the standard will be for determining success. If possible, include interim steps or stages to have part of the individual's rights restored.

2	☐ Same text As Above(Pull text from row above) If not checked, Text Field	☐ Same text As Above(Pull text from row above) If not checked, Text Field	☐ Same text As Above(Pull text from row above) If not checked, Text Field

7. I have questions or concerns about the Rights Modifications process .

❍ No ❍ Yes, document concerns and discussion:

8. Human Rights Committee (HRC) review necessary? [Only show for participants enrolling in IDD waivers (DD, SLS, CES, CHRP)]

❍ No (Skip to Section 18- Advanced directives)
❍ Yes, because:
- ☐ Of a Rights Modification
- ☐ Use of psychotropic medication 1) administered by a paid support and/or 2) receiving residential habilitation

9. HRC Review Status/Outcome

❍ To be submitted (Skip to Section 18- Advanced directives)
❍ Submitted, awaiting review (Skip to Section 18- Advanced directives)
❍ Review completed

10. HRC review outcome and recommendations:

18. ADVANCE DIRECTIVES

1. I have established advance healthcare directives.
❍ No [Skip to Item 4- Assistance to establish/update]
❍ Yes

If yes, type of advance healthcare directive:
- ☐ Durable power of attorney
- ☐ Health care advocate
- ☐ Advance directives concerning care (e.g., DNR, extraordinary measures, etc.)
- ☐ Physician Orders for Life-Sustaining Treatment (POLST)
- ☐ 5 Wishes
- ☐ Other; describe type of advance healthcare directive:_____

2. My advance healthcare directives are located:_____

3. Sharing directives with my doctor, healthcare/service provider, and/or family/friends.
❍ Already shared with everyone I want
❍ Choose not to share
❍ Want to share. Who I need to share with and who will share it:_____

4. I would like assistance to establish or update advance healthcare directives.
- ❍ No [If "No" to items 1 and 4, Skip to Section 19- Case Management Monitoring, otherwise skip to Item 5- The following person will help me develop]
- ❍ Yes, establish
- ❍ Yes, update

If yes, I want assistance with developing/updating:
- ☐ Durable power of attorney
- ☐ Health care advocate
- ☐ Advance directives concerning care (e.g., DNR, extraordinary measures, etc.)
- ☐ Physician Orders for Life-Sustaining Treatment (POLST)
- ☐ 5 Wishes
- ☐ Other, describe assistance needed:_____

5. The following person will help me develop, update, and/or share my advance directives.
Name of Person: _____
Relationship: _____
Contact Information: _____
Development, updates, and/or sharing will occur by:_____

19. CASE MANAGEMENT MONITORING

1. **My Case Manager has explained the minimum monitoring requirements of the waiver I am enrolled in, and I understand these requirements.**
   - ❍ Yes (Explain the specific the minimum monitoring requirements of the applicable waiver program)

2. **I would prefer that my Case Manager check in with me:**
   - ❍ The minimum amount required
   - ❍ More than the minimum, describe:

3. **My preferences for how my Case Manager contacts me:**
   - ☐ In person
   - ☐ By telephone
   - ☐ By email
   - ☐ By text
   - ☐ Other, describe contact preference:_____

4. **When I meet with my Case Manager in person, I would prefer these meetings happen at:**
   - ❍ My home
   - ❍ Other location(s) where services are being delivered:_____

5. **If something important occurs, such as a change to my service eligibility, I would prefer that the following people also be notified:**
   - ❍ No one
   - ❍ The following people:

   Show "Person's name, email, text number… if "the following people" response is selected

   ☐ Person 1's Name:_____
   Phone number:_____ Primary email:_____ Primary text number:_____

   ☐ Person 2's Name:_____
   Phone number:_____ Primary email:_____ Primary text number:_____

Additional individuals may be added in the automated version

6. **Are there any individuals that you do not want to be in contact with or who should not be around you?**

❍ No (Skip to Item 7: Things I Would Prefer That My Case Manager)

❍Yes

Name of Person	Relationship to Participant	Is there legal documentation justifying the	Instructions if this person tries to make contact

		reason this individual should not contact participant?	
Text field	❍ Spouse/boyfriend/ girlfriend ❍ Ex-Spouse/ boyfriend/girlfriend ❍ Child ❍ Sibling ❍ Other family member ❍ Friend ❍ Other, describe relationship to participant:_____	❍ No. Who made no contact determination? _____ ❍ Yes, describe:____	Text field

7. Other things I would prefer that my Case Manager do or not do when monitoring my plan or services:

20. SHARING MY ASSESSMENT

1. **I would like to identify specific information from the assessment that should not be shared with my service providers authorized in the Support Plan.**
   - ❍ No
   - ❍ Yes, the following information should not be shared with the identified providers:

Service Provider Name	Do Not Share These Modules
Service Provider Name from Service Authorization Table in Section 11.1a & 11.1b	☐ Share All Assessment Modules (mutually exclusive response) ☐ Share No Assessment Modules (mutually exclusive response) ☐ Personal Story- Personal Profile ☐ Personal Story- People Important to Me ☐ Personal Story- My Future ☐ Personal Story- Other Plans or Protocols ☐ Memory & Cognition ☐ Functioning ☐ Health ☐ Sensory & Communication ☐ Psychosocial ☐ Housing & Environment ☐ Employment, Volunteering and Training ☐ Safety & Self-preservation ☐ Participant Engagement

*Legally Recognized Representatives are individuals who have a legal right to decide what will and will not be included in the Support Plan. This includes designated power of attorney (DPOA), power of attorney (POA), guardian, and/or parent of a minor child.

	☐ Caregiver

Automated system should create a new row for each service provider identified in the Service Authorization table in items 11.1a & 11.1b

21. COMMENTS, GUIDANCE, AND CONCERNS FROM MEMBERS OF MY TEAM

1. **Comments, guidance, and concerns about services, supports, next steps, or other areas of the Support Plan. If no comment, enter "None". If there is no representative of the category, enter "N/A".**
   a. Case Manager

   ☐ **Case Manager attests that the services and supports included in this Plan are related to an assessed need or a personal goal.** (This must be selected)
   b. Agency Representative. Identify agency: Click or tap here to enter text.
   c. Agency Representative. Identify agency: Click or tap here to enter text.
   d. Other Support. Identify name and relationship: Click or tap here to enter text.
   e. Other Support. Identify name and relationship: Click or tap here to enter text.
   f. Other Support. Identify name and relationship: Click or tap here to enter text.
2. Summary of changes to the plan to address team members' comments, guidance, or concerns:
3. Parent, Guardian, or Legal Representative comments, guidance and concerns (If applicable)
4. Summary of the changes to the plan to be taken to address parent, guardian, or legal representative's comments, guidance, or concerns:
5. My comments, guidance and concerns
6. Summary of the changes to the plan to address my comments, guidance, or concerns:
7. I led the creation of my Support Plan as much as I wanted and am capable of.

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❍Strongly Agree ❍Agree ❍Neither Agree nor Disagree ❍Disagree ❍Strongly Disagree

My representative believes that he/she was able to play a leading role in creating my Support Plan. **(Only show if response to Section 1, "Participant's Identifying Information", item 2, "Participant has someone who assists with or is legally authorized to make decisions" is "Yes".)**

8.

❍Strongly Agree ❍Agree ❍Neither Agree nor Disagree ❍Disagree ❍Strongly Disagree ❍Not applicable

9. Date all providers signed off on Support Plan:_____ **Date field**

10. Date participant considers plan as final:_____ **Date field**

*Legally Recognized Representatives are individuals who have a legal right to decide what will and will not be included in the Support Plan. This includes designated power of attorney (DPOA), power of attorney (POA), guardian, and/or parent of a minor child.