COLORADO
Department of Health Care Policy & Financing

# Person-Centered Service Plan Development, Frequently Asked Questions

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## How can case managers facilitate the process to identify personal goals?

**If an individual does not readily have a personal goal, case managers can assist the process by reviewing areas of need or interest and discussing how there may be barriers to supporting those needs or interests. In situations where other people are providing insight to an individual's personal goal (e.g. court-appointed guardian or parent of a minor child), the identified goal must be the individual's goal.**

## How many personal goals can a person have?

**There is no limit to the number of personal goals an individual may have. However, the Bridge allows for up to five active personal goals per line item.**

## Are service goals required as well as personal goals?

**Service goals are not a required part of the person-centered service plan. Service goals developed with providers and individuals should support an individual's personal goals that are documented within the person-centered service plan.**

## What is to be entered in the Support Detail section for Inventory of Needs and Goals section on the Bridge?

**Support Details provide expanded information regarding who is providing the service and what service is being provided to support the needs identified on the Inventory of Needs and the individual's personal goals. Case managers can either name the provider or indicate the waiver service. (e.g. Personal**

**Care).**

## What is to be entered in the Additional Service Description in each Line Item section on the Bridge PPA?

**Additional Service Description allows for expanded details such as amount, scope, duration, and frequency of service being provided and by whom.**

## If an individual has a safety plan with their residential service provider or ACF, is it sufficient for case managers to write, "see Safety Plan" or "see file" in the Contingency Plan section?

**No, the Contingency Plan is a required part of the service plan. It must include specific details of how an individual's health and safety needs will be met when services and or supports are unavailable. Stating, "see Safety Plan" or "see file" does not fulfill that requirement.**

## If a new need is identified for an individual that requires a revision, can services be added to a plan even if other services are not yet being fully utilized?

**Yes, revisions should be completed when an individual's needs have changed. Case managers can use this time as an opportunity to review the other services authorized in the service plan and discuss with the individual if additional services would require revisions as well.**

## What sections of the BUS must be filled out for Service Plans (Initial / CSR)?

**Case managers must complete the following sections in the BUS when completing a Service Plan: Service Plan Information, Medicaid Long Term Care Disclosures, Roles and Responsibilities, Complaint Process, Service and Provider Choice, Statement of Agreement, Service Plan Participants, and Contingency Plan.**

## What sections of the BUS must be filled out for revisions to Service Plans?

**Case managers must complete the following sections in the BUS when completing a revision to a Service Plan: Service Plan Information, Medicaid Long Term Care Disclosures, Roles and Responsibilities, Complaint Process, Service and Provider Choice, Statement of Agreement, and Service Plan**

**Participants.**

## How do case managers complete the Natural Supports, Home-Health, Third Party Resources, State Plan Benefits, HCBS Services, and Personal Goal sections in the BUS now that those areas are required to be completed in the Bridge?

**Case managers shall choose the "No XX" option when there are no supports.**

**If an individual has supports in a particular area (for example Natural Supports), case managers should choose the "Add XX" option and then type "see Bridge" in the BUS for the Natural Supports, Home-Health, Third Party Resources, and State Plan Benefits.**

**The HCBS section requires at least one service be entered. To do so, case managers shall select the "Add HCBS Benefit" link, choose a service from the drop-down in the "Services" bar, select a "Service Goal Type", select "yes" at "HCBS service provider available", type "see Bridge" in the "Service Goal" text box, and then click "Save". Next, click on the "Provider" tab at the top of the HCBS Services box. Click on the "Enter Provider" hyperlink and type "see Bridge" in the text box and click Save. Next, click the "Service Frequency Scope Duration" tab at the top of the HCBS Services box. Enter the "Service Start Date" and "Service End Date", "Item Description" (can use "see Bridge"), enter information in one of the rows to calculate units for the service, click the "Update Calculation" hyperlink, and click on Save.**

**Case managers shall write, "see Bridge" in the "Personal Goals" text box.**

**Please Note: although case managers can verify a Service Plan without completing all these sections, they must follow all of the steps outlined above and finalize the Service Plan. These steps allow case managers to verify and finalize the Service Plan on the BUS as required by the Department.**

## Who is required to sign the Service Plan or Revision?

**The individual receiving services, guardian (if applicable), and case manager of the individual are required to sign the Service Plan.**

## Can a Power of Attorney sign a Service Plan or Revision for an individual?

**When informed a Power of Attorney (POA) is to sign Service Plans and Revisions for an individual, case managers must receive a copy of the authorization for the POA, review the authorization to ensure that the POA has the appropriate authority to sign Service Plans and Revisions for the individual, and retain that authorization paperwork in the individual's file.**

## How are case managers to ensure an individual fully utilizes the services authorized in the service plan?

**Case managers should be monitoring the services with the individual periodically throughout the year, through monitoring contacts. Additionally, prior to authorizing services, case managers should discuss the individual's goals and support needs, and only authorize services to the scope, frequency, and duration that support an individual's goals and needs.**