Individual Support Plan Guide

**FACILITATING
INDIVIDUALIZED SERVICES AND SUPPORTS**

MISSOURI DIVISION OF **DEVELOPMENTAL DISABILITIES**

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

www.dmh.mo.gov/dd   MISSOURI DEPARTMENT OF MENTAL HEALTH

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INTRODUCTION

The purpose of this guide is to focus on the components that are required in an Individual Support Plan (ISP) and will provide a brief overview of the person-centered planning process.

The ISP is a document that results from the person-centered planning process and the Division of Developmental Disabilities requires that each person eligible for Division supports have an Individual Support Plan (ISP).

In January of 2014, the Centers for Medicare and Medicaid Services (CMS) published a final rule 42 *CFR 441.301(c)(1)* regarding changes to Home and Community-Based Waiver Services (HCBS). You can read more about this rule by going online to: www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf. This guide has been updated to ensure compliance with the rule. The Person-Centered Planning section of the rule distinguishes between the person-centered planning process 42 *CFR 441.301(c)(1)* and the person-centered individual service plan 42 *CFR 441.301(c)(2)*. You can find references to the CFR throughout this guide.

The final HCBS rule specifies that service planning for individuals must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. The rules require that the person-centered planning process is directed by the individual with long-term support needs, and may include a representative that the individual has freely chosen and others chosen by the individual to contribute to the process. The rule describes the minimum requirements for Individual Support Plans (ISPs) developed through this process, including that the process results in an ISP with individually identified personal outcomes, goals and preferences, including those related community participation, employment, income and savings, health care and wellness, education and others. The ISP reflects the services and supports (paid and unpaid), who provides them and whether an individual chooses to self-direct his/her services. This planning process, and the resulting ISP, will assist the individual in achieving personally defined outcomes in the most integrated community setting, ensure delivery of services in a manner that reflects personal preferences and choices, and contribute to the assurance of health and welfare.

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

Icons*

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

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

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

Visit MO Family to Family to learn more about
"Charting Your Life Course"
mofamilytofamily.org

*Icons taken from www.lifecoursetools.com, a free online resource from Missouri Family to Family © UMKC Institute for Human Development, UCEDD 2012-2014

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

PART I: OVERVIEW OF INDIVIDUAL SUPPORT PLANNING PROCESS

A person-centered planning process is the means by which information is gathered to create an individualized support plan. 42 CFR 441.301(c)

> "Person-Centered Planning process: The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's representative. In addition to being led by the individual receiving services and supports, the person-centered planning process*:*
>
> - Includes people chosen by the individual.
> - Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
> - Is timely and occurs at times and locations of convenience to the individual.
> - Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.
> - Includes strategies for solving conflict or disagreement within the process, including clear conflict-of interest guidelines for all planning participants.
> - Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.
> - Offers informed choices to the individual regarding the services and supports they receive and from whom.
> - Includes a method for the individual to request updates to the plan as needed.
> - Records the alternative home and community-based settings that were considered by the individual."
> 42 CFR 441.301(c)(1)(i-ix)(2014) pp.3029-3030

THE INDIVIDUAL SUPPORT PLANNING TEAM

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

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

INDIVIDUAL DIRECTING THE PERSON-CENTERED PLANNING PROCESS

It is important that the Person-Centered Planning Process provide necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions. The individual may choose a representative and other team members to contribute to the person-centered planning process.

Tools that can assist the individual in directing his/her own planning process include:
- **Individual Support Plan (ISP) Individual and Family Guide** (*In development*)
- **My Choice! Guide for Creating your Own Individual Support Plan when Self-Directing Supports Online Viewing** (*This document will be updated in 2016*)

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

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

PART II: CREATING THE INDIVIDUAL SUPPORT PLAN

The Individual Support Plan (ISP) is a document that results from the person-centered planning process, and is based on assessments that allow for the gathering of comprehensive information concerning each individual's preferences, individual needs, goals and abilities, health status and other available supports and is used in developing the individual plan.

The ISP must:
- "Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter." 42 CFR 441.301(c)(2)(vii) (2014) pp.3030
- Be written by the Support Coordinator who is responsible for gathering information from all team members in order to develop a comprehensive ISP that is representative of the input from all members of the team.
- "Reflect clinical and support needs as identified through an assessment of functional need." 42 CFR 441.301(c)(2)(iii)(2014) pp.3030
- "Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed." 42 CFR 441.301(c)(2)(vi)(2014) pp.3030

REVIEW OF PREVIOUS YEARS' INFORMATION, ASSESSMENTS AND SUPPORTS

A review of assessments should be conducted prior to the planning meeting in order to facilitate discussion of findings to incorporate into the ISP. Assessments may lead to valuable information about supports, personal outcomes, and goals. A review of the previous year's supports and progress made towards personal outcomes and goals should be conducted in order to identify the ongoing support needs. There should also be a review of service / support definitions to ensure that the required components for those supports are included in the final plan document.

Previous Year's Information may include:
- Review of information from support monitoring, health inventories, nursing reviews, event reports - Action Plan Tracking System (APTS)
- MOCABI/Vineland
- Level of Care (LOC)
- Support Intensity Scale (SIS)
- Risk Assessments/Exploratory Questions

ISP TIMETABLE

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

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

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

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

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

It is the Support Coordinator's responsibility to ensure the ISP meeting "Is timely and occurs at times and locations of convenience to the individual." 42 CFR 441.301(c)(1)(iii)(2014) pp. 3030

ISP COMPONENTS

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

Each Table Indicates Whether Subcategories Are Mandatory, Optional Or Contingent:

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

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

DEMOGRAPHICS & CONTRIBUTORS/SUPPORT TEAM

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

Contributors / Support Team:
Those who contributed to the plan through interviews, reports, letters, questionnaires, etc. and those present at the plan meeting. NOTE: The support coordinator assures that individuals and his/her guardians receive a copy of the ISP document as well as all providers of services that are actively delivering funded supports. The ISP is to "Be distributed to the individual and other people involved in the plan." 42 CFR 441.301(c)(2)(x)(2014) pp. 3030

DEMOGRAPHIC and CONTRIBUTORS INFORMATION	
Full Legal Name (may use middle initial)	Mandatory
Nicknames and/or alias	Optional
Date of Birth	Mandatory
DMH ID	Mandatory
Individual Plan Meeting Date	Mandatory
Individual Plan Implementation Date	Mandatory
Regional Office or Satellite Office / Habilitation Center	Mandatory
TCM Agency	Mandatory
Healthcare Resources Utilized (Including Medicare, Medicaid, dental insurance, Spend down and private health insurance) Do not include ID numbers.	Mandatory

LEGAL DEMOGRAPHICS	
Supported Decision Making Representative	Contingent
Legally Designated to Help the Individual make decisions: (Conservatorship, Power of Attorney, etc., name, address, phone number and relationship to the individual)	Mandatory
Specific restriction placed by court	Contingent
Consent for Treatment Signatures* The ISP must "Be finalized and agreed to, with the informed consent of the individual (Guardian) in writing, and signed by all individuals and providers responsible for its implementation." 42 CFR 441.301(c)(2)(ix)(2014) pp. 3030 (Consent for treatment – RSMO 633.110.1) *Provider Bulletin on Individual/Guardian Signatures on ISP's is available. *Provider Bulletin on Provider Signatures on ISP's is available.	Mandatory
Voter Status	Contingent
Custody (children)	Contingent

CONTRIBUTORS	
States how the individual participated in the development of his/her ISP	Mandatory
List those who contributed and how he/she did so	Mandatory
If the individual is not present at the planning meeting, the team must justify the individual's absence and how the individual was otherwise involved in the planning process.	Mandatory

VISION FOR A GOOD LIFE

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

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

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

VISION FOR A GOOD LIFE	
What an overall 'Good Life' looks like: Hopes, Dreams & Wants	Mandatory
Needs or conditions that must be in place to achieve a good life	Mandatory
Personal Strengths and Assets	Mandatory
Preferences, Likes (Special Interests) & Dislikes	Mandatory
What the Individual Would Like to Try	Mandatory
Support Preferences (e.g., Does the individual prefer a female or male for his/her support needs or for a specific task / activity such as bathing?)	Mandatory
"Reflects cultural considerations of the individual…" 42 CFR 441.301(c)(1)(iv)(2014) pp. 3030	Mandatory
Information about the general topic of important relationships	Mandatory
Information about relationships the individual may want to enhance or explore	Contingent

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

This information helps define *what is important to know and do in order to support* the individual across all domains. The support information in the plan is a crucial component in order to ensure that assessed needs are met. This area identifies "how" the supports need to be provided day to day.

"The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State's 1915(c) HCBS waiver, the written plan must: Reflect the individual's strengths and preferences." 42 CFR 441.301(c)(2) and (ii) (2014) pp. 3030

Supports describe:
- The role of the supporter: what he/she are supposed to do – specifically to assist in the way the individual prefers
- Specifics about what works and does not work for the individual
- The specifics or protocols necessary to develop and/or maintain the health, safety, behavioral or risk issues for the individual and justify support needs.

The information in the support sections can be used for:
- New staff working with the individual or family
- Matching the characteristics of staff to the individual supported
- Teaching and learning tools developed by those who know and care about the individual
- Routines (for example, traveling from home to work, change in schedules, transitioning from weekday to weekend, change in staff, etc.)

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

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

RELATIONSHIP, COMMUNITY-BASED, AND OTHER ELIGIBILITY BASED SUPPORTS (NON-DIVISION SUPPORTS)

The intent of division services is to supplement and strengthen existing natural supports, such as those provided by family, friends, and the community. Supports MUST not be duplicative.

The ISP must **"**Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports." 42 CFR 441.301(c)(2)(v)(2014) pp. 3030 The ISP must: *"Prevent the provision of unnecessary or inappropriate services and supports."* 42 CFR 441.301(c)(2)(xii)(2014) pp. 3030

Natural supports and relationships are an integral part of everyone's lives and should be fostered and encouraged by all planning team members to assist with the development of an integrated life.

Planning teams need to determine an individual's eligibility for Mo HealthNet (state plan) services and other eligibility based supports.

Information should:
- define the support
- define the purpose of the support
- define the frequency of the support

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

PART III: MISSOURI QUALITY OUTCOME LIFE DOMAIN AREAS

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

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

Daily Life and Employment / Career Planning

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

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

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

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

> **Transition Youth**
> Although schools may not require transition planning until age 16 (or younger if determined by the Individualized Education Program planning team), *the Division of Developmental Disabilities Individualized Support Plan <u>must reflect supports and actions</u> that will be taken to improve employment and post-secondary outcomes for school age children under the age of 16.*

School age under 16: It is important for the team to discuss: Self-determination skills; social and other "soft skills" that are critical to success; Explore interests, aptitude, abilities and understanding adult roles; Assist the individual to learn about available work and career opportunities; Expand and build social capital (community connections/business leaders); Participate in monitored early work experiences such as volunteerism, job shadowing and community service; Develop, improve and practice independent living skills.

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

| Assessment and Tools That May Be Used in Planning ||
Assessment/Tools	Purpose
Daily Life and Employment Exploratory Questions	Tool used to assist the planning team in having meaningful and purposeful discussion, which affirms protected rights of employment, opportunities to explore employment, informed choice and individualized employment planning.
Charting the LifeCourse - Daily Life and Employment	Facilitates discussion and assists the individual with beginning the process of exploring employment and career planning.
Youth Transition and Employment Services	The Employment page of the Division of DD website has many helpful resources for employment supports.
Disability Benefits 101	Benefits calculator funded by DD to educate and provide individualized guidance on earned income, asset development and increased financial independence.
A Guide for Career Discovery – Missouri DD Council	Facilitates discussion and assists the individual with beginning the process of exploring employment and career planning.
My Next Move	Interactive tool to assist individuals in learning more about his/her career options and the tasks, skills and salary information of these career options.

ISP REQUIREMENTS: DAILY LIFE AND EMPLOYMENT / CAREER PLANNING FOR EVERYONE	
Supports or 'Personal Outcomes' discovered during the assessment process as part of planning.	Contingent
Documentation of benefits counseling and planning to assist individuals and stakeholders with making informed choices on asset development and financial literacy.	Contingent

ISP REQUIREMENTS: DAILY LIFE AND EMPLOYMENT / CAREER PLANNING ADDITIONAL REQUIREMENTS FOR EMPLOYED INDIVIDUALS	
Identify the following information: Name of employer, average number of hours worked a week, work is in a competitive and integrated setting, and job title	Contingent
If waiver funded services are used to maintain employment: Describe how natural supports are being developed and the specific-targeted job skills are being developed. Include the methodology for evaluating the need for continuation of these services.	Mandatory
For Individuals in Group Supported Employment: Document the justification for Group Supported Employment if the individual demonstrates the capacity to work in an individual setting similar to those not receiving HCB services.	Contingent

ISP REQUIREMENTS: DAILY LIFE AND EMPLOYMENT / CAREER PLANNING ADDITIONAL REQUIREMENTS FOR INDIVIDUALS WITHOUT CAREER PLANNING OUTCOMES	
Describe the rationale for excluding employment as an outcome. Outline the activities, experiences and conversations that will occur in promoting future career planning outcomes.	Contingent

COMMUNITY LIVING

COMMUNITY LIVING

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

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

Choice Housing

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

Assessment and Tools That May Be Used in Planning	
Assessment/Tools	**Purpose**
Community Living and Choice Housing Exploratory Questions	Tool used for planning to ensure the individual has chosen where he/she lives, have privacy and have the support he/she needs in his/her home.
"It's My Home! A Guide for Individuals and Families to Understand the Division of Developmental Disabilities' Housing Initiative with added information from the Final HCBS Rule"	This guide helps facilitate discussion about information that is important to individuals regarding his/her home. It provides information about the Division's Housing Plan, and what the guiding principles mean for individuals and families.
Transition Manual Housemate Survey Tool Housemate Compatibility Tool (Brief Version)	Identifies an individual's preferences and interests to assist in determining compatibility of potential housemates. This is a more comprehensive version of this tool.
Safe and Sound: Tips to consider when looking for compatible housemates	Used to assist the planning team in determining compatibility of potential housemate.
Housing Information & Resources Tip Sheet	Used to help identify resources which may assist the individual in obtaining affordable, accessible housing

ISP REQUIREMENTS: HOUSING	
Supports or 'Personal Outcomes' discovered during the assessment process as part of planning.	Contingent
"Reflect that the setting in which the individual resides is chosen by the individual…" 42 CFR 441.301(c)(2)(i)(2014) pp. 3030	Mandatory for Residential Services
"Records the alternative home and community-based settings that were considered by the individual." 42 CFR 441.301(c)(1)(ix)(2014) pp. 3030	Mandatory for Residential Services
"The [housing / residential setting options identified for an individual are supported by an assessed need] and documented in the person-centered service plan based on the individual's needs [and] preferences…" 42 CFR 441.301(4)(ii)(2014) pp. 3030	Mandatory for Residential Services

Transitioning Into Different Living Settings

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

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

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

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

ISP REQUIREMENTS: COMMUNITY TRANSITION	
Supports or 'Personal Outcomes' discovered during the assessment process as part of planning.	Contingent
The ISP must be updated or amended to include current information regarding the change in living situation. It must include adequate supports for health and safety and to minimize difficulty in adjusting to any changes in his/her life that may occur with the change in living arrangements or supports.	Mandatory
Outcomes and action steps may need to be developed at the post-move review meeting held within one month of the move.	Contingent
In the case of an individual who is transitioning from a nursing home or habilitation center and who is participating in Money Follows the Person, the ISP must include the following statement throughout his/her MFP participation period: 　　As __Name__ is moving into a __number__ person ISL/group home, he/she is eligible for the Money Follows the Person Demonstration. __Name's__ guardian has been notified of this option and has signed the agreement for his/her participation for one year. During this time, surveys will occur prior to discharge from _institution_, at one year and again at two years. If ___name___ is hospitalized or placed in an inpatient setting, regardless of the amount of time, the MFP project director (573-751-8021) must be contacted. This will be the responsibility of __Support Coordinator name__, Support Coordinator. The ___area___ Regional Office provides a 24-hour call-in number for emergency back-up assistance if needed. ___Name___ and his/her guardian have been provided this number in the event that emergency backup is needed.	Mandatory if transitioning from a nursing home or habilitation center and who is participating in 'Money Follows the Person'
Additional individualized back-up plans should also be noted.	Mandatory
When the Community Transition Service is used, the ISP must identify that the services are necessary for the person to move from the congregate setting. The ISP must include a specific list of approved transition start-up costs. See the Community Transition Service Tip sheet for additional information.	Mandatory

ISP REQUIREMENTS: TRANSITIONING FROM HABILITATION CENTER TO COMMUNITY LIVING SETTING	
The Transition Plan must identify all supports, services, accommodations, equipment, furnishings, etc. needed for the individual to be successful in the community.	Mandatory
Following the 30-day review meeting, the receiving Support Coordinator completes an addendum to the ISP, which includes objectives for implementation in the community.	Mandatory

SOCIAL AND SPIRITUALITY

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

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

Assessment and Tools That May Be Used in Planning	
Assessment/Tools	**Purpose**
Personal Relationship Exploratory Questions	Tool used for planning to assist in ensuring individuals have the support he/she needs to enhance personal relationships.
Community Connections Exploratory Questions	Tool used for planning to assist in ensuring individuals have the support he/she needs to access the community.
Charting the LifeCourse Integrated Supports Star	All people need support to lead good lives. Using a combination of many different kinds of support helps to plot a trajectory toward an inclusive, quality, community life. This tool will help families and individuals brainstorm the supports that he/she already have or might need in order to work in partnership to make his/her vision for a good life possible.
Charting the LifeCourse: Experiences and Questions Booklet	This booklet helps individuals and families know the questions to ask and things to think about throughout the life course, in order to have the experiences that help lead to the good life that he/she envisions. Most of the questions and life experiences in this booklet could apply to anyone, whether he/she has a disability or not! Community Living Section Pages 8 & 9

ISP REQUIREMENTS: COMMUNITY MEMBERSHIP	
Supports or 'Personal Outcomes' discovered during the assessment process as part of planning.	Contingent

	HEALTHY LIVING
	People Are Able to Choose Health/Mental Health Resources **and Are Supported in Making Informed Decisions regarding their Health and Well-Being** ISP helps ensure the individual's right to receive physical, emotional and mental health care from the practitioner of their choice. Individuals receive information and education on ways to maintain their health and well-being. Individuals are supported in making healthy choices.

Healthy Living emphasizes the individual's right to receive physical, emotional and mental health care from the practitioner of his/her choice. Individuals receive information and education on ways to maintain his/her health and well-being. Individuals are supported in making healthy choices. This section identifies and addresses all health issues, conditions, risks and related supports.

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

As part of ongoing support to meet the individual's health needs, it is essential the health section of the ISP identify all health issues, conditions, risks and related supports. As part of the information gathering process, there are a number of resources available that should be considered, including, but not limited to consultations, formal assessments by medical professionals, diagnoses, family/medical history, etc. Any recommended prevention measures for the individual should also be included in the plan.

Assessment and Tools That May Be Used in Planning	
Assessment/Tools	**Purpose**
Healthy Living Exploratory Questions	Questions designed to determine the needs and preferences of the individual when developing the ISP. Use the questions to start conversation about what the individual needs to do in order to be successful and self-determined throughout his/her lives and to help him/her think about his/her choices, decisions, and experiences that can help him/her build the future he/she desires.
Health Reference Manual	This is a tool to understand and discuss healthcare issues. The Health Reference Manual is utilized with the Health Inventory. The manual includes teaching strategies and guidelines for supports for each health indicator on a health inventory.
Self-Medication Assessment	*In development*
Division Directive 3.090 HIPS Process - Health Inventory	This tool is used with individuals who receive DMH residential services. This tool has indicators that can help identify an individual's applicable health risks and conditions that should be addressed in the person-centered plan including necessary guidance to staff. (This tool is not all inclusive as what health supports are needed, there may be other health factors that are not found on this health inventory – such as health issues with cardiac, cancer, certain respiratory diseases, etc.) Once identified in the ISP, medical conditions, which require greater detail to direct delivery of care, may be found in a Implementation Plan*. *See Appendix (to be developed)

ISP REQUIREMENTS: HEALTHY LIVING	
Supports or 'Personal Outcomes' discovered during the assessment process as part of planning.	Contingent
Primary Care Physician (name / contact / service or specialty and minimum frequency)	Contingent
Other Medical Specialist Physician (name / contact / service or specialty and minimum frequency)	Contingent
Known or Suspected Health Risks: Choking / Aspiration, Falls, Skin Breakdown, Bowel Problems, Dehydration, Seizures, etc. When individuals have an elevated level of health risks, specific areas of support needed are documented.	Mandatory
Purpose of medications, treatments, or procedures (e.g., parameters, protocols for contacting physician, such as diabetes, hypertension, seizures, etc.)	Contingent
Dietary needs	Mandatory
Allergies/Sensitivities/Reactions	Contingent
Mental Health supports (counseling, therapy, medications, etc.)	Mandatory
PRN psychotropic medication protocol	Contingent
Self-administration (supports needed to maintain this skill) Note: If the individual is learning to self-administer, this is expected to be addressed as an outcome.	Contingent
Adaptive equipment	Mandatory
If specific (more detailed) supports are not in the plan, then note where the information is located and that supporters must use this information to guide what supports they provide (e.g., bowel and bladder management, seizure information, dietary, etc. and other individual/private information).	Contingent
Family Medical History (if available)	Contingent
Diagnoses	Mandatory
History that may not be present at the current time, but is still relevant for caregivers to know – such as: Past Physical illnesses (examples; past surgeries, healed wounds, past fractures or other significant injuries, bowel obstructions or impactions, etc.). Past Mental illnesses, traumatic experiences, or life style stressors (examples: child abuse, SIB, psychiatric admissions, loss of loved ones, frequent moves, etc.)	Mandatory

ISP REQUIREMENTS: HEALTHY LIVING ADDITIONAL REQUIREMENTS FOR RECIPIENTS OF COMPREHENSIVE WAIVER RESIDENTIAL	
Medical, vision, hearing, oral care conditions and supports per HIPS process (Division Directive 3.090 Health Identification and Planning System Process) including Immunizations and cancer screenings.	Mandatory for Residential Services
All Health Indicators marked on the Health Inventory (Annual and Change of Health) should be addressed in the ISP. The plan should identify the issue, condition, or risk requiring support and identify what that support is, who is providing, at what frequency, etc. The Health Reference Manual serves as a guideline for identifying possible supports needed. The agency nurse should also contribute to the planning process. Some areas may result in a measureable outcome and may be time limited or ongoing. Items that require additional detail to guide staff in how to support the individual may be referred to in additional supporting documents such as a Health Care Plan developed by the nurse, etc.	Mandatory for Residential Services

SAFETY & SECURITY

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

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

Supports Needed For Safety

Safety information MUST be included when there is a need to highlight important or extensive safety issues, and is contingent in that it is only required if the individual has needs in this area.

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

Assessment and Tools That May Be Used in Planning	
Assessment/Tools	**Purpose**
Safety & Security Exploratory Questions	Tool used for planning to assist in ensuring individuals have the support he/she need to mitigate risk.
Preparing for Disaster for People with Disabilities and other Special Needs	For the millions of Americans who have physical, medical, sensory or cognitive disabilities, emergencies such as fires, floods and acts of terrorism present a challenge. The same challenge also applies to the elderly and other special needs populations. Protecting yourself and your family when disaster strikes requires planning; this booklet will help you get started.
Preparing Makes Sense for People with Disabilities and Special Needs	The likelihood that you and your family will recover from an emergency tomorrow often depends on the planning and preparation done today. While each person's abilities and needs are unique, every individual can take steps to prepare for all kinds of emergencies from fires and floods to potential terrorist attacks. By evaluating your own personal needs and making an emergency plan that fits those needs, you and your loved ones can be better prepared. This guide outlines common sense measures that caregivers and individuals with disabilities or special needs can take to start preparing for emergencies before they happen. Preparing makes sense for people with disabilities and special needs.
Red Cross Types of Emergencies	Visit as indicated to obtain more in depth information on types of emergency and planning.

ISP REQUIREMENTS: SAFETY & SECURITY	
Supports or 'Personal Outcomes' discovered during the assessment process as part of planning.	Contingent
Supports needed for potential home dangers, cooking , water temperature, chemicals, etc.	Contingent
Mobility support needs, falls, supports and adaptations for evacuation, etc.	Contingent
Criminal and / or other behavior that places the individual or others at risk	Contingent
Altered levels of supervision, restrictions, probation and /or parole	Contingent
Provide information on: **Preparing for Disaster for People with Disabilities and other Special Needs**	Contingent

🔒 Behavioral Risk And Prevention

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

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

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

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

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

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

Assessment and Tools That May Be Used in Planning	
Assessment/Tools	**Purpose**
Behavioral Risk Exploratory Questions	Behavioral Risk Exploratory Questions have been developed to assist with identifying potential needs for behavioral support services and/ or the development of a "Crisis Safety Plan".
Assessment of Common Risk Factors	Tool to create the Crisis Safety Plan in order to plan for high risk situations with strategies to prevent them or to assist the person through the situations.
Crisis Safety Plan	To provide the individual and circle of supports a consistent and planned series of interventions to prevent and address crisis situations all of which are designed towards safety of the individual and others.
Functional Behavior Assessment	Completed by a qualified licensed behavioral services provider and provides information about the situations that are related to challenging behaviors, identifying the likely contributing variables and possible strategies to reduce or eliminate the challenging behaviors.

ISP REQUIREMENTS: BEHAVIORAL RISK AND PREVENTION	
Supports or 'Personal Outcomes' discovered during the assessment process as part of planning.	Contingent
Supports or personal outcomes discovered during **Assessment of Behavioral Risk Factors** and resulting "Crisis Safety Plan"	Mandatory
Must Identify the "Crisis Safety Plan" and where it is located	Contingent
Functional Behavior Assessment attached to ISP	Contingent
Behavior Support Plan attached to ISP	Contingent

Individual Rights / Due Process

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

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

Assessment and Tools That May Be Used in Planning	
Assessment/Tools	**Purpose**
Individual Rights Exploratory Questions	Tool used for planning to assist in ensuring individuals have the support he/she needs to protect his/her rights.
A Guide for Individuals with Developmental Disabilities to Understanding Rights and Responsibilities	Tools used to help individuals and families understand rights of individuals receiving services. *(any of the tools listed can be used)*
Individual Rights of Persons Receiving Services Brochure for community services ASL Video Los derechos de los consumidores	

ISP REQUIREMENTS: INDIVIDUAL RIGHTS	
Supports or 'Personal Outcomes' discovered during the assessment process as part of planning.	Contingent
Information about how individual is informed of rights	Mandatory

When an individual is receiving a paid service and the planning team determines that a limitation of rights is necessary, the ISP process <u>must</u> ensure the following requirements are documented in the support plan and referred to the Due Process Review Committee. Please note that anyone providing a paid service cannot implement a limitation of rights without review of due process.

ISP REQUIREMENTS: INDIVIDUALS WHO HAVE MODIFICATION (RESTRICTIONS) TO RIGHTS	
Specific restriction(s) to legal rights	Mandatory
Justification - purpose & rationale ☐ Describe the restriction ☐ "Document less intrusive methods of meeting the need that have been tried but did not work." (HCBS Rule) 42 CFR 441.301(c)(2)(xiii)(C)(2014) pp. 3030 ☐ Identify a specific and individualized assessed need ☐ Explain the reason the limitation or restriction is being put in place ☐ Explain if the restrictions or limitations are necessary to keep the person safe or others safe ☐ Describe any historical pattern or significant situation which has occurred that would justify a limitation or restriction ☐ Include a summary of current data including the source of the data which supports the need for the limitation or restrictions	Mandatory
Conditions - under which the restriction is applied Explain where the restriction or limitation will be imposed (i.e. only at home, in the community, day program, in kitchen, etc.) ☐ "Include a clear description of the condition that is directly proportionate to the specific assessed need." 42 CFR 441.301(c)(2)(xiii)(D)(2014) pp. 3030 ☐ Explain when the restriction will be imposed (e.g. at all times, in morning, after/before a specific event or situation, if family present, only when in the community, etc.)	Mandatory
Teaching or Support Strategies ☐ Outcomes/Strategies that are being taught to help an individual develop skills in order to overcome the need for this restrictive support ☐ "Document the positive interventions and supports used prior to any modifications to the person-centered service plan." 42 CFR 441.301(c)(2)(xiii)(B) (p. 3030) ☐ Provide evidence that this type of intervention/teaching has worked in the past and information on why this is the method by which the person learns best ☐ There may be situations where an individual has multiple restrictions. If a team decides to prioritize/focus teaching outcomes on only a few restrictions at a time, versus all the restrictions at once, the team will need to prioritize. ☐ If there are restrictive supports that are required to keep the person or others safe and teaching strategies have not been identified, the supports need to be identified in the ISP along with the efforts that are being explored to support the person in the least restrictive way. ☐ For teaching and support strategies, document who is responsible for the training of the strategies.	Mandatory

Monitoring methods
☐ "Include an assurance that interventions and supports will cause no harm to the individual." <u>42 CFR 441.301(c)(2)(xiii)(H) pp. 3030</u>
☐ "Include a regular collection and review of data to measure the ongoing effectiveness of the modification." <u>42 CFR 441.301(c)(2)(xiii)(E) pp. 3030</u>
☐ Information on data collection methods should include…
    • Who is documenting
    • Where data is kept (e.g., daily progress notes, outcome data sheets, MAR, etc.)
    • What is the frequency of documentation (e.g. daily, weekly, monthly, etc.)
    • How often is the data reviewed by team
☐ If the plan is being referred for annual review, there must be documentation noting the progress or lack of progress from the past year of implementation (i.e. summary of monthly reviews, quarterly reviews, behavioral data results, evaluations about the effectiveness of medications/interventions)
	Mandatory

Criteria for restoration ☐ Describe what will it take for the restriction to be lifted / how the individual and team will know when the restrictive support is no longer needed or could be reduced in intensity/frequency ☐ The criterion needs to be in specific observable and measurable terms (i.e. if individual has three consecutive months of no attempts to elope, chimes will be removed from the exterior door)	Mandatory
Review schedule ☐ "Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated." <u>42 CFR 441.301(c)(2)(xiii)(F) pp. 3030</u> ☐ State how often team will submit plan to Due Process Committee for review (minimum is annually)	Mandatory
Notice of right to due process ☐ "Include informed consent of the individual." <u>42 CFR 441.301(c)(2)(xiii)(G) pp. 3030</u> ☐ Document that the individual and the guardian are aware of the restrictions, were part of the planning process to develop interventions, know he/she has a right to due process, and have information on what to do if he/she does not agree with the restrictions or interventions. ☐ Signed authorization page (can either be signed by guardian only or can be signed by guardian and individual)	Mandatory

	CITIZENSHIP & ADVOCACY
	People Have Opportunities to Advocate for Themselves, Others and Causes They Believe In, including Personal Goals and Dreams This outcome emphasizes the importance of self-advocacy. Training and ongoing support are often times required to assist an individual in developing their self-advocacy skills.

Personal Income (Formerly Management Of Individual Funds)

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

Age 17 – Additional Activities: Social Security and Medicaid Eligibility Determination Recommendation:
At least six months prior to turning 18, the DD support coordinator should educate the family about Social Security and *MO Health Net* benefits. In Missouri, often individuals who are found eligible for social security benefits may also be found eligible for Medicaid. Beginning the process early helps ensure a more seamless transition to an adult service system. The intent is that eligibility would go into effect on the child's 18th birthday.

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

There are **no restrictions** from Social Security on what recreational activities an individual chooses. The Division manages an individual's NAFs account to ensure that his/her total resources are less than $999. If resources increase beyond this amount, the individual will no longer be eligible for Medicaid and will no longer qualify for the Home and Community-Based Medicaid Waiver or Medicaid State Plan Supports.

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

Assessment and Tools That May Be Used in Planning	
Assessment/Tools	**Purpose**
Personal Income Exploratory Questions	Tool used for planning to ensure the individual has the support he/she needs to manage his/her funds.
http://www.socialsecurity.gov/pubs/10076.html	Outlines the Social Security guidelines for payee of benefits.

ISP REQUIREMENTS: PERSONAL INCOME	
Supports or 'Personal Outcomes' discovered during the assessment process as part of planning.	Contingent
Supports needed to maintain benefits	Mandatory

Supports needed to manage funds
    • If the individual has a representative payee, provide relevant information.
    • If the individual serves as his/her own payee, what, if any, supports (either natural or paid) are needed to assist the individual?
	Mandatory

ISP must document:
    • That the individual's resources were considered when given options for residential room and board
    • What housing resources (e.g., vouchers and other rental assistance options) were explored
    • That individual was given the information necessary to make an informed choice regarding housing options
	Mandatory for those receiving residential supports

Information regarding how the individual wants to spend/save his/her excess funds after daily living expenses are paid. (i.e. dental insurance, burial plans, leisure activities, etc.).	Mandatory for all residential services
If the individual lives in a residential setting, what is the monthly personal spending allowance? What support does the individual need to manage/access these funds?	Mandatory for all residential services
Support needed in preparation of application for SSI	Contingent School Transition Youth at age 17

Self-Directed Supports

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

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

ISP REQUIREMENTS: SELF-DIRECTED SUPPORTS	
Supports or 'Personal Outcomes' discovered during the assessment process as part of planning.	Contingent
Identifies the *Designated Representative* (when appointed)	Mandatory
Supports or 'Personal Outcomes' discovered during review of the Support Brokers Assessment (*Personal Outcomes must be identified for SB service.)*	Mandatory
The services being self-directed are listed and what supports are being provided by these services (Personal Assistance, Community Specialist, and Support Broker Assessment is used as the tool) *The ISP is used as a training document for employees and must provide enough details in order for all employees to understand what is needed to provide supports. (Personal Outcomes must be identified for SB and CS.)*	Mandatory
Justifies any training exemptions on the Personal Assistant "Training Checklist".	Mandatory
If receiving Medical Personal Assistance, does the ISP list the "licensed medical professional*" who will be providing the training, delegation and periodic supervision of care? (*Licensed Medical Professional as defined by the Nursing Practice Act Chapter 335. RSMo)	Contingent
Identifies the back-up plan which includes provisions for: support in the case of scheduled employees not being able to provide the support; Employer/Designated Representative is not capable or available to manage employees; and handling other emergencies *May refer to separate document(s) to attach to the plan.	Mandatory*
In the case of a paid family member *(the paid family member cannot be the guardian or designated representative, or parent/step-parent of child under 18)* - the plan must reflect that: • The individual is not opposed to the family member providing the support. • The supports, to be provided, are solely for the individual and not household tasks expected to be shared with people who live in a family unit. • The support team agrees that the family member providing the individual assistance will best meet the individual's needs.	Mandatory
For new individuals to SDS and those with a change in allocation, the SDS Budget Allocation tool is complete and matches $ amount on Authorization Form.	Mandatory
If individual is receiving Medicaid State Plan Personal Care Services through Health and Senior Services, Division of Senior and Disability Services (DSDS) service authorization system has been checked to ensure that these services are not being self-directed. **Does the individual currently, or at any time in the past received self-directed services through state plan and/or have an existing Employer Identification Number (EIN)?**	Mandatory

Choice of Setting, Service Provider and Option of Self-Directed Supports

"The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State's 1915(c) HCBS waiver, the written plan must…" 42 CFR 441.301(c)(2)(2014) pp.3030

The ISP must "Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS." 42 CFR 441.301 (c)(2)(i)(2014) pp. 3030

The ISP process: "Offers informed choices to the individual regarding the services and supports they receive and from whom." 42 CFR 441.301(c)(1)(vii)(2014) pp. 3030

Technical Assistance Manual for Regional Offices, County Senate Bill 40 Boards, and Other Not-for-Profit Agencies, states:

D. Further Discussion of Free Choice: Individuals and their guardians must be given free choice of all waiver and other MO HealthNet providers and services. ISPs for waivered services must not restrict choice. This requires the support coordinator to give all pertinent information and not to bias individuals' free choice.

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

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

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

Assessment and Tools That May Be Used in Planning	
Assessment/Tools	**Purpose**
Choice_Exploratory Questions	Tool used for planning to assist in ensuring individuals have the support he/she needs to make choices about services.
Provider Profile Directory	Used to provide individuals, families and guardians information about potential service providers.
"A Guide to Understanding MoHealthNet (Medicaid) Services"	A guide to understanding MOHealthNet and Waiver Services.

ISP REQUIREMENTS: CHOICE OF SERVICE PROVIDER AND OPTION OF SELF-DIRECTED SUPPORTS	
How was the individual educated and informed of the options list in the "*Medicaid Waiver, Provider, and Services Choice Statement*." http://dmh.mo.gov/docs/dd/h15wvrchoiceform.doc	Mandatory for all waiver recipients
How was the individual educated and informed of the full range of HCBS available to support achievement of personally identified goals.	Mandatory for all waiver recipients
"Includes a method for the individual to request updates to the plan as needed." 42 CFR 441.301 (c)(1) (viii)(2014) pp. 3030	Mandatory for all waiver recipients
"Records the alternative home and community-based settings that were considered by the individual." 42 CFR 441.301(c)(1)(ix)(2014) pp. 3030	Mandatory for all waiver recipients

Conflict Resolution

The ISP *"Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants."* [42 CFR 441.301(c)(1)(v)(2014) pp.3030](#).

Requirements of Family or Guardian of Minor Child:
If the individual is a minor child, information from the parent(s) or guardian <u>MUST</u> be included in the plan. If the individual is an adult with a guardian, information must be included if the guardian requests that it be included. The plan (support section or personal outcome / goals as applicable) should describe how guardian concerns are being addressed.

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

ISP REQUIREMENTS: CONFLICT RESOLUTION	
Provides information regarding who to contact if unhappy with services or supports	Mandatory
Provides information on making an anonymous complaint	Mandatory
Provides a section on dissenting opinions of team members	Mandatory
Individual is provided clear information regarding any potential conflict of interest	Contingent

ISP REQUIREMENTS: CONFLICT RESOLUTION FAMILY OF MINOR CHILD OR GUARDIAN	
Parents of Minor Child differentiate what is important to the guardian if different from the Individual	Mandatory
Guardian (per request) differentiate what is important to the guardian if different from the Individual	Mandatory

PART IV: PERSONAL OUTCOMES, GOALS AND IMPLEMENTATION STRATEGIES

The ISP must "Include individually identified goals and desired outcomes." 42 CFR 441.301(c)(2)(iv)(2014) pp. 3030 Personal outcomes are what drive a person's ISP. These are things that the individual is interested in trying, learning, doing, or achieving in the next year. Personal Outcomes must relate to what is important to the individual—personal outcomes are not simply support needs, although they may contain components of supports a person needs in specific areas or with specific tasks. The Support Coordinator facilitates the development of Personal Outcomes and Goals with the person and others in the person's life if applicable (e.g. guardians, providers, family, friends, and others the person may wish to involve). An outcome is not required for every funded service, however all supports must be justified in the ISP.

Goals describe the actions to be taken towards achieving the Personal Outcome, and are developed as a part of the person-centered planning process. Each Goal has Implementation Strategies in place to provide step-by-step actions and instruction for the people responsible for implementing the Goal.

Each Personal Outcome may have multiple Goals, each of which have at least one measure of success. Measures of success are defined by the individual and are specifically identified. Each Goal identifies who is responsible for implementation and the timeline. Some Goals build upon each other and are not all necessarily implemented at the same time. Progress and changes to the Goals are noted on the monthly progress documentation and do not require the ISP to be updated, unless the Personal Outcome has changed.

Individuals may have "Support Needs" that do not require specific goals or Implementation Strategies. For example, if an individual has a support need for 'briefs' an outcome or action plan is not required.

Please note that some services are habilitative in nature and require Outcomes / Goals and Action Planning such as Independent Living Skills Development and Individualized Supported Living. See **WAIVER SERVICES REQUIRING PERSONAL OUTCOMES AND IMPLEMENTATION STRATEGIES** and reference the Utilization Review Desktop Reference for details.

Guidance to Health and Human Services Agencies for Implementation Principles of Section 2402(a) of the Affordable Care Act: Standards for Person - Centered Planning in Home and Community-Based Services Programs, states: "Goals must be documented in the person's and/or representative's own words, with clarity regarding the amount, duration, and scope of HCBS that will be provided to assist the person. Goals will consider the quality of life concepts important to the person."

- An outcome IS NOT a service such as "will receive residential services". The result is not the residential service.
- An outcome IS NOT a statement for continued supports, such as, "will continue to receive day services".
- An outcome IS NOT an implementation strategy. The implementation strategies are the "stepping stones" to reach the outcome. The purpose of an implementation strategy is to help the team to define what it takes (teaching, action from others, etc.), to make the outcome a reality.

Implementation Strategies:
The provider responsible for providing the service(s) used to help the individual achieve his/her personal outcome(s) and related goals develops the Implementation Strategies. See Appendix B for information on Implementation Strategies.

ISP REQUIREMENTS: PERSONAL OUTCOMES AND GOALS	
Regardless of whether an individual has funded supports or support coordination only, at least one Personal Outcome must be identified.	Mandatory
List the Specific Personal Outcome and related Goals.	Mandatory
Information that is important to know about the Personal Outcome: ☐ Current situation, things that have been tried or the individual may like to try**,** why the Outcome is important to the individual (and family). ☐ What the outcome means specifically to the individual, in his/her words if possible. The Outcome is written in "…*plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter."* 42 CFR 441.301(c)(1)(iv)(2014) pp.3030	Mandatory
Timelines, frequency and duration regarding completion of Personal Outcome and related goals.	Mandatory
What Personal Strengths and Assets (skills, abilities, knowledge, attributes, passions, hobbies, etc.) does the individual have in relation to the Personal Outcome and related goals? (May be identified within other sections of the ISP)	Mandatory
What technology (computer, tablet, apps, smart phone, watch, alarm clock, etc.) can be used to achieve the Personal Outcome and related goals? (May be identified within other sections of the ISP)	Mandatory
What relationships (friends, family, connections at places of interest etc.) does the individual have, which can help achieve the Personal Outcome and related goals? (May be identified within other sections of the ISP)	Mandatory
What community resources (clubs, community associations, gyms, library, animal shelter, etc.) can be used to achieve the Personal Outcome and related goals? (May be identified within other sections of the ISP)	Mandatory
Which provider is responsible for writing the Implementation Strategies? (May be identified within other sections of the ISP)	Mandatory

PART V: BUDGET / AUTHORIZATION PAGE

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

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

ISP REQUIREMENTS: The Budget Shall Outline the Following Information	
Time span of service(s)	Mandatory
Name of each service	Mandatory
Name of each service provider	Mandatory
Number of units to be provided in the time span indicated for each service	Mandatory
Service rate per unit for each service	Mandatory
Total cost per time span of each service	Mandatory
Total budget cost for all combined services	Mandatory

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

PART VI: MONITORING OF ISP

ISP REQUIREMENTS: MONITORING OF ISP	
"Identify the individual and/or entity responsible for monitoring the plan." 42 CFR 441.301(c)(2)(viii)(2014) pp. 3030	Mandatory

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

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

"Review of the Person-Centered Service Plan. The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required by § 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual." 42 CFR 441.301(c)(3)(2014) pp. 3030

The planning process "Includes a method for the individual to request updates to the plan as needed." 42 CFR 441.301(c)(1)(viii)(2014) pp. 3030

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

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

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

The ISP process should be fluid. The ISP should change as the individual's life changes to include any transition. This fluidity and the impact of transitions shall be reflected in the support plan. Any member of the planning team may request a review of the Individual Support Plan.
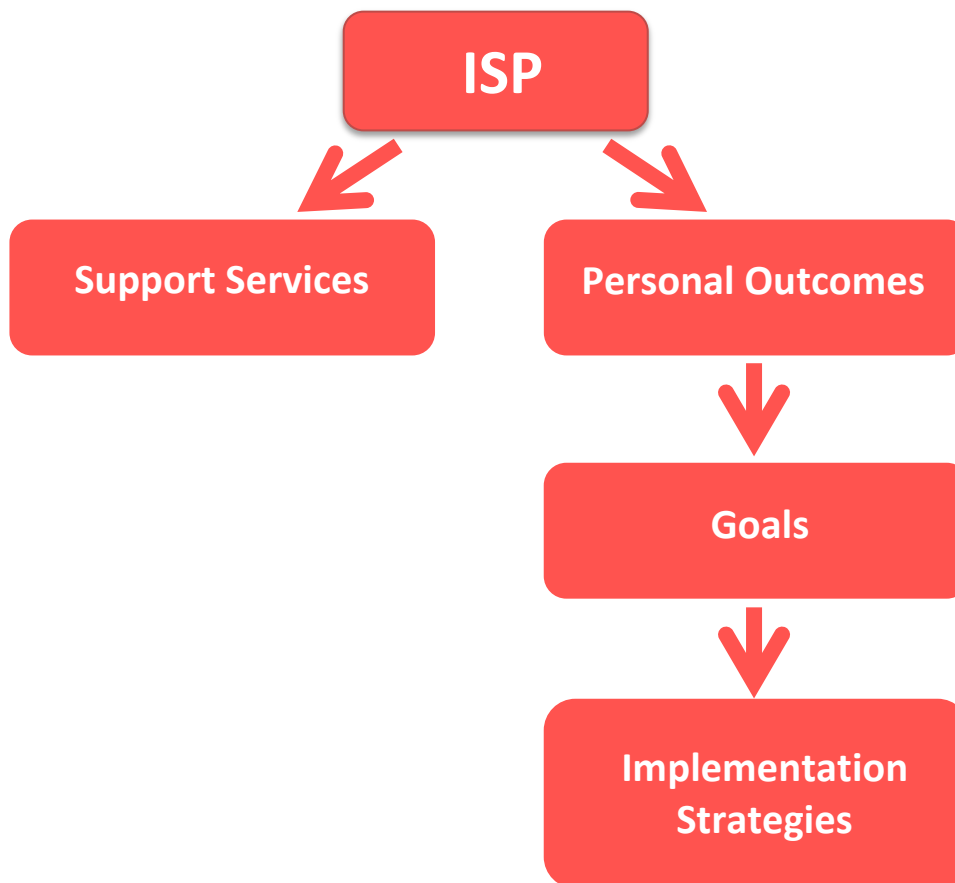
APPENDIX A: ADDITIONAL REFERENCES / RESOURCES

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

APPENDIX B: IMPLEMENTATION STRATEGIES FRAMEWORK

The implementation strategies are teaching methods used to help the person achieve his/her Personal Outcomes, and goals. The Implementation Strategies are developed by the agency responsible for providing the service(s). The Implementation Strategies are part of the provider's documentation to ensure Personal Outcomes and goals are achieved, and are a dynamic document which can be changed throughout the plan year without changing the ISP.

The following are the components of the ISP implementation framework:

```
                        ┌─────────────┐
                        │     ISP     │
                        └─────────────┘
                       ↙               ↘
        ┌──────────────────┐    ┌──────────────────┐
        │ Support Services │    │ Personal Outcomes│
        └──────────────────┘    └──────────────────┘
                                          ↓
                                ┌──────────────────┐
                                │      Goals       │
                                └──────────────────┘
                                          ↓
                                ┌──────────────────┐
                                │  Implementation  │
                                │    Strategies    │
                                └──────────────────┘
```

Personal Outcomes:
The ISP must "Include individually identified goals and desired outcomes." 42 CFR 441.301(c)(2)(iv)(2014) pp. 3030 Personal outcomes are what drive a person's ISP which are the things the individual is interested in trying, learning, doing, or achieving in the next year. Personal Outcomes must relate to what is important to the individual—personal outcomes are not simply support needs, although he/she may contain components of supports a person needs in specific areas or with specific tasks. The Support Coordinator facilitates the development of Personal Outcomes and Goals with the person and others in the person's life if applicable (e.g. guardians, providers, family, friends, and others the person may wish to involve). Changes to a personal outcome require updating the ISP.

Personal Outcomes Shall Focus On
- The individual's long-term or "big picture" desired outcomes
- The current situation or "baseline"

Goals:

Goals describe the actions to be taken towards achieving the Personal Outcome, and are developed as a part of the person-centered planning process. Each Goal has Implementation Strategies in place to provide step by step actions and instruction for the people responsible for implementing the Goal.

Each Personal Outcome may have multiple Goals, each goal has one measure of success. Measures of success are defined by the individual and are specifically identified. Each Goal identifies who is responsible for implementation and the timeline. Some Goals build upon each other and are not all necessarily implemented at the same time. Progress and changes to the Goals are noted on the monthly progress documentation and do not require the ISP to be updated, unless the Personal Outcome has changed.

Goals Shall Focus On
- o Actions taken, or stepping stones, to reach the broader Personal Outcome(s)
- o Specific measures of success or progress
- o Specific time frames for evaluation

Implementation Strategies:

Implementation Strategies are teaching methods and action steps specifically identifying how the individual will be supported to achieve each Goal. Implementation Strategies are updated based on the individual's preferences and progress.

Providers responsible for writing implementation strategies are identified in the ISP.

Strategies Shall Focus On
- Engagement of the individual
- How the individual learns best (if teaching is involved)
- Teaching instructions
- Defines what it takes to reach the goal and measure progress

This is the information needed to understand the individual's expectations, family / team expectations, staff / agency expectations, etc., to implement each action.

Support needs vs. Personal Outcome development: The things that are _working and need to be maintained_ should be addressed in the support section of the ISP - *What we need to know or do to support the person.*

IMPLEMENTATION STRATEGIES FRAMEWORK MUST INCLUDE	
List the Personal Outcomes and Related Goals	Mandatory
Implementation Strategies (These Implementation Strategies are developed by the agency responsible for providing the service(s). • Individual teaching activities and necessary tools/supplies/technology. • Process used to facilitate learning based on an individuals' learning style and support needs. • Responsible party • Specific, individualized, measurable *stepping stones* necessary for the individual to achieve his/her Personal Outcome, to get from point A to point B**.** • States the timelines / target dates for completion. • This helps the team to determine if progress is occurring, what needs to continue to occur, if more time is needed to achieve the action taken, if the means of measuring progress is working or not working and if the timeline makes sense.	Mandatory

APPENDIX C: REFERENCES / AUTHORITY

HOUSING ISP REQUIREMENTS

Authority and Other References

The setting…"*Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact."* —42 CFR 441.301(c)(4)(iv) pp. 3030

"The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board." —42 CFR. 441.301(c)(4)(ii) pp.3030

"The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS." —42 CFR. 441.301(c)(4)(i) pp. 3030

The setting *"Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint."* —42 CFR 441.301(c)(4)(iii) pp. 3030
Support Coordinator Manual Section: Community Living: Housing
http://dmh.mo.gov/docs/dd/scmanual/scmanualhousingsection.docx

COMMUNITY TRANSITION, Transitioning from Habilitation Center to Community Living Setting

Authority and Other References

Community Transition Manual
DD Waiver Manual- Section F
Support Coordinator Manual Section I: Community Living
Division webpage:
http://dmh.mo.gov/dd/olmstead/
http://dmh.mo.gov/dd/communitytransitionprocess.html
http://dmh.mo.gov/dd/progs/mfp.html

Community Membership ISP Requirements

Authority and Other References

"Home and community-based settings must have all of the following qualities, and such other qualities as the [planning team] determines to be appropriate, based on the needs of the individual as indicated in his/her person-centered service plan: The setting is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS."
—42 CFR 441.301(c)(4) and (c)(4)(i) pp. 3030
Support Coordinator Manual Section : Community Membership

ISP Requirements, Additional Requirements for Recipients of Comprehensive Waiver Residential

Authority and Other References

Division Directive 3.090: Health Identification and Planning System (HIPS) Process
Directive 3.060: Community RN (IF MODIFIED)
*Add waiver resource

ISP Requirements

Authority and Other References

Division webpage http://dmh.mo.gov/docs/dd/riskguide.pdf

ISP REQUIREMENTS, Supports

Authority and Other References

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

INDIVIDUALS WHO HAVE MODIFICATION (RESTRICTIONS) TO RIGHTS

Authority and Other References

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

PERSONAL INCOME ISP REQUIREMENTS

Authority and Other References

SELF-DIRECTED SUPPORTS ISP REQUIREMENTS

Authority and Other References

The ISP "Include those services, the purpose or control of which the individual elects to self-direct." 42 CFR 441.301(c)(2)(xi) pp.3030
DD Waiver Manual- Section D
Support Coordinator Manual Self-Directed Supports
SDS Division webpage http://dmh.mo.gov/dd/progs/selfdirect.html

ISP Requirements

Authority and Other References

42 CFR 441.301(c)(1)(vii) pp. 3030
Technical Assistance Manual for Regional Offices, County Senate Bill 40 Boards, and Other Not-for-Profit Agencies

APPENDIX D: EXPLORATORY QUESTIONS

Individual Support Plan (ISP) Exploratory Questions

MISSOURI DIVISION OF DEVELOPMENTAL DISABILITIES

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

www.dmh.mo.gov/dd   MISSOURI DEPARTMENT OF MENTAL HEALTH

Individual Support Plan (ISP) Exploratory Questions are designed to assist in discovering supports or personal outcomes' during the assessment process as part of creating an ISP.

☀ DAILY LIFE AND EMPLOYMENT
Questions for All Individuals School Age Through Adulthood
Are you provided the opportunity to complete tasks/chores on your own to promote higher levels of independence?
Have you had the opportunity to observe and explore careers and community activities?
Do you know that you can have earned income from employment and still receive supports you need?
Do you need support with making choices with becoming an active member of your community for both employment and non-work activities?
Do you know the employers and types of jobs available in your community?
Do you know the activities, organizations and leisure programs available in your community?
Do you need support with getting to and from non-work and work activities in your community?
Do you feel comfortable in accessing your community?
If you are over the age of 16, do you need support with completing applications, resumes, job interviews and/or contacting potential employers?
Is where you spend your day integrated in and supports full access to the greater community and engagement in community life**?**
Do you work, or spend your day with people who do not have disabilities?
Do you spend your day doing activities similar to others your age?
Do you want to learn a new skill to stay busy or earn money in retirement?
Am I learning about changes in my body as I age?
Do I need support to learn about end of life planning, benefits, or health care?
Questions for Individuals Currently Employed
Is the career planning/employment activity you currently participate in your choice; and reflect your preference and abilities?
Do you work at a community-based business?
Do you have co-workers without disabilities that do the same, or similar, work as you? Are these co-workers paid similar wages as you?
If the work site is in a segregated setting
What current barriers exist to community employment? What supports do you need to assist you in obtaining employment in a competitive and integrated setting?
For Individuals Reaching Retirement Age
Do you want to learn a new skill to keep me busy or earn money in retirement?
Are there classes nearby that I am interested in attending?
Am I learning about changes in my body as I age?
Do I need support to learn about end of life planning, benefits, or health care?

COMMUNITY LIVING - CHOICE HOUSING
Did you choose to live in this home?
Do you want to continue to live here?
Did you choose your current housemates?
Do you enjoy living with your housemates and do you get along with them?
Do you share your bedroom with someone? If so did you choose to share your room with him or her?
Is there anyone you would prefer to live with in the future? If so who?
Is there anywhere else you would prefer to live in the future? If so where?
Do you have space for privacy?
Can move around freely in your home?
Are there any home modifications needed that would enhance your quality of life or your ability to be independent?
Is it easy for you to get to work from home?
Is your home located among other private homes and businesses so it is easier for you to do things in your community?
Do you have friends who live close by?
Do you decide who can and cannot come into your home?
Do you decide what activities you do in your home and your daily schedule?
If You Don't Live in Your own home or a Home with Family
Do you have a lease or written residency agreement?
If so does it provide protections to address eviction processes?
Do you know your rights and responsibilities regarding housing and when you could be required to relocate?
Do you know how to request new housing?
Do you know how much you pay for rent and utilities?
Do you know about resources which can help pay for part of a person's rent or utilities?

SOCIAL AND SPIRITUALITY - PERSONAL RELATIONSHIPS
Do you have friends (not paid supports) who you can spend time with?
Do you need help to contact your friends/family on a regular basis?
Do you interact well with others by being a good listener and expressing yourself?
Do you have friends who will share decision-making about what you both talk about and do together?
What kind of relationships do you have or want in your life?
Do you know where/how you can find someone to date?
Do you want to get married or have children?
Do you have ways to express your sexuality and choices regarding love and intimacy?
Can you differentiate appropriate relationship behaviors as with family, co-workers, intimate partners (how we talk and touch others)?
Are you able to make appropriate decisions concerning marriage and intimate relationships?
Do you understand consent and permission with regard to sexual contact?

HEALTHY LIVING

Do you have a primary care Physician?
Do you see any specialist and if so for what reason?
Do you see a counselor or psychiatrist?
Do your doctors help you understand issues with your health?
Do you need speech, physical for therapy services?
Do you need help getting any of these services?
How do you let people know that you are not feeling well?
Do you have a medical problem which requires regular monitoring?
Do you need assistance with eating or drinking?
Is your nutrition and exercise adequate for good health?
What do you do to stay healthy?
Do you need help to take your medications?
Do you need help to order or refill prescriptions?
Do you need help to notify people when your medication changes?
Do you need any medical or adaptive equipment?
Do you have any allergies?
Do need or want help with making choices about your health?
Does anyone help you take care of your health? (Who? What? Paid? Unpaid?
Can you make and communicate decision regarding medical treatment, including understanding the consequences of not accepting treatment?
Do you understand health consequences associated with high risk behaviors (substance abuse, overeating, high-risk sexual activities, etc.)?

SAFETY & SECURITY

Do you avoid common environmental dangers (traffic, sharp objects, hot stove, and poisonous products)?
Are you able to recognize when someone is taking advantage of you or abusing you (physical, sexual, emotional) and protect yourself?
Do you know who to contact if you are in danger, being exploited or being treated unfairly?
Do you need supports due to refusal for services to maintain their health and safety?
Do you need support in developing and implementing an emergency plan to safely manage emergency situations?
Do you need support in evacuating your home, taking shelter in the event of a major emergency or practice safety drills?
Do you need support in managing /utilizing safety devices in the home? (changing batteries in smoke detectors, CO indictors, flashlights, radio for energies, visual fire alarms)
Do you need support in contacting emergency services?
Do you need support to safely regulate water temperature?
Support to effectively manage strangers who visit home?
Support to carry and use personal identification?
Support to ask assistance such as directions to destinations?
Support to provide medical information to first responders?

BEHAVIORAL RISK AND PREVENTION

Have you engaged in behavior that is injurious to yourself?
Have you had incident of physical or verbal aggression towards others?
Have you had inappropriate behavioral of sexual nature?
Have you had behavioral expression resulting in property damage?
Have you had elopement where absences raised reasonable concern for your safety?
Have you participated activities that were illegal?
Have you been hospitalized or sought hospitalization for behaviors that put yourself or others in danger?
Are you prescribed behavioral control or psychotropic medications?
Have you lost services (day services, employment, residential) because of behavioral problems?

INDIVIDUAL RIGHTS
Do you understand your rights and responsibilities?
Can you communicate for yourself?
Do you understand the process to making an official complaint?
Are you able to understand and communicate consent and/or permissions regarding legal documents?
Are you registered to vote?
Are your rights restricted?
Do you understand your education and employment rights?

CITIZENSHIP & ADVOCACY - PERSONAL INCOME	
Income Sources:	□ Government Benefits □ Wages; □ Trust Fund □ Other
Other Sources:	□ Food Stamps □ Home Energy Assistance Program (HEAP) □ Housing Assistance (HUD, Metro, etc) □ Medicaid □ Medicare □ Insurance □ Checking Account □ Savings Account □ Other

Do you need support in protecting yourself from financial exploitation (e.g. credit card offers, solicitors)?
Do you need help maintaining or obtaining benefits? Do you need help setting up automated payments?
Does the individual have a Medicaid spend down?
Do you need help with banking?
Do you need help managing your money?
Do you want to be more involved in: □ Paying your bills □ Budgeting your money? □ Banking? □ Saving money?
Do you need additional supports when caring and/or spending money for purchases?
Do you have any needs for shelter or food that are not met by your resources?
Do you have other financial needs that have not been met?
Do you have outstanding debt?
Is there anything that you want to save money for?
Would you like supplemental insurance?
Do you have burial arrangements?
Do you need or want help making choices about your money and benefits?
Does anyone help you with your money or benefits: Who? What? Paid? Unpaid?

CHOICE
Are you knowledgeable of other providers who provide the services you receive?
Do you know how and to who make a request for a new provider of services?
What supports do you need to assist you in making choices that allow you to feel empowered to make decisions?
Do you like who supports you? If not, do you know how to request a change?