

**Commonwealth of Pennsylvania
Department of Public Welfare
Office of Developmental Programs**

**Individual Support Plan (ISP)
Manual**

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Section 1: ISP Process

The ISP is developed by the individual and his or her team and is facilitated by the SC, who then creates the ISP document in HCSIS. The SC develops the ISP based on information provided by the individual, family, and the team, including recommended services and supports to address the individual's current assessed needs. Needs for waiver participants must be identified using the ODP statewide needs assessment, Supports Intensity Scale (SIS)[™] and PA Plus, as per the rollout strategy established by ODP. The team consists of:

- The individual.
- The individual's family, guardian, surrogate, or advocate.
- The SC.
- Providers of service.
- School district employees who work with children who are near graduation.
- Other people who are important in the individual's life and who the individual chooses to include such as the surrogate performing the role of common law employee or managing employer.

For licensed services the ISP will be the first source of review to determine compliance with planning and assessment standards. Qualified providers of services must participate in the assessment and planning process, including participation in ISP team meetings, and provide necessary information to the SC for incorporation into the ISP. Qualified providers should maintain documentation of the submission of ISP information to the SC. Qualified providers are not required to develop their own separate ISPs, if the individual has a SC. Individuals that are private pay or funded by another state may not have an SC.

Qualified providers are responsible for completing assessments and evaluations related to the individual and progress notes that ensure service delivery is occurring at the quality, type, frequency, and duration stated in the ISP outcomes and consistent with applicable regulations and policies.

Anyone who has been found eligible for mental retardation services and is receiving at least one Pennsylvania ODP-funded service must have an ISP completed and entered in HCSIS:

- Abbreviated ISPs may be completed for an individual receiving non-waiver services that cost less than \$2,000 in a Fiscal Year (FY); however a full ISP is encouraged. An example of an abbreviated ISP is a Family Supports Services (FSS) (Family Driven) or Life Management Plan. When completing an abbreviated ISP, the following minimum screens must be completed:
 - Individual Preferences.
 - Outcome Summary.
 - Outcome Actions.
 - Services and Supports Directory (Provider, Vendor, Financial Management Services agent, or any applicable combination).
 - Service Details (only for individuals who have a funded service).

- Although the cost of Targeted Service Management (TSM) and Base-funded Case Management services will not be included in the \$2,000 limit listed in the previous bullet, ODP recommends that individuals, SCs and teams include in the ISP the specific actions the SC will perform in support of the person's outcomes and priorities.

An ISP must be completed, but not entered in HCSIS, for any individual who attends a facility licensed under 55 PA Code Chapters 2380, 2390, 6400, and 6500, but does not have an SC. These specific ISPs will be monitored during ODP's licensing inspection.

Section 2: ISP Process Supporting Information

2.1: SIS™ and PA Plus

The SIS™ is the statewide needs assessment chosen by ODP to assess the needs of Waiver participants. The SIS™ is an assessment tool that focuses on the services desired and needed by the individual. The statewide needs assessment complements the ISP process as it addresses what is important both to and for the individual.

The PA Plus is an assessment tool that was developed by ODP with stakeholders in Pennsylvania to be administered concurrently with the SIS™. The PA Plus is designed to support the ISP process and better meet individual's needs by providing the team with additional information necessary for ISP development.

The SIS™ and PA Plus are administered together by an independent contractor, and the results are available to SCs in HCSIS in the form of the PA Universal Summary Report. This report includes all the information gathered during the assessment process, and it is a valuable document that should be reviewed by the team at each ISP meeting. Needs for Waiver participants must be identified using the ODP statewide needs assessment, the SIS™ and PA Plus. The ISP Signature Sheet includes space to indicate whether the SIS™ and PA Plus assessments were reviewed and used to create and/or update the ISP. When a SIS™ and PA Plus assessment have been completed, this information should be entered in the Non-Medical Evaluation section of the ISP.

Please refer to Bulletin 00-08-11, *Supports Intensity Scale and PA Plus Users Manual*, or any approved revisions, for additional information on the SIS™ and PA Plus process.

2.2: Prioritization of Urgency of Need for Services (PUNS)

PUNS is the current process for categorizing an individual's urgency for services. PUNS focuses on the existing services and supports received by the individual, the categories of services requested, and the urgency of need for requested services. This information is used by AEs, Supports Coordination Organizations (SCOs), and ODP to prioritize waiting lists. The following are the PUNS categories of need:

- Emergency Need - Indicates a need for services within the next six months.
- Critical Need - Indicates a need for services greater than six months but less than two years in the future.

- Planning Need - Indicates a need for services greater than two years but less than five years in the future.

The PUNS should be reviewed at every ISP meeting and updated as necessary based on changes in the individual's needs. The team determines if the individual will have any anticipated unmet needs in the next five years, and also identifies any natural supports that might help address these unmet needs. Individuals enrolled in the Consolidated Waiver are entitled to have assessed needs addressed, through the use of non-Waiver services and supports and through the Waiver within the allowable service limits identified in the Waiver. If an individual has unaddressed needs, the SC must complete or update the PUNS to reflect current needs of the individual as per the current ODP bulletin , *Prioritization of Urgency of Need for Services (PUNS) Manual*, or any approved revisions. The PUNS must be completed and/or updated with the individual or family at every annual review update meeting. It is recommended that anyone in the emergency status in PUNS should have a full ISP, not an abbreviated ISP.

2.3: Independent Monitoring for Quality (IM4Q)

IM4Q is the method that Pennsylvania has adopted to independently review the quality of services individuals statewide receive in the mental retardation services system. Focusing on individual satisfaction and outcomes, IM4Q is one of the few statewide programs of this kind in the country, pioneering community participation in the quality improvement process. Community participation is promoted by having individuals with disabilities, family, and interested citizens as part of each IM4Q survey team. Such participation also helps to ensure the independence of the IM4Q survey process since team members are not affiliated with any services that the individual receives.

Independent monitoring is one of a number of monitoring components within the mental retardation service system. IM4Q also helps to:

- Provide a more comprehensive view of quality by engaging individuals with disabilities, families and citizens as stakeholders in the lives of people in their community.
- Strengthen the advocacy base for individuals with disabilities in the community.
- Reinforce for the community what human service professionals already know about the individual, or raise issues that the community would want to know.
- Offer an additional safeguard for the health and well-being of individuals receiving services.

When an individual receiving services participates in an IM4Q interview, the individual may elect whether or not to share the information divulged with the appropriate AE or SCO. If the individual chooses not to share the information, the survey data is entered into HCSIS for its aggregate value only. If the individual chooses to share the information with the AE, then the IM4Q program forwards any considerations or issues to the AE, which then forwards the report to the SCO. Actions to address considerations are developed with the individual and his or her team. SCOs and provider agencies are involved to the extent necessary to address service and outcome-related issues and concerns. Considerations are linked to the ISP process when there is a change in services stemming from the IM4Q consideration, or when the individual or family wants

the ISP team to be involved in decisions related to a consideration. Considerations and the actions that address them should be documented in a service note in HCSIS. Not all considerations need to be included in the ISP.

2.4: Lifesharing/Family Living

The SC is expected to discuss Lifesharing options with individuals and their families as part of the ISP process and/or before a new residential service is authorized. This discussion is expected to occur when an individual and family begin to consider the need to locate a new home for the individual and when an individual who is living in another type of residential service location (such as an Intermediate Care Facility for persons with Mental Retardation (ICF/MR) or community home) may be interested in considering Lifesharing options. This discussion is expected to include:

- A description of Lifesharing.
- A description of how health, welfare, and positive community outcomes are structured into Lifesharing settings through program support and supervision, home studies, training of Lifesharers, and monitoring by SCs, IM4Q, and licensing.
- A review of the availability of Lifesharing providers in and around the geographical area.
- A review of the benefits of Lifesharing including longevity of relationship, permanency, and social integration.
- An opportunity to address the individual's/family's questions/concerns.
- An opportunity for the individual and family to discuss Lifesharing with practitioners, including provider agency representatives and Lifesharers, as well as family members of individuals in Lifesharing arrangements.

Please note that when the SC answers the Lifesharing indicator in an individual's ISP "yes", "no", or "N/A", the SC shall include an explanation for the answer chosen in the annual update meeting service note.

2.5: Employment

ODP expects AEs to institute standard practices to promote employment through the ISP. The AE shall have these practices in place for individuals ages 16-25, and for all individuals attending a facility licensed under 55 Pa.Code Chapter 2390 who are interested in obtaining employment in the community. An individual who does not fall into one of these groups should still have access to employment supports, and should discuss it with their SC. AEs shall ensure that individuals are:

- Advised about the availability of employment services.
- Given the opportunity to choose employment services.
- Given the opportunity to meet with employment providers and people who have jobs if they so choose.

The SC should discuss employment and the availability of employment supports and services at every annual review update meeting. The employment supplement should also be done annually or as needs change and used to determine if an Office of Vocational Rehabilitation

(OVR) referral is warranted and what type of employment services might be warranted. The SC shall document all discussions regarding employment in a service note in HCSIS. The Functional Level Employment Screen should be completed for any individual age 16-25, any individual with vocational services and/or outcomes regardless of their age and setting, and any individual leaving a State Center. The Employment Screen in the ISP should be filled out for all individuals who have employment services (job finding, job support, transitional work).

Achieving employment and community inclusive outcomes are cornerstones of ODP policies, principles and practices. Achieving these outcomes requires individuals to be engaged with community resources on an ongoing and consistent basis. Employment practices must ensure that individuals receive information about feasible employment opportunities and services and that prevocational, vocational, adult training and supported employment services promote an employment outcome.

2.6 Positive Practices Resource Team (PPRT)

The PPRT is a joint initiative between ODP and the Office of Mental Health and Substance Abuse Services (OMHSAS) to serve those individuals with a developmental disability who are demonstrating at-risk behavioral challenges and who the team determines may be needing enhanced levels of support not readily known or available to them. The goals of this initiative are two-fold:

- To build capacity within the provider network in Pennsylvania to serve individuals who are dually diagnosed with mental retardation and mental health.
- To encourage State Hospital and State Center diversion through providing consultative services that assist the provider in continuing to serve the individual in their home and the community.

Section 3: ISP Preparation

Developing an individual's ISP is based on the philosophies and concepts of *Everyday Lives*, Self-Determination, Person-Centered Planning and Positive Approaches that capture the true meaning of working together to empower the individual to dream, plan and create a shared commitment for his or her future.

The SC should encourage individual, family and team participation in the ISP process. The individual and his or her family or surrogate, determines who should be present and involved in the development of the ISP and determines the date and location of the ISP team meeting. It is important to include people who know the individual best and who will offer detailed information about the individual and his or her needs. Information gathered should include topics such as what, if anything has changed in the individual's life (such as health status, incidents, relationships, and/or external monitoring findings). Discussions should also occur to determine whether progress is being made concerning current outcomes.

Once the ISP meeting details are confirmed, the SC develops the ISP meeting invitation letter and sends the invitations to the team members. Team members shall be given 30 calendar days advance notice to attend the ISP meeting. A copy of the invitation letter shall be maintained in the individual's file at the SCO. Please note, the invitation letter should identify all team members who were invited to participate in the ISP meeting or a separate letter for each team member must be maintained in the individual's file.

Preparation for the ISP meeting involves information gathering. Information gathering should begin within 90 calendar days prior to the Annual Review Update date and include:

- Involvement of people who know the individual best and can offer rich and detailed information about the individual and his/her needs.
- Identification, coordination, and collection of new and/or updated information from team members and/or other professionals by the SC in the following areas:
 - Communication
 - Personal preferences (interests and hobbies).
 - Personality traits.
 - Interactions with others.
 - Relationships that impact the individual's quality of life.
 - Learning styles.
 - Physical development.
 - Educational background.
 - Employment preferences/experiences.
 - Social/emotional information.
 - Interest in Lifesharing.
 - Medical information.
 - Environmental influences.
 - Evaluation of risk (incident histories).
 - IM4Q considerations and other external monitoring, if relevant.
 - Formal and informal assessments, including ODP's statewide needs assessment.
 - Financial information.
 - If a Lifetime Medical History.

Section 4: Questions to Facilitate the ISP Meeting and ISP Development

In addition to the information in the Annotated ISP, (which is located in the Learning Management System (LMS) and the following questions may help to generate information that ensures the individual and team have considered significant aspects of the individual's everyday life. It should be noted that not all areas are applicable to every individual and therefore not all areas need to be discussed during the ISP meeting. If there is an area of an individual's life that clearly stands out as an area that the individual desires to have change, this area should also be included in the information gathering process as well as developed into outcomes.

- Choice and Decision Making: Is there evidence or information in the ISP that answers the following questions regarding how the individual is being supported to make choices and assume control/responsibility for his/her life?
 - ❖ Day to Day Choices:
 - What type of decisions does the individual make on a daily basis?
 - How can this person exercise choice and control everyday?
 - Does the individual understand the concepts of cause and effect and responsibility for results of decisions he or she may make?
 - ❖ Decisions about Personal Information:
 - Are there personal or private pieces of information concerning the individual that are shared with others outside of the individual's home?
 - Who is this information shared with?
 - Is the individual aware that the information might be shared with others?
 - Can this individual make the decision around who should have access to his or her personal information?
 - Is there someone else (family member or surrogate) who should be involved in this type of decision?
 - ❖ Decisions about Relationships:
 - Who makes decisions around who the individual spends time with?
 - Who makes decisions around who this individual's friends are?
 - Who makes decisions around intimate relationships?
 - Did this individual select his or her SCO?
 - Did this individual choose the agency and the personnel who provide services to him or her?
 - What level of choice is important to the individual?
- Communication: Is there evidence or information in this section of the ISP that answers the following questions?

- How does the individual make his or her needs known, both in expressive and receptive communication?
 - Does his or her communication style vary? If so, how and under what circumstances?
 - How does the individual prefer to communicate?
 - Are there additional communication methods or strategies that the individual would like to learn or that the team feels might be helpful to explore?
 - Are there any barriers to accessing these additional methods or strategies?
 - Can the people who the individual knows and relates to (at home, work, school and the community) understand how the person communicates?
 - Are the SC and team aware of communication resources to ensure that all persons can communicate effectively with the individual and all communication barriers are addressed?
- Relationships, Family and Friends: Is there evidence or information in the ISP that answers the following questions?
 - ❖ Family:
 - What is the individual's current relationship with his or her family members?
 - Is he or she satisfied with the current relationship with family members?
 - How would the individual like to see his or her relationship with family member's progress?
 - Who in his or her family is particularly important to him or her?
 - How can and does contact with the individual's family occur?
 - ❖ Friends:
 - What is the individual's current relationship with his or her friends?
 - Is he or she satisfied with those relationships with friends?
 - How often, and where, does he or she see friends?
 - Does the individual have contact with friends outside of day programs or employment?
 - What can be done to support the individual to build relationships?
 - ❖ Housemates:
 - Has the individual chosen his or her housemates?
 - Does the individual like his or her housemates?
 - Does the individual have any problems with his or her housemates?
 - What are the characteristics of people who the individual gets along with best?
 - What are the common characteristics of people who the individual does not get along with well?
 - Are there common rituals or routines that are critical in the individual's relationships?

- ❖ Intimate Relationships:
 - Does the individual have an intimate relationship with another person?
 - Does the individual want an intimate relationship?
 - What can the team do to support the individual's interests in this area?
 - Were health and welfare concerns, such as birth control, discussed?

- Work and Education: Is there evidence or information in the ISP that answers the following questions?
 - ❖ Formal Education:
 - Is the family or team, as applicable, satisfied with the Individual Education Plan (IEP)? How it is written and how it is implemented?
 - Are the IEP and ISP interrelated?
 - Do the IEP and ISP coincide?
 - Will the student transition in the near future?

 - ❖ Paid Work:
 - Has the individual expressed an interest in earning money? (Or more money, if already employed?)
 - Has the individual worked in the past?
 - Is the individual working now? If yes, is he or she satisfied with his or her job?
 - Does the individual have the skills needed to do the work in which he or she is interested?
 - What gifts and talents does the individual have?
 - Where could he or she be paid for those gifts and talents?
 - Was an employment supplement completed for the individual, if the individual is between the ages of 16-26?
 - Are there barriers to access employment options?
 - What are the areas of support the individual needs to participate in paid work?

 - ❖ Volunteer Work:
 - Has the individual expressed an interest in volunteering to help a particular organization?
 - Has the individual ever volunteered in some way in the past?
 - Are there particular gifts and talents this individual has that could be helpful in a volunteer opportunity?
 - Are there barriers for accessing volunteer work?
 - What are the areas of support an individual would need to participate in volunteer work?

- ❖ Continuing Education or Learning:
 - Is there a topic of interest this individual would like to learn more about?
 - Are there areas of the individual's life that he or she would like to learn more about in order to increase his or her control over that part of life (such as learning about budgeting to have more control regarding how he spends his personal funds)?

- Community Participation and Contributions: Is there evidence or information in the ISP that answers the following questions?
 - ❖ Community Activities, Events and Opportunities for Contributions:
 - What are the individual's gifts and talents?
 - Is there a place in the community these gifts and talents would be appreciated?
 - Are there regular community activities that need participants?
 - Are there annual community activities that need participants?
 - What events does the community sponsor – walks, festivals, parades, fund raising, street fairs, park concerts, etc.?
 - How can the individual contribute to his or her community? Regular activities? Occasional activities?

 - ❖ Religious or Spiritual Belonging:
 - Does the individual have a religious preference?
 - Does he or she have the opportunity to express it?
 - Has the individual attended a church/religious organization in the past?
 - Does he or she have the opportunity to try any religious membership?
 - What resources would the individual need to be able to establish and maintain a religious membership?
 - What resources exist in the community that may offer spiritual enrichment?

 - ❖ Hobbies, Clubs or Organizations:
 - What is the individual interested in?
 - Is there an organized club or community association related to that interest?
 - What interests has the individual tried in the past?
 - Was there a particular interest from the past that has been stopped? Could it start again?
 - What are the areas of support the individual would need to participate?

- Self Image and Self Esteem: Is there evidence or information in the ISP that answers the following questions?
 - Are there people in the individual's life who make him or her feel valued or important?

- Does the individual feel that he or she plays an important role in someone's life?
 - What activities does the individual participate in that make him or her feel important or valued?
 - If the individual stopped participating in a regular activity outside of home, a day program or employment, would he or she be missed by others who also participate in or are affected by that activity?
- Safety, Health and Individual Rights: Is there evidence or information in the ISP that answers the following questions?
 - ❖ Safe at home, safe at work, safe at school, in the community:
 - What areas related to safety does someone who supports this individual need to know?
 - How will they know?
 - What do they need to do to make sure safety is assured?
 - What are the individual's feelings related to safety?
 - Does he or she feel safe at home, in the neighborhood, at work or school?
 - Is the individual able to make decisions about acceptable levels of risk in his or her own life?
 - What emergency response plans exist for the individual?
 - Has all information regarding incident and injuries to guide the team in addressing proactive planning to avoid similar occurrences been gathered?
 - ❖ Health Promotion:
 - Are all medical issues being addressed?
 - Does the individual have a primary physician?
 - Are there health treatment practices, protocols, and issues that are undesirable to the individual?
 - Are there ways to make the undesirable treatment more desirable?
 - Are there issues of health that are out of the context of what is important to the individual?
 - How can the issues of health be addressed within the context?
 - Are there issues of health that could have long-term effects?
 - What quality of life questions exist related to medical care or treatment?
 - ❖ Individual Rights:
 - Is the individual aware of his or her right to privacy?
 - Does he or she have access to privacy when desired?
 - Is the individual treated with dignity and respect?
 - Do people listen to the individual?
 - Is the individual aware of his or her civil rights?
 - Have steps been taken to ensure the individual's rights related to services, due process, grievances, and the like?

- Relaxing and Having Fun: Is there evidence or information in the ISP that answers the following questions?
 - What types of things does the individual do during his or her free time?
 - Does the individual need to be encouraged to take advantage of his or her free time?
 - What types of things does the individual do for fun?
 - What opportunities have been provided to the individual to allow him or her to explore new options for relaxing and having fun?
 - What type of things would the individual like to do for fun, but is not currently participating in to the extent that he or she would like?
 - What resources or services would the individual need to participate or to participate more than he or she is able to at the present time?

- Home Life and Housing: Is there evidence or information in the ISP that answers the following questions?
 - Who decided where the individual would live?
 - Who decided with whom the individual would live?
 - What does the individual like about his or her current living situation?
 - What does the individual dislike about his or her current living situation?
 - Did the individual have a say in how he or she is living?

- Satisfaction with Services: Is there evidence or information in the ISP that answers the following questions?
 - ❖ Satisfaction with services during the day and with services provided at home:
 - Did the individual participate in choosing the services he or she receives during the day?
 - What options was the individual given in choosing his or her day services?
 - Is the individual able to communicate the type of day service he or she would like to receive during the day?
 - How was information obtained about the individual's preference for day services?

 - ❖ Satisfaction with Supports Coordination:
 - How does the individual feel about the service provided by the SC, in terms of accessibility, responsiveness to needs, and promptness of addressing requests and issues?

 - ❖ Satisfaction with access to services:
 - Is the individual receiving services that he or she feels are or will be beneficial?

- Did the individual participate in selecting the services he or she would receive to meet his/her assessed needs?
- Did the individual have a say in who would provide those services?
- Did the individual participate in selecting staff that would provide the services?
- Is there a mechanism in place that the individual can utilize, without fear of intimidation, to report when he or she is not satisfied with services?

Section 5: ISP Meeting

Section 5.1: Development and Review of Information Gathered

The ISP meeting is held 60 – 90 calendar days prior to the Annual Review Update date. All team members play vital roles in the ISP meeting by fully participating to share knowledge, perspective, and insight. The information collected presents a complete and comprehensive picture of the individual. The team reviews this information during the assessment and information gathering stage of the plan meeting to ensure that identified needs lead to services, which promote outcomes, that are based upon the assessed needs and personal preferences of the individual to meet those needs. If the individual chooses not to attend the ISP meeting, the ISP should be reviewed with the individual to ensure there is agreement with content and outcomes.

ODP recognizes that there are many assessment instruments, both formal and informal, that are being utilized statewide. Both types are considered to be valuable tools. Formal assessment types include, but are not limited to: the SIS™ and PA Plus, Vineland, Adaptive Behavior Scale (ABS), Alpern-Boll Developmental Profile (LPRN BOAL), and therapy and medical evaluations. While the SIS™ and PA Plus are the primary statewide needs assessments for every individual enrolled in the P/FDS and Consolidated Waivers, any of these assessments may be relevant in identifying an individual's need for a particular service. Informal assessments include, but are not limited to, a provider's annual assessment, OVR assessments, IEPs, other school aged assessments, family and friends' observations, observations by direct care professionals, and understanding of the individual and his or her needs. Other information should be considered as well, such as, possible changes in an individual's living situation or health status, any incidents reported and possible monitoring findings. Part of the assessment process also reflects input from an individual's natural network of family and friends. This information should be listed in the relevant assessments linked to outcomes and described in the appropriate section(s) of the ISP.

Each team member ensures that information provided is current and is presented professionally and with sensitivity. Any changes to demographic information should also be addressed at this time. Service options must be promoted and fully explored with every individual. Once an assessed need is identified, the team should discuss whether the need can be met through natural supports, family, friends, or medical professionals, etc. or if the need requires the support of a paid service. Paid services are appropriate when naturally occurring supports are not available or when a person or entity with special skills or training is necessary to support the assessed need. While all needs must be reviewed, not all needs require a paid service. If the individual and the ISP team determine an additional paid service is necessary to address an assessed need, then the specific skill the individual wants to work on is identified and a measurable outcome is developed to support that skill development. Measurable outcomes are

developed based upon an individual's ability to acquire, maintain, and improve a skill, including those that increase the individual's safety and well-being. SCs will review each service and its necessity during their ongoing monitoring activities and document the results in their monitoring report and/or service notes.

Specific examination of information such as possible changes in the individual's living situation or health status, any incident reports documented in HCSIS, monitoring findings, or other changes that will impact the individual's health and welfare, services and supports, or ability to have an everyday life is incorporated during this stage.

Section 5.2: Service Utilization

Service utilization is an important piece of ISP development. Service utilization is a comparison of the amount and type of services authorized on an individual's ISP with what services have been successfully billed. Service utilization will assist in management of services by ensuring the individual's assessed needs support the services, which promote the achievement of the outcomes, identified in the ISP. The use of service utilization data can assist in the determination of the amount, frequency and duration of the service necessary to address assessed needs.

The SCs role in service utilization is to monitor and verify the type, duration, amount and frequency of services and supports outlined in the ISP on a regular basis and summarize the information on an annual basis. The SC should have conversations about service utilization with the individual, family and ISP team and document those conversations in the individual's service notes and monitoring tools in HCSIS. Documentation should include the reason for any under or over utilization that has occurred.

There are five guiding principles that should be addressed when looking at service utilization on a particular ISP:

1. Determine if the designated service has the desired effect to address the specified need, which promotes the achievement of an outcome.
2. Determine if there is an established limit associated with the service.
3. Determine that units on the ISP are necessary based on the individual's current needs and not above the established limit.
4. Previous year's utilization should be reviewed and considered.
5. Service utilization should be reviewed to determine continued need and skill attainment.

It is important to understand why someone is over or underutilizing services and supports. Four types of utilization issues that may be identified through service utilization reviews are:

1. Service Delivery – utilization issue is occurring due to problems with service delivery (i.e. Provider staffing; individual not home when service delivery identified to occur);
2. Billing Issues - Provider is not billing regularly or successfully. Therefore, services rendered are not reflected when looking at utilized units;

3. Temporary Change in Need – an issue is occurring due to a life event that is happening to an individual or their family member that would cause temporary change to a service need (ie. Short term Hospitalization of caregiver, resulting in temporary need for increased supports); or
4. Permanent Change in Need – an issue is occurring due to a life event that is happening to an individual or their family member that would cause a permanent change of service need.

These issues will help identify the reasons for over or under utilization, and may help identify the direction of resolution.

Section 5.3: Outcome Development

Outcomes represent what is important to the individual, what the individual needs, what the individual wants to change, or what he or she would like to maintain in his or her life based on their assessed needs. Outcome development builds on information gathered during the ISP process and signifies a shared commitment to take action that could make a difference in the individual's life in meeting their assessed needs. It is crucial to address barriers and obstacles that may affect the individual's success in achieving the Outcome, especially if these obstacles can impact his or her health and welfare.

Within ISP outcomes, those things that are important to maintain or change (Outcome Statements) are joined with the method to attain them (Outcome Actions). Outcome Actions specify what will occur to achieve the Outcome, including paid services (when they are necessary), to meet assessed needs and maintain health and welfare. For example, Supports Coordination is a waiver service therefore; the services that a SC performs can be attached to an Outcome when any of these services are required in order for the Outcome to be accomplished. There is no need to have a separate "Supports Coordination" Outcome Statement.

Outcome development criteria:

- The team develops Outcome Statements and Actions to support the attainment of what is important to the individual within the context of his or her everyday life.
- Outcomes should build on gathered information, reflect the individual's needs and preferences to meet those needs, represent desired changes and important things that should be maintained or make a difference in the individual's life in meeting their assessed needs and signify a shared commitment to take action.
- There should be a clear connection between the individual's needs and preferences to meet those needs, choices, and the Outcomes that are developed at the ISP meeting.
- The individual and team and work together to find acceptable Outcomes that enable the individual to exercise his or her choices while at the same time meet needs, minimize risk, and achieve or maintain good health.
- Although every funded service must be linked to an Outcome, not every Outcome requires a funded service. There may be Outcomes that are important to the individual but do not relate to or are not supported by a funded service. These should be addressed prior to Outcomes that require a funded service.

- Any barriers or concerns that prevent the Outcomes from being tangible and reachable must be addressed during the ISP process.
- An Outcome related to a funded service should relate back to the service definition and the assessed need for the service. For example, an Outcome attached to Home & Community Habilitation (HCH) should show how the individual will learn, maintain or achieve the skill(s) listed in the HCH service definition.

Section 5.4: Outcome Actions

A completed ISP should provide a means of achieving Outcomes important to the person. Outcome Actions help the ISP team determine what actions, services, and supports are needed to achieve the Outcome. When developing actions to support Outcomes, the ISP team begins by considering the natural and non-paid services available. When identifying services and supports, the team considers all available resources, which includes natural supports, such as friends, family, spiritual activities, neighbors, local businesses, schools, civic organizations, and employers.

Enlisting natural and non-paid supports in supporting Outcomes encourages teams to find ways for people to foster choice, develop meaningful personal relationships, exercise control in their lives, and experience rewarding inclusion in their communities.

Teams may determine it is necessary to include paid services in Outcome Actions to meet assessed needs and ensure health and welfare while the Outcome is being pursued. These “service-related” Outcomes should give clear statements regarding the expected Outcome, given the service the individual is receiving, by answering the following questions:

1. What difference will the service make in the individual’s life?
2. What is the current value of the service and is it helpful?
3. What assessed needs and/or health and welfare concerns is the service intended to address?
4. What does the person hope to learn and accomplish?

An important part of connecting services to Outcomes is having open discussions during ISP meetings. By keeping the lines of communication open, the team can identify new and creative ways to help identify Outcomes and address needs and preferences. Outcomes can represent desired changes or describe important things that should be maintained in the individual’s life. Outcome development builds on information gathered during the ISP process and signifies a shared commitment to take action that could make a difference in the individual’s life. It is crucial to address barriers and obstacles that may affect the individual’s success in achieving the Outcome, especially if these obstacles can impact his or her health and welfare.

Finally, team members should work in partnership to ensure that the individual is making progress towards Outcomes and Outcomes are being achieved or remain relevant. The ISP must be a living document, responsive to the individual and his or her needs. In order for the ISP to be responsive, changes to the services and Outcomes in the ISP should occur throughout the year as necessary.

Section 6: Identification of Services and Supports

A completed ISP should provide a means of achieving Outcomes important to the individual by integrating natural supports and funded supports. The ISP must address all needs that affect the individual's health and welfare, including services that, if absent, would cause the individual to be placed in an institutional setting.

- Natural supports and other funding sources should be considered prior to ODP funding. If natural supports are not currently available, the SC should document efforts to explore natural supports through a service note in HCSIS. Non-ODP funding sources include the Pennsylvania Medical Assistance (MA) State Plan, Behavioral Health, the Office of Vocational Rehabilitation (OVR) and the Department of Education.
- The team uses Outcomes as a guide to determine what services are needed and to ensure that services reflect the actions needed to promote the achievement of Outcomes.
- Each funded service must be linked to an Outcome.
- The team should identify the needed type, duration, frequency and amount of each service needed to promote the achievement of the Outcome identified in the individual's ISP.
- The type, frequency, duration, and amount of each service identified by the team must be documented by the SC in the *Service and Supports* section of the ISP.
 - Type of service is documented through the service name on the *Service Details* screen in HCSIS.
 - Frequency of services is documented on the *Outcome Actions* screen in the *Frequency and Duration of the actions needed* field. The frequency of a service is the number of times that the service is rendered (i.e. daily, weekly, monthly, or annually depending on service being rendered) based on the needs of the individual.
 - Duration of services is documented through the start and end dates of the service on the *Service Details* screen in HCSIS. Duration is also documented under the *Outcome Actions* section in the *Frequency and Duration of actions needed* field. Duration means the length of time.
 - Amount of services is documented through the number of units included on the ISP in the *Service Details* screen in HCSIS.

6.1: Participant Directed Services (PDS)

Many people and entities play a part in explaining choices for service delivery and how to manage services. At intake, ISP meetings and upon request, the SC, AE, and County Program are responsible to provide individuals with information on self-directing Participant Directed Services (PDS) and the various choices of service management in accordance with the approved

Waivers, ODP policies and the *Pennsylvania Guide to Participant Directed Services*. Financial Management Service (FMS) organizations are responsible to explain the delivery of the administrative services the FMS offers and how to complete any applicable paperwork related to the use of the financial management option the FMS provides.

Who can self direct Participant-Directed Services?

- To self-direct PDS, the participant who is able **must live** in his or her own private residence or the residence of a family member or friend.
- Participants living in licensed and unlicensed agency owned, rented, leased, or operated homes **may not** participate in PDS at this time, but must be given choice in their lives.
- Participants or their surrogate who choose to self-direct must select one of the FMS options to assist with PDS.
- The participant's ISP must have authorized PDS that are paid by a FMS organization.
- The Participant's ISP must include the designated procedure code for the FMS organizations monthly administrative service per ODP instructions.

How is this different from choosing a traditional provider to manage all of my services?

- The participant and his/her surrogate is a common-law employer or managing employer.
- The participant and his/her surrogate along with the team is directly involved in deciding what services the individual needs, when the individual needs the services, and who will provide the services.
- The participant and his/her surrogate decide how to meet the individual's identified needs, with the support of family, friends, and professionals.
- The participant and their surrogate will have "**Employer Authority**" and "**Budget Authority**".

What is Employer Authority?

Employer authority means you are a type of employer and as an employer you can:

- Be more active in choosing and managing qualified Support Service Workers (SSWs).
- Take on some designated responsibilities as the common-law employer or managing employer.

What are the types of Employer Authority you can choose from?

There are two FMS options to choose from that offer employer authority:

- Vendor Fiscal/Employer Agent (VF/EA) FMS option: The participant or their surrogate becomes the "**Common Law Employer**".

- Agency With Choice (AWC) FMS option: The participant or their surrogate becomes the “**Managing Employer**”.

What is Budget Authority?

Budget authority is available to common-law employers and managing employers. Budget authority is the ability to:

- Choose the services that are necessary to address the participant’s identified needs.
- Choose or recruit SSWs to provide necessary services and how much the SSWs will be paid using the established wage ranges.
- Shift services among the authorized PDS included in the PDS portion of the participant’s ISP **with** prior approval from their SC and contingent on applicable service limits.

AE’s, County Programs and SCO’s must ensure that ISPs are developed through a person-centered process. SC’s will complete ISP’s for individual’s who are self-directing their services based on ODP established requirements for ISP development.

Section 6.2: Choosing Providers for Funded Services

The SC is responsible to provide information regarding potential willing and qualified providers for necessary services upon enrollment, the initial plan meeting and at least annually thereafter. SC’s should document the offering of choice of willing and qualified providers in a service note. Providers that are willing and qualified to provide services necessary to support the individual’s assessed needs and Outcomes are reviewed with the individual and his or her family, guardian, or advocate. The individual and his or her family shall exercise choice in the selection of willing and qualified providers. This selection is documented on the *ISP Planning Process Participants’ Signature Page* and the submission screen of the ISP in HCSIS. Providers of waiver services are qualified according to the standards established in the approved Waivers. Providers who are providing non-waiver services are qualified according to the standards established by the County Program.

The individual and his or her family may also elect to self-direct participant-directed services. If a decision is made to self-direct some or all of the services, the individual and his or her team would then select either the AWC or VF/EA FMS option. Documentation of choice of these options is documented on the *ISP Planning Process Participants’ Signature Page*.

The SC is responsible to make timely referrals to chosen providers based on the selections made by the individual and the other members of their team.

Section 6.3: Implementation of Services

The ISP should be entered into HCSIS and submitted for approval to the AE no later than 30 calendar days prior to the Annual Review Update date.

Those responsible for service implementation are accountable for services as indicated in the ISP, and are responsible for documentation to support the provision of services as per the current ODP bulletin, *Provider Billing Documentation Requirements for Waiver Services* or any approved revisions or bulletins which update or replace this bulletin.

Services must be implemented as per the current ISP, including the frequency listed in the Outcome Actions. If all units authorized on an ISP are not utilized, the unused units will not be added to the authorized amount in the next fiscal year ISP unless they are accompanied by a change in need.

Section 7: Creating and Updating ISPs in HCSIS

There are seven ISP formats in HCSIS that are used in creating and updating ISPs. It is recommended that if any of the following ISP formats are utilized, all information and/or changes known at the time (such as demographic changes) be included in the ISP.

- Plan Creation
- Fiscal Year (FY) Renewal
- Critical Revision
- Bi-Annual Review
- Quarterly Review
- General Update
- Annual Review Update

Plan Creation

A plan creation is used when creating an ISP for the first time in HCSIS, (referred to as the initial ISP), when there is not a current ISP in HSCIS, or when there is a time-span or gap between two ISPs. The team sets proposed ISP review dates, within the 365 calendar day required timeline. The initial ISP is considered a “bridge plan” with a start date that is generally 60 to 90 calendar days after the initial ISP meeting, and an end date of the following June 30, the last day of the FY. The initial ISP does not encompass an entire FY, due to the timing of the initial ISP meeting. The “bridge plan” is used to align the ISP end date with the FY end date.

Fiscal Year Renewal

A fiscal year renewal is used to renew the ISP for the following FY. The ISP will reflect a FY begin date of July 1 and a FY end date of June 30. The start date of the HCSIS ISP coincides with the start of the FY, or July 1. The FY ISP “expires” at the end of the fiscal year, or June 30. ISPs are developed on a FY basis in order to create service authorizations that encompass the full FY. Authorization takes place by service, and each service is assigned a start and an end date. The FY ISP can include up to one year of service. The ISP created through a fiscal year renewal will pre-populate with information from the previous ISP. Therefore, care should be taken to ensure that services continue to be accurately reflected. This process of renewing plans on the FY promotes efficiency in provider billing, as well as the ability to generate reports that accurately reflect all services and payments by FY. Additionally, as major changes to the Waivers typically occur at the beginning of the FY, it allows for easier maintenance of any changes that are made. If an annual review update and the FY renewal planning activities fall within the same month, it is recommended that the annual review update be completed first.

Critical Revision

A critical revision to the ISP is used when an individual experiences life changes during a plan year. Life changes, include an emergency situation, or other change in need which requires a change in current services, addition of services or a change in the amount of funding required to meet the needs of the individual. A critical revision to an ISP must go through the AE re-approval and re-authorization process. Discussion and agreement amongst the team members must occur before all critical revisions are finalized.

Bi-Annual Review

A bi-annual review is a requirement for Pennhurst Class Action members only, regardless if there are any updates and all monitoring visits are completed as required. A bi-annual review is used for editing or updating an existing ISP that requires a review of the ISP twice a year, or every six (6) months. This review can be used to edit or update an existing plan. This option will not allow the SC role to modify the plan start and end dates.

Quarterly Review

A quarterly review is used to edit or update an existing ISP at least every 3 months when no changes to the existing services and supports are required. The 4th quarterly review date originates from the date of the annual review and therefore, is the annual review update. This option will not allow the SC role to modify plan start and end dates.

General Update

A general update is used for changes to information such as medical information that does not modify services and supports. A general update to the ISP does not require approval or authorization. A life change or emergency situation that has no impact on funding or services can be updated using this category of plan changes.

Annual Review Update

An annual review update is used to document the results of the annual review ISP meeting. The annual review meeting takes place no later than 60 calendar days prior to the annual review update date, which is 365 calendar days or less from the date that the previous annual review update ISP was approved and authorized. Annual review updates without changes to services or funding do not require authorization but do require approval. Annual review updates with changes to services or funding require both approval and authorization.

The incorporation of the annual review meeting preserves the ability of the ISP team to review and update the ISP at various times throughout the year, preventing a situation where all ISPs are due at the same time of the year, while allowing the use of a FY authorization.

Section 8: Services

This section contains information on each specific service reflected in approved service definitions. Each service definition identified contains:

- A service description.
- Suggestions for determining need.
- Any additional documentation that is necessary.
- Service specific guidelines.

The following questions should be answered and documented in the ISP for each particular service:

- What service would best support each assessed need of the individual?
- How will this service protect the individual's health and welfare?
- What formal statewide needs assessments or informal needs assessments were used to determine the assessed needs of the individual?
- What will the individual be learning or gaining by receiving this service?
- Is there any specific training (beyond general staff orientation to the individual to be served) and/or any specific skills needed to provide this service?
- Have the necessary prior authorization or service limitations/exceptions been approved by ODP?
- What is the amount, frequency and duration of the service needed?
- How many units of service are required to attain the specific Outcome(s)?
- What Outcome(s) are to be achieved?
- How will progress and/or success be measured and reached?
- If progress and success are not being demonstrated, what is the rationale for continuing the service?

If any additional questions are necessary to determine the need for a specific service, a sub-section titled "Determining the Need for Services" will appear under that service heading in this

manual. If there are no additional questions, the questions listed above are sufficient to assist in the identification of the most appropriate service.

Section 8.1: Home and Community Habilitation (Unlicensed)

Service Description:

These services assist individuals in acquiring, maintaining and improving self-help, domestic, socialization and adaptive skills. Individuals learn, maintain or improve skills through their participation in a variety of activities of everyday life. These activities must be necessary for individuals to live in the community, to live more independently, or to be more productive and participatory in community life

Determining the need for services:

The team should address the following additional questions:

- Is the outcome of the service for the individual to acquire, maintain, and/or improve self-help, domestic, socialization and adaptive skills?
- Is there a measurable Outcome for habilitation?

Additional Documentation needed in the ISP:

- What are the specific skills the individual needs to acquire, maintain or improve?
- How many units of service are needed or how many units of service can this individual tolerate in a day/week to acquire the skill?
- There may be multiple uses and outcomes associated with this service with different providers within the ISP as long as there is documented need and there are no conflicts or overlaps in regards to day and/or time of service.
- Ensure the correct procedure code (W-code) and service level, as identified in the current service definitions, is used to reflect the needed staff to individual ratio.
- If an enhanced level of service is necessary, the SC should document the assessed need for enhanced level in the *Individual Outcome Summary and Outcome Action Plan* section of the ISP and include:
 - Baseline staffing level: Indicate the individual's current level of staffing.
 - Describe the purpose of the enhanced staffing level: Why is this support needed?
 - What risk does the person present to themselves or others that requires this level of staffing/support? What other less restrictive measures have been attempted?
 - Address the desired Outcomes of this level of enhanced staffing/support: This should include the expanded interactions, activities, programs and/or whether training will be provided, supervision for health and safety reasons.
 - Specify the data to be collected: What data and information will be collected and used to determine the effectiveness of enhanced staff/support and the progress being made toward the reduction or elimination of the service.

- Frequency of enhanced staff/support: Indicate the proposed hours that the individual will need the additional staff/support.

Service Guidelines:

- When unlicensed home and community habilitation is used as a non-traditional day service for an individual who resides in a licensed residential setting, the non-traditional day service should occur during traditional day service hours (Monday thru Friday 8:00-5:00, no evenings and weekends) and cannot occur at the licensed residential setting.
- Supplemental habilitation staff available through the licensed residential habilitation service may not be used to provide the separate and discreet service of unlicensed home and community habilitation a person may be authorized to receive.
- Staff providing enhanced habilitation must meet the following: licensed nurse or a professional with at least a 4-year degree.
- The use of enhanced levels of service is based on the individual's assessed need as indicated by the SIS™ or County Mental Retardation Program assessment process, not the service worker's personal qualifications.
- There must be a measurable Outcome for habilitation.
 - If the measurable Outcome only relates to supervision or minimal assistance, then companion is the appropriate service.
- Relatives, legal guardians and legally responsible persons may provide this service with limitations; please review the current and approved service definitions.
- This service is provided in the individual's home or other unlicensed residential or community setting.
- This service cannot be provided in a licensed setting.
- Habilitation cannot occur at the same day and time as companion services, licensed day habilitation, prevocational, transitional work, and other unlicensed home and community habilitation.
- Services that are solely diversional (i.e. related to recreation and leisure or entertainment activities) are not considered habilitation services and are not an eligible waiver service. Membership and entrance fees are not allowable waiver costs. Recreation services and fees may be provided under family support services with base funding only.
- Agency-based habilitation providers are responsible for the full range of transportation services needed by the individual to participate in services and activities specified in the ISP. Transportation costs are included in the service rate for agency-based services.

Section 8.2: Licensed Residential Habilitation

Service Description:

Licensed residential habilitation services are direct (face to face) and indirect residential services provided to protect the health and welfare of individuals by assisting them in acquiring, maintaining and improving self-help, domestic, socialization and adaptive skills.

Determining the need for services:

The team should address the following additional question:

- Does the individual require habilitation provided in a licensed residential setting? If so, which of the residential options could best address the individual's needs?

Additional Documentation needed in the ISP:

- The SC will need to include in the ISP:
 - For bed reservation days, the SC should document planned therapeutic and medical leave days in the ISP through an Outcome Action related to the therapeutic leave in the *Frequency and Duration of the actions needed* field.
 - If an individual uses unplanned therapeutic leave, an update to the ISP is only necessary if the ISP does not include an appropriate Outcome for therapeutic leave.
 - The therapeutic and medical leave days should not be included separately in the Service Details page.
 - The information in the Service Details page of the ISP should reflect the total number of residential habilitation days, including therapeutic and medical leave.
 - The SC should update the ISP through a General Update as a result of planned or unplanned medical leave, and indicate any changes resulting from the leave (e.g., changes in medication).

Service Guidelines:

- Licensed residential habilitation is provided in provider owned, rented, leased homes and family living homes.
- This service includes transportation services that are necessary to enable the individual to access services and resources outlined in the ISP, including transportation to and from day or employment services.
- The licensed residential provider is not responsible for transportation to community activities for which another provider is responsible.
- Licensed residential habilitation may not include other home and community services, for example, physical therapy or nursing. These other services must be included separately on the individual's ISP.
- This service is authorized as a day unit. A day is defined as a period of a minimum of 12 hours of non-continuous care rendered by a residential habilitation provider within a 24-hour period beginning at 12:00 a.m. and ending at 11:59 p.m.
- Bed reservation days may be utilized for temporary absences, which are defined as absences in which an individual is expected to return to the residential setting.
 - Therapeutic leave is defined as an absence from the residential habilitation site to visit with a relative or friend, including absence due to vacation when the individual is not accompanied by a staff person from the residential site, and is therefore, not receiving services from the residential provider. Payment will not

be made for a therapeutic leave day if the provider uses the bed for an alternative purpose.

- Medical leave is defined as a temporary absence when an individual has been admitted into a nursing facility, acute care general hospital, rehabilitative hospital, rehabilitation unit of an acute care general hospital, or short term stay in a rehabilitation facility, psychiatric hospital, or psychiatric unit of an acute care general hospital and is expected to return to the residential site.
- Permanent vacancy is defined as a vacancy in which the individual is no longer eligible for and is, therefore, dis-enrolled from the Consolidated Waiver because the individual is not expected to return to the residential habilitation site due to one of the following situations. This list is all inclusive:
 - The individual dies.
 - The individual moves out of the state of Pennsylvania.
 - The individual is permanently placed in an alternative setting such as an ICF/MR or a nursing home.
- Licensed residential habilitation may not be provided in a Personal Care Home (PCH). Relatives/guardians may not provide licensed residential habilitation, but may form a Microboard © that can provide the service.
- All waiver funded licensed residential habilitation homes must be located within Pennsylvania, integrated and dispersed in the community in non-contiguous locations and may not be located on campus settings. The location must be separate from any other location that the provider owns, rents, or leases, and be surrounded by properties owned, operated, or leased by the general public.
- Waiver-eligible services cannot be provided in licensed residential settings established on or after January 1, 1996, with an approved program capacity of more than 10 unrelated individuals or in homes established after January 1, 1996, with an approved program capacity of four or more unrelated individuals. These size limitations do not apply to base-funded residential services.
- Waiver-eligible services may be provided to individuals who reside in previously certified ICFs/MR of 10 beds or less, if they have been converted to waiver-funded homes.
- Licensed Residential Habilitation is only available through the Consolidated Waiver and base funds.
- Family living homes may provide services to no more than two individuals per home who are not family members or relatives of the host family regardless of the type of funding.

Section 8.3: Residential Enhanced Staffing

Service Description:

Residential enhanced staffing may be utilized in waiver-funded residential settings and involves 3 possible components, which are treated as add-ons to the traditional residential service as indicated by need:

- The provision of residential habilitation provided by licensed nurses.

- The provision of *short-term* supplemental habilitation (SH) staff, as part of the licensed residential service to meet temporary medical or behavioral needs of the individual. This service must be prior authorized by ODP.
- The provision of additional individualized staffing (AIS), as part of the residential habilitation service, to meet the long-term staffing needs of the individual when the individual’s long-term staffing needs can no longer be met as part of the usual residential habilitation staffing pattern. This service must be prior authorized by ODP.

Individuals residing in residential settings may also receive additional services (ex. Physical Therapy) based on need.

Determining the Need for Services:

The determination of need is specific for each residential enhanced staffing:

- For short-term SH staff, the team must identify the initial need supported by the recommendations of appropriate professionals.
- The continued need for residential enhanced staffing should be reviewed in accordance with the time frames set forth in the ISP and annually as part of the ISP process.

Additional Documentation Needed in the ISP:

- The SC should document the need for SH or AIS in the *Individual Outcome Summary* and *Outcome Action Plan* section of the ISP and include:
 - Baseline staffing level: Indicate the individual’s current level of staffing.
 - Describe the purpose of the enhanced level: Why is this support needed?
 - What risk does the person present to themselves or others that require this level of staffing/support? What other non-restrictive measures have been attempted?
 - Address the desired Outcomes of this level of staffing/support: This should include the expanded interactions, activities, programs and/or whether training will be provided, supervision for health and welfare reasons.
 - Specify the data to be collected: What data and information will be collected and used to determine the effectiveness of enhanced staff/support and the progress being made toward the reduction or elimination of the service.
 - Frequency of staff/support: Indicate the proposed hours that the individual will need SH and AIS services.

The SC should document in the supervision care needs section of the ISP, under “reasons for intensive staffing/support”:

- The unique medical or behavioral needs to be addressed and when, where and how the enhanced support will occur.
- The plan for reducing intensive staffing supports. Include the specific role and purpose of the staff as well as the plan for the eventual discontinuance or reduction of the intensive staffing.

Service Guidelines:

- When an individual has medical needs that require a licensed nurse to render residential habilitation, the nursing modifier is used in conjunction with the appropriate residential waiver code and there are no term limits on the authorization periods.
- When residential habilitation is provided by a licensed nurse, alternative nursing arrangements must have been discussed such as: Nursing through the MA state plan or private insurance. Discrete Nursing authorized through one of the Waivers should also be discussed and used, if applicable.
- SH is used to *temporarily* supplement the licensed or unlicensed residential habilitation service to meet the short-term unique behavioral or medical needs of an individual. This can only be authorized for a maximum of 12 consecutive months.
- If there is a long term or permanent need for additional habilitation staff, SH is not the appropriate service. Permanent or long-term needs should be met through the use of the AIS component. AIS is long-term when the individual's staffing needs can no longer be met as part of the usual residential habilitation staffing pattern.
- Providers may offer other services (ex. physical therapy) in addition to residential habilitation services, but the individual is not obligated to choose the residential habilitation provider to deliver other services. The individual retains free choice of willing and qualified providers for all services.
- All other services provided by the residential provider must be included on the ISP as a separate service and billed discretely. The provider must be qualified to deliver each discrete service.
- Residential habilitation is only available for individuals who are receiving Consolidated Waiver and base funding.

Section 8.4: Unlicensed Residential Habilitation

Service Description:

Unlicensed residential habilitation services are direct (face to face) and indirect residential services provided to protect the health and welfare of individuals by assisting them in acquiring maintaining and improving self-help, domestic, socialization and adaptive skills.

Determining the need for services:

The team must address the following additional questions:

- Does the individual require habilitation provided in a residential setting?
- Would the setting the individual needs comply with the exemption from licensure set forth in 55 Pa.Code Chapter 6400.3 or 6500.3?

Additional Documentation needed in the ISP:

- In the Supervision Care Needs section of the ISP, under Staffing Ratio - Home, the SC shall document the amount of supervision the individual requires.

Service Guidelines:

- Unlicensed residential habilitation cannot be selected when the total service provided to all individuals in the home is expected to exceed an average of 30 hours a week. A licensed residential habilitation service should be considered instead.
- Unlicensed residential habilitation is provided in provider owned rented, leased homes and agency operated family living homes.
- All waiver-funded unlicensed residential habilitation homes must be integrated and dispersed in the community in non-contiguous locations and may not be located on campus settings. The location must be separate from any other location that the provider owns, rents, or leases, and be surrounded by properties owned, operated, or leased by the general public.
- The unlicensed residential home may only be located in Pennsylvania.
- Unlicensed residential habilitation includes transportation services that are necessary to enable the individual to access services and resources outlined in the ISP.
- The unlicensed residential habilitation provider is not responsible for transportation to community activities for which another provider is responsible.
- The unlicensed residential home may only serve 3 or fewer individuals, if it is a community home. The unlicensed residential home may only serve 1 or 2 individuals, if it is a family living home.
- The unlicensed residential home may only service individuals who are 18 years of age or older.
- Unlicensed residential homes will not be tracked or utilized in the state's vacancy management process.

Section 8.5: Companion Services

Service Description:

Companion services are provided to individuals living in private residences for the purpose of providing supervision and necessary care that is focused solely on the health and safety of the adult individual (18 and older) with mental retardation.

Determining the need for services:

Determine that companions are either supervising or providing care and assistance that is focused solely on the health and safety of the individual.

Additional Documentation needed in the ISP:

- The supervision and/or care the companion will be providing and why it is necessary to ensure the individual's health and safety in the Outcomes section of the ISP.

Service guidelines:

- Companion services are used to protect the health and safety of the individual when a habilitation outcome is not appropriate or feasible.
- The companion service should only be authorized when it is necessary to ensure the individual's health and safety.
- Companion services may be provided during temporary travel per the ODP travel policy.
- The companion service may not be provided at the same time as any other direct service. Supported employment indirect services (not directly with the individual) may be provided on the same day and time as companion services.
- The companion service is not available to individuals who are residing in agency owned, rented, leased or operated (unlicensed or licensed residential habilitation) homes.
- The companion service may not be provided by persons legally responsible for the individual.
- The companion service may be used to supervise individuals during socialization or non-habilitation activities only when necessary to ensure the individual's health and welfare.
- Companion and home and community habilitation (unlicensed) services have a combined maximum limit of 24 hours per participant, per calendar day.

Section 8.6: Day Services [Includes both Adult Training Facilities and Older Adult Daily Living Centers]

Service Description:

Day service is a direct service (face-to-face) that must meet the regulatory requirements of either 55 Pa.Code Chapter 2380 (Adult Training Facilities) or 6 Pa.Code Chapter 11 (Older Adult Daily Living Centers). Day services consist of supervision, training, and support in general areas of self-care, communication, community participation, and socialization. Areas of emphasis include: therapeutic activities, fine and gross motor development, mobility, personal adjustment, use of community resources, and relationship development.

Licensed Day Habilitation Services:

Licensed day habilitation services consist of supervision, training, and support in general skill areas of self-care, communication, community participation, and socialization. Areas of emphasis include: therapeutic activities, fine and gross motor development, mobility, personal adjustment, use of community resources, and relationship development that:

- Help the individual to acquire, maintain, and improve skills.

- Help the individual live more independently in the community or to be more productive and participatory in community life.
- Teach skills that can be incorporated into everyday life to improve the performance and independence of an individual's activity of daily living or prevent the complications of motor disorders.

Determining the Need for Services:

The team must address the following additional question when determining the extent to which day services are necessary and appropriate:

- Does this individual need to have supervision, training and support during the day to learn a skill or participate in an activity?

Additional Documentation needed in the ISP:

- The SC shall indicate the appropriate staffing ratio in the Supervision Care Needs – Staffing Ratio-Day section of the ISP.

Service Guidelines:

- Licensed day habilitation services must be provided in a licensed setting. However, this does not preclude the licensed day habilitation provider from taking the individuals into the community to provide the service.
- Licensed day habilitation, prevocational, transitional work, and supported employment have a combined total limitation of 40 hours (160-15 minute units) per individual per calendar week based on a 52 week year. The services listed in this bullet may not overlap in terms of day and time. The licensed day habilitation service may not be provided at the same time as any other direct service.
- For individuals requiring 1:1 or 2:1 staffing, the licensed day service provider is responsible to provide the staffing and the plan for the eventual discontinuance or reduction of staffing. The continued need for enhanced staffing should be reviewed in accordance to the time frame set forth in the ISP and annually as part of the ISP process.
- Individual needs are related to the licensed day habilitation general skill areas listed above and are most appropriately addressed through day habilitation services rather than a prevocational or vocational service.
- Transportation to and from an individual's home is not included in the licensed day habilitation service.

Section 8.7: Prevocational Service, Vocational facilities

Service Description:

Service is provided to assist individuals in developing skills necessary for placement in a higher level vocational program and ultimately into competitive employment. The service may be provided as facility-based employment, occupational training, vocational evaluation, a vocational facility, or a work activities center.

Determining the Need for Services:

The following additional questions should be used to determine a need for this service:

- Does the outcome desired by this individual involve the development of competitive work skills?
- Is the individual interested in learning work skills to obtain competitive employment?
- Does this individual have a formal prevocational assessment that includes the use of planned activities, observation and testing, potential for employment and identification of employment objectives by the provider to assure that the individual can be appropriately supported in this type of environment?

Additional Documentation needed in the ISP:

- OVR determination that the service is not available through OVR (Rehabilitation Act of 1973).
- Prevocational services for an individual under 22 years of age and still in school are funded under the Individuals with Disabilities Education Act (IDEA).
- The SC shall indicate the appropriate staffing ratio in the Supervision Care Needs – Staffing Ratio-Day section of the ISP.

Service Guidelines:

- If an individual requires 1:1 or 2:1 staffing during licensed day habilitation, the day licensed day habilitation service provider is responsible to provide the staffing and the plan for the eventual discontinuance or reduction. Needed day staffing may not be provided by the individual's residential, unlicensed habilitation, or other non-day habilitation provider and these types of services may not be used to supplement the licensed day habilitation service.
- OVR determination must be completed and received.
- Licensed day habilitation, prevocational, transitional work, and supported employment have a combined total limitation of 40 hours (160-15 minute units) per individual per calendar week based on a 52 week year. The Prevocational service must be provided in a licensed setting.

- Transportation to and from an individual's home is not included in the prevocational service.
- Handicapped employment as defined in 55 Chapter 2390 cannot be funded under prevocational services.

Section 8.8: Supports Coordination (Waiver-Funded) Services

Service Description:

Supports Coordination services involve locating, coordinating and monitoring needed services for waiver participants. All the SC's work on behalf of an individual should be documented in service notes in HCSIS.

Locating services consists of assistance to the participant and his or her family in linking, arranging for, and obtaining services specified in an ISP, including needed medical, social, habilitation, education, or other needed community services. Coordinating consists of development and ongoing management of the ISP in cooperation with the participant, his or her family, members of the plan team, and qualified providers of service. Monitoring consists of ongoing contact with the participant and their family, and oversight, to ensure services are implemented as per the participant's plan.

In addition to the traditional locating, coordinating, and monitoring activities mentioned, Supports Coordination also includes providing information and assistance in order to help participants decide whether to select participant direction of services (locating), and assistance for participants who opt to self-direct services (coordinating).

Section 8.9: Supports Broker Services

Service Description:

Supports broker services assist individuals in arranging for, developing, and managing, the services they are self-directing through either employer authority (hiring/managing workers) or budget authority (determining worker salaries within the established wage ranges, shifting units and associated funds between approved services). Relatives, legal guardians, and legally responsible individuals may provide this service.

Determining the need for services:

The following additional questions should be used to determine a need for this service:

- The individual and/or surrogate is self-directing the individual's services.
- The purpose of the supports broker service is to assist the individual and provide training and support, not to actually perform the actual activities.
- Determine what assistance or support is needed for the individual to perform the managing employer functions and define the timeframe and activities to be provided.

- Documentation to support the continued need for service as necessary for service re-authorization i.e.; to train on a new skill, or progress demonstrated on current Outcomes to date.

Additional Documentation needed in the ISP:

- That the individual is self-directing services and that each role the support broker will perform is vital to the support of the individual in self-directing those services.
- The specific activities that supports broker will be completing to support the outcome of the service.

Service Guidelines:

- Support brokers should assist individuals with the functions and activities utilized to manage or, co-manage their SSWs.
- Only those activities listed in the service definitions may be provided by the supports broker.
- This service is limited to a maximum of 1040 units per individual per FY based on a 52-week year.
- The support broker service is limited to individuals who are self-directing their services through employer and/or budget authority.
- Designate support broker activities to be provided within a defined timeframe.
- Relatives/legal guardians and persons legally responsible for the individual may provide this service with limitations.
- Support brokers may not replace the role or perform the functions of a SC.
- Support broker services may not be provided by agency or individual providers that provide other direct waiver services or administrative services.

Section 8.10: Supported Employment Services

Service Description:

Direct and indirect services provided in community employment work sites with co-workers that do not have disabilities for the purposes of finding and supporting individuals in competitive jobs of their choice. Supported employment consists of job finding and job support.

Determining the Need for Services:

The following additional questions should be used to determine a need for this service:

- Is this individual interested in competitive employment?
- Is this individual currently successful (meeting or exceeding outcomes and goals) in a prevocational or transitional work environment?
- If the individual is not already employed, can the individual successfully maintain competitive employment with support?

Additional Documentation needed in the ISP:

- The SC shall enter applicable information in the employment screen in HCSIS for those receiving employment services and at least for all individuals from 16 to 25 years of age.
- OVR determination that the service is not available through OVR (Rehabilitation Act of 1973).
- Employment services for an individual under 22 years of age and still in school are funded under IDEA.
- The provision of job finding services must be evaluated at least every 6 months.
- The provision of job support services must be evaluated at least annually to determine whether the individual continues to require the current level of authorized services.

Service Guidelines:

- Individual must receive minimum wage or higher.
- OVR referral and determination must be completed and received.
- The travel time for supported employment services is built into the existing rate for the service, thus cannot be billed as a discrete service.
- Services may not be available under the Rehabilitation Act of 1973 as amended or IDEA.
- Services may not be provided in any licensed setting.
- Licensed day habilitation, prevocational, transitional work, and supported employment have a combined total limitation of 40 hours (160-15 minute units) per individual per calendar week based on a 52 week year.
- The supported employment service is limited to support for individuals that cannot be provided by the employer through regular supervisory channels.

Section 8.11: Transitional Employment

Service Description:

This consists of services that support individuals in transition to integrated, competitive employment through work that occurs in a location other than a facility subject to 55 PA Code Chapters 2380 and 2390 regulations.

Determining the Need for Services:

The following additional questions should be used to establish a determination of need for transitional employment services:

- Is this individual interested in transitional or competitive employment?
- Is this individual currently successful (meeting or exceeding outcomes and goals) in a prevocational environment?
- Would the individual benefit from a supportive environment to increase appropriate work skills?

Additional Documentation needed in the ISP:

- OVR determination that the service is not available through OVR (Rehabilitation Act of 1973).
- Transitional work services for individuals under 22 years of age and still in school are funded under IDEA.
- Progress needs to be documented such that the trainer is phased out as the person meets established production goals in work station and affirmative industry.
- Employment screen for those receiving employment services and at least for all individuals from 16 to 25 years of age.

Service Guidelines:

- OVR determination must be completed and received.
- Must occur in a mobile work force, workstation in industry, affirmative industry, or enclave.
- Transportation to and from an individual's home is not included in this service.
- Provider is responsible for all transportation integral to the service. For example, transportation to a work activity.

Section 8.12 General information on Therapies:

Physical therapy, occupational therapy, speech and language therapy and behavior therapy are state MA plan services and may only be funded through the Waivers or base allocation when the service may not be provided under the state plan and/or private medical insurance because the state plan or private insurance limitations have been reached or the service is not covered by the state plan or private insurance. Documentation of this fact must be maintained in the individual's file and updated on at least an annual basis by the SC. The documentation requirement can be met by including detailed information in the individual's hard copy file and/or a service note in HCSIS. In addition, a summary of the documentation should be included in the "Outcome Summary" page of the HCSIS ISP (in the concerns related to outcome field).

If a child is aging out of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) (reaching their 21st birthday) or the school system (IDEA) and receiving therapy services, they will not automatically receive therapy services through ODP. Instead they must be re-evaluated by a physician, physician's assistant, or certified nurse practitioner as unlicensed staff may be able to provide the same services under a different service.

For children under 21 years of age receiving EPSDT services, ODP-funded therapy services cannot be used to supplement EPSDT therapy services as those services meet the child's need by definition.

Implementation of a Home Therapy Program can be done by the individual and those people that support the individual. A Home Therapy Program is a set of activities for an individual, designed to reach particular goals and taught to the individual and their caregivers by a therapist;

performed at home by the individual and their caregivers on a regular basis (often daily); and monitored by a therapist. Home programs require infrequent, periodic monitoring by the appropriate therapist to assure that progress is being made and that the program continues to be appropriate for the needs of the person. Evaluation, development, training, and monitoring of a home program should be done by the appropriate licensed therapist.

All individuals, families and staff share in the responsibility to reinforce independence and skills that individual's are learning. Successful therapy outcomes require implementation and repetition of the learned skills outside of the therapy sessions.

Section 8.13: Physical Therapy

Service description:

The Physical Therapy Practice Act (63 P.S. §1301 et seq.) defines physical therapy as follows: "...the evaluation and treatment of any person by the utilization of the effective properties of physical measure such as mechanical stimulation, heat, cold, light, air, water, electricity, sounds, massage, mobilization, and the use of therapeutic exercises and rehabilitative procedures including training in functional activities, with or without assistive devices, for the purpose of limiting or preventing disability and alleviating or correcting any physical or motor conditions and the performance of tests and measurements as an aid in diagnosis or evaluation of function."

Physical therapy is a service designed to do the following:

- Help the individual to acquire, maintain, and improve skills.
- Help the individual live more independently in the community or to be more productive and participatory in community life.
- Enhance skills requiring gross motor function.
- Enhance skills that can be taught and incorporated into everyday life to improve performance and independence in Activities of Daily Living (ADL's) or to prevent the complications of motor disorders.

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- Does this individual have a prescription for physical therapy?
- Is there a formal assessment by a physical therapist that establishes a need for physical therapy?
- Does this individual have gross motor limitations (e.g. difficulty navigating, getting around, or moving around)?
- Does this individual have a diagnosis of a clinical condition known to have an impact on gross motor skills, e.g. cerebral palsy, hemiplegia, quadriplegia?
- Does this individual need to work on specific skills in the areas listed above?

- Does this individual need to have regular stretching to prevent contractures because of increased or decreased muscle tone?
- Is this individual capable of or does he or she have someone supporting him or her that can maintain a home program?
- Does this individual have a degenerative condition that impacts on their gross motor skills including balance and coordination?
- Has this individual recently had an injury, stroke, surgery or other occurrence that precipitated the need for therapy? In this case, the therapy may be medically necessary under their health insurance plan (e.g. Private health insurance, access or managed care company)?
- How long has the individual been receiving physical therapy?
- How has the individual benefited from physical therapy?
- How are families and staff implementing learned skills outside of the physical therapy sessions?

Additional Documentation needed in the ISP:

- Functional limitation in gross or fine motor skills.
- Evaluation of need for physical therapy.
 - Need for physical therapy.
 - Ability to benefit from physical therapy.
 - Outcomes for physical therapy (e.g. to increase range of motion or teach to do stand pivot transfer either independently or with an assist).

Service Guidelines:

- Physical therapy must be ordered by a health care practitioner under the scope of their practice. This includes physicians (MDs or DOs), physician’s assistants (PAs), or certified registered nurse practitioners (CRNPs).
- Evaluation, development, training, and monitoring of physical therapy completed at home should be done by a licensed physical therapist.

Section 8.14: Occupational Therapy

Service description:

The Occupational Therapy Practice Act (63 P.S. §1501 et seq.) defines occupational therapy as follows: “The evaluation of learning and performance skills and the analysis, selection and adaptation of activities for an individual whose abilities to cope with the activities of daily living, to perform tasks normally performed at a given stage of development and to perform essential vocational tasks which are threatened or impaired by that person’s developmental deficiencies, aging process, environmental deprivation or physical, psychological, injury or illness, through specific technique which include: (1) Planning and implementing activity programs to improve

sensory and motor functioning at the level of performance for the individual's stage of development. (2) Teaching skills, behaviors and attitudes crucial to the individual's independent, productive and satisfying social functioning. (3) The design, fabrication and application of splints, not to include prosthetic or orthotic devices, and the adaptation of equipment necessary to assist patients in adjusting to a potential or actual impairment and instructing in the use of such devices and equipment. (4) Analyzing, selecting and adapting activities to maintain the individual's optimal performance of tasks to prevent disability."

This service is designed to do the following:

- Help the individual live more independently in the community or to be more productive and participatory in community life.
- Enhance skills requiring fine motor function.
- Enhance skills that can be incorporated into everyday life for improvement in the independence and performance of ADLs or for prevention of the complications of motor disorders.

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- Does the individual have a prescription for this service?
- Is there a formal assessment by an occupational therapist that establishes a need for occupational therapy?
- Does this individual have fine motor limitations?
- Does this individual have a diagnosis of a clinical condition known to impact on fine motor skills (e.g. cerebral palsy, hemiplegia, and quadriplegia)?
- Does this individual need to work on specific skills in the areas listed above?
- Does this individual need to have regular stretching to prevent contractures because of increased or decreased muscle tone?
- Is this individual capable of or does he or she have someone supporting them that can maintain working on a home program?
- Does this individual have a degenerative condition that impacts on their fine motor skills and abilities to perform ADLs?
- Does this individual have a feeding problem (dysphagia) and is it safe for the person to eat by mouth?
- Has this individual recently had an injury, stroke, surgery or other occurrence that precipitated the need for therapy? In this case, the therapy may be medically necessary under their health insurance plan (e.g. Access or managed care company)?
- How long has the individual been receiving Occupational therapy?
- How has the individual benefited from Occupational therapy?
- How are families and staff implementing learned skills outside of the Occupational therapy sessions?

Additional Documentation needed in the ISP:

- Functional limitation in fine motor skills.
- Evaluation of the need for occupational therapy.
 - Need for occupational therapy.
 - Ability to benefit from occupational therapy.
 - Outcomes for occupational therapy (e.g. to increase range of motion or teach to do feed self either independently or with an assist).

Service Guidelines:

- Occupational therapy must be ordered by a healthcare practitioner under the scope of their practice. This includes physicians (MDs or DOs), physician's assistants (PAs), or certified registered nurse practitioners (CRNPs). Occupational therapists may not order their own treatment.

Section 8.15: Speech and Language Therapy

Service description:

Services provided by a licensed and American Speech-Language-Hearing Association (ASHA) certified speech-language pathologist including the evaluation, counseling, habilitation and rehabilitation of individuals whose communicative disorders involve the functioning of speech, voice or language, including the prevention, identification, examination, diagnosis and treatment of conditions of the human speech-language system, and including the examination for, and adapting and use of augmentative and alternative communication strategies, including, assistive devices and assistive technology.

This service is designed to do the following:

- Help the individual to acquire, maintain, and improve skills.
- Help the individual live more independently in the community or to be more productive and participatory in community life.
- Enhance skills requiring communication functions.
- Enhance skills that can be incorporated into everyday life to improve the ability of the individual to communicate and participate in community life.

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- Does this individual have a prescription for speech and language therapy?
- Is there a formal assessment by a speech and language pathologist that establishes a need for speech and language therapy?

- Does this individual have communication limitations (e.g. lack of language or inability to communicate)?
- Does this individual need to work on specific skills in the areas listed above?
- Is this individual capable to or does he or she have someone supporting them that can maintain working on a home program?
- Does the individual have a feeding problem (dysphasia) and is it safe for the person to eat by mouth?
- Has this individual recently had a brain injury such as a stroke, surgery or other occurrence that precipitated the need for therapy? In this case, the therapy may be medically necessary under their health insurance plan (e.g. Access or managed care company)?
- How long has the individual been receiving Speech and Language therapy?
- How has the individual benefited from Speech and Language therapy?
- How are families and staff implementing learned skills outside of the speech and language therapy sessions?

Additional Documentation needed in the ISP:

- Functional limitation in communication skills.
- Evaluation of need for speech therapy.
 - Need for speech/language therapy.
 - Ability to benefit from speech/language therapy.
 - Clear Outcomes for speech/language therapy (e.g. to increase ability to communicate using words, gestures or assistive communication devices).

Guidelines for service authorization:

- Speech therapy must be ordered by a health care practitioner under the scope of their practice including physician (MD or DO), physician’s assistant (PA), or certified nurse practitioner (CRNP). Speech therapists may not order their own treatment.

Section 8.16: Behavioral Therapy

Service description:

The treatment, by psychological means, of the problem of an emotional nature in which a licensed psychologist or psychiatrist establishes a professional relationship with an individual, in an attempt to alleviate or ameliorate the emotional distress disturbances, reverse or change maladaptive patterns of behavioral challenges, and promote positive personality growth and development. Such therapy may take the form of individual therapy with the individual and the psychologist or psychiatrist, or in a group setting supervised and directed by the psychologist or psychiatrist.

This service is designed to treat a mental illness that is known to respond to various forms of behavioral therapy.

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- Does this individual have a clinical diagnosis of a mental illness?
- Has a licensed psychologist or psychiatrist recommended behavioral therapy for this individual based on an evaluation?

Additional Documentation needed in the ISP:

- Mental Health diagnosis made by a clinician.
- Evaluation recommending behavioral therapy.

Service Guidelines:

- The service can be provided by either a licensed psychologist or psychiatrist.
- All individuals, families and staff share in the responsibility to reinforce independence and skills that they are learning.
- Behavior therapy is not behavior support, nor does it include the development of a behavioral support plan.
- Behavioral therapy must be listed on the ISP as a discrete service.

Section 8.17: Visual/Mobility Therapy (V&MT)

Service description:

This therapy is for individuals who are blind or have visual impairments. The provision of therapy is for the purpose of increasing individuals' travel skills and/or access to items used in activities of daily living.

This service may include evaluation and assessment of individuals and the environments in which they interact, direct service (face-to-face) to individuals, and training of support individuals. The provision of this service may result in recommendations for adapting environments or purchasing assistive technology.

This service is designed to do the following:

- Develop skills needed to move safely and independently as possible in home, school, work, and community environments.
- Enhance skills that can be incorporated into everyday life to improve the performance and independence in ADLs or to prevent the complications of motor disorders

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- Is this individual blind or does he or she have a visual impairment that impacts on his or her ability to navigate their environment?
- Formal or informal assessment by a visual and mobility therapist that establishes a need for visual and mobility therapy.

Additional Documentation needed in the ISP:

- Blindness or visual impairment.
- Denial from blind and visual services.
- Difficulty getting around in the environment related to the visual problems.
- Evaluation from a visual/mobility therapist that specifies:
 - Ability to benefit from Visual/Mobility Therapy (V&MT).
 - Need for V&MT to help the individual navigate their environment.
 - Outcomes related to navigating in his/her environment.

Service Guidelines:

- This service may be provided by a trained visual or mobility specialist/instructor.
- There are no requirements for location for this service.
- Successful V&MT outcomes require implementation and repetition of the learned skills outside of the therapy sessions.

Section 8.18: Nursing

Service description:

49 Pa. Code Chapter 21 (State Board of Nursing) provides the following service definition for the practice of professional nursing: "Diagnosing and treating human responses to actual or potential health problems through such service as case finding, health teaching, health counseling, provision of care supportive to or restorative of life and well-being, and executing medical regimens as prescribed by a licensed physician or dentist. The term does not include acts of medical diagnosis or prescription of medical, therapeutic or corrective measures, except as may be authorized by rules and regulations jointly promulgated by the State Board of Medicine and the Board, which rules and regulations will be implemented by the Board."

An individual's need for nursing should be based on the individual's needs assessment results, and other appropriate medical professional assessments.

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- Is there evidence that the individual is no longer eligible for health care benefits for this condition (evidence may include a termination of coverage letter, explanation of benefits, etc.)?
- Does this individual have an unstable airway that without immediate intervention could cause respiratory arrest (stop breathing)?
- Does this individual need clinical treatments that either require the presence of a nurse or that can be taught to a lay person and monitored by a nurse?
- Does this individual have someone supporting him or her that can be taught treatment techniques and maintain equipment and service in a home program?

Additional Documentation Needed in the ISP:

- That an evaluation indicating the need for nursing services, specifying the need for services by a licensed registered nurse (RN) or licensed practical nurse (LPN), has been completed.
- The supports to be provided by each nursing professional must be determined to arrive at the appropriate units of service.
- An emergency action and transportation plan consistent with the patient's condition is present prior to the beginning of service.
- Outcomes related to nursing are specified.
- Annual documentation that services are not available through the state plan and/or private insurance may be placed in a service note in HCSIS or in the person's hard copy file.
- A summary of the documentation must also be included in the Outcome Summary section of the ISP.

Service Guidelines:

- The service must be provided by a licensed RN or LPN.
- Implementation of the home program can be done by the individual and those people that support him or her.
- Skills that can reasonably be done by a lay person can be provided by direct support professionals with appropriate training and monitoring by a licensed nurse.
- All individuals, families and staff share in the responsibility for maintaining the individual's health and welfare.
- Home programs require periodic treatment and monitoring by a licensed nurse to assure that the skills are maintained and to monitor the individual's clinical condition.
- Home Biphasic Intermittent Positive Airway Pressure (BiPAP) and Continuous Positive Airway Pressure (CPAP) do not require nursing presence.

- The changing of new tracheostomy and gastrostomy tubes requires treatment by a health care practitioner (physician, physician's assistant, certified nurse practitioner) and not a nurse.
- Care can be safely and effectively administered in the home setting and life-supporting equipment can be managed.
- Licensed community homes under 55 Pa.Code Chapter 6400 with more than 8 individuals residing in the home are required to have medications administered by a licensed nurse.
- If a child is aging out of EPSDT (reaching their 21st birthday) and receiving home health services, they will not automatically receive nursing services through ODP. Instead they must be re-evaluated by ODP.
- Children aging out of the school system (IDEA) and receiving nursing services must be re-evaluated for service needs by ODP.
- For children under 21 years of age receiving EPSDT services, ODP nursing services cannot be used to supplement EPSDT nursing services as those services meet the child's need by definition.
- Nursing services are MA state plan services and may only be funded through the Waivers or base allocation when the service may not be provided under the state plan and/or private medical insurance because the state plan or private insurance limitations have been reached or the service is not covered by the state plan or private insurance. Documentation of this fact must be maintained in the individual's file and updated on at least an annual basis.
- The need for the service must be evaluated on a periodic basis, at least annually as part of the ISP process. This evaluation must review whether the individual continues to require the current level of authorized services, and that the service continues to result in positive outcomes for the individual.

Section 8.19: Behavioral Support

Service Description:

Behavioral support is a direct/in-direct service that includes: functional assessment; the development of strategies to support the individual based upon assessment; and the provision of training to individuals, staff, parents and caretakers. Services must be required to meet the current needs of the individual, as documented and authorized in the ISP.

Determining the need for services:

- Behavioral support must be based on an assessment and the strategies to support the individual based on that assessed need.

Additional Documentation needed in the ISP:

- Summary of behavior support plan in the section of the ISP to include:
 - Current need for behavioral support.
 - Specific activities that the behavior support worker will be completing to support the Outcome of the behavioral support service.
 - The formal or informal needs assessment that establishes the need for behavioral support.
 - Documentation related to direct/in-direct activities.

Service Guidelines:

- The service is performed by an individual with a Masters Degree in Human Services (or a closely related field) or under the supervision of an individual with a Masters Degree in Human Services (or a closely related field).
- Behavioral support is limited to the following activities:
 - Observation of the individual in various settings for the purpose of developing a Behavior Support Plan.
 - Interaction with the individual and caregivers in various settings for the purpose of developing a Behavior Support Plan.
 - Collaboration with individuals, their families, and their ISP teams for the purpose of developing a Behavior Support Plan that must include positive practices and may not include physical, chemical, or mechanical restraint procedures.
 - Collaboration with individuals, their families, and their ISP team in order to develop positive interventions to address specific presenting issues.
 - Development and maintenance of Behavior Support Plans which utilize positive strategies to support the individual.
 - Consultation, training, and education for the individual, family members, and staff related to the content and implementation of the Behavior Support Plan. This includes education about and information on identified clinical issues (for example, the individual's specific psychiatric symptoms, diagnoses, and medications).
 - Implementation of activities and strategies identified in the individual's Behavior Support Plan.
 - Monitoring implementation of the Behavior Support Plan through collaboration with the individual and the ISP team.
 - Revising the Behavior Support Plan at least annually, or as needed based on the changing needs of the individual.
 - Collection and evaluation of behavioral data.
 - Completion of required paperwork related to data collection, progress reporting, communication (for example, correspondence that relays psychiatric symptom data and information to psychiatrists and others) and development of annual planning material.
- Behavioral support may be provided during the same day and time as other services, but may not duplicate other services.

Section 8.20: Respite

Service Description:

Respite is a service that provides short-term relief for persons normally providing care to reduce stress, address personal crisis or provide care to the individual due to the caregiver's absence or need for relief. Individuals can receive two categories of respite services: 24-hour respite and 15-minute respite.

Determining the Need for Services:

The team must address the following additional questions when determining the extent to which respite is necessary:

- What are the specific supports the individual needs during respite?
- Have the availability of informal/natural supports been discussed and utilized?
- Is this service necessary due to the caregiver's absence or need for relief?

Additional Documentation needed in the ISP:

- The number of units on an ISP may not go over the service unit limitations indicated in the service definitions without ODP prior approval.
- The SC will document the assessment upon which the need for service was determined and any specific training (beyond orientation to the individual to be served) and/or skills needed to provide this service.
- Activities expected of the respite provider beyond supervision must be identified in the ISP.

Service Guidelines:

- The need for respite is determined by an assessment made by the team and primary caregiver.
- Respite services do not cover the care provided to a minor child when the primary caregiver or legally responsible individual is absent due to work.
- The level of services provided are directly related to the intensity of the physical, and behavioral or personal care needs of the individual served, and the availability of natural supports.
- The provision of respite services does not prohibit supporting the individual's participation in activities in the community during the period of respite or prohibit the individual's participation in day and employment services.
- Relatives/legal guardians may provide waiver-funded respite services with limitations, if they are not the individual's primary caregiver.
- Relatives/legal guardians may provide base-funded respite services with limitations, only if they do not live in the same household as the individual.

- Respite may be provided in hospitals and nursing homes only with base funding under Base Funded Respite Care.
- Waiver-funded respite services may not be provided in nursing homes, hospitals or ICFs/MR.
- 24-hour respite is provided for periods of more than 16 hours, and is limited to 30 units (days) per individual per fiscal year, except when extended by the ODP regional office based on individual needs.
- 15-minute respite is provided for periods of 16 hours or less, and is limited to 480 (15 minute) units per individual per FY, except when extended by the ODP regional office based on individual needs.
- Respite services can be provided in the following Pennsylvania locations:
 - An individual's home.
 - A licensed or unlicensed community home.
 - Family living settings.
 - An approved foster family home.
- Respite services may also be provided in an unlicensed home of a qualified individual, qualified camps where the setting meets applicable state or local codes and the provider meets the provider qualifications established by the Department, and other community settings.
- Respite services are limited to individuals residing in private homes (their own home or the home of a relative or friend), not agency-owned, rented/leased, or operated licensed and unlicensed family living homes.
- Waiver-funded licensed 6400 community homes may provide respite in a vacant bed within the established approved program capacity without ODP approval. On a case-by-case basis, ODP may approve the provision of respite services above a service location's approved program capacity for emergency situations only. Written emergency approval to provide respite services above a service location's approved program capacity must be obtained from the ODP regional Waiver Capacity Manager (WCM) before the provision of respite occurs. In no circumstance will this emergency approval result in more than 4 individuals receiving services at the service location in a calendar day, regardless of the service location's licensed capacity.
- Respite services should not be used to provide scheduled and on-going services to the individual. (This would be either companion or habilitation services).
- Respite services are not to provide recreational or social opportunities to the individual.
- Cost associated with room and board are ineligible for waiver funding in settings that are not licensed or accredited and must be paid with state base/waiver ineligible funds

Section 8.21: Transportation

Service Description:

This is a direct service to provide transportation enabling individuals to access services and community activities in accordance with their approved ISP. This includes transportation that is provided by willing and qualified transportation providers.

The transportation service as referenced above is not to be confused with the transportation that is an integral part of the provision of activities within habilitation service settings nor is it transportation associated with residential habilitation services, as transportation in these situations is a part of the habilitation service and is not considered transportation.

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- Does the individual need transportation to or between services/community activities?
- Are there natural supports available to provide the needed transportation prior to utilizing waiver-funded transportation?

Additional Documentation needed in the ISP:

- The need for transportation must be reflected in an outcome and necessary for the service/activity to be provided.

Service Guidelines:

- **Mile:** Transportation (Mile) is used to reimburse the qualified licensed driver who transports the individual to and from services and resources specified in the ISP when using non-agency vehicles. This service can be provided by relatives, legal guardians, persons legally responsible for the individual, friends, and other licensed drivers using non-agency vehicles to transport the individual to services specified in the ISP. Unit is equal to one mile. Rate for this service is the current state rate for mileage reimbursement effective the 1st of January immediately preceding the beginning of the impacted FY. This is the total Mileage required to transport the individual to and from a service or resource specified in the ISP. Mileage will be paid round trip.
- **Public transportation:** Transportation that is available to the general public and provided to the individual to enable access to services specified in the ISP. Public tokens and transit passes may be purchased by the AE, FMS, contracted payment agents or qualified providers of service. Tokens may be provided to the individual on a daily, weekly or monthly basis.
- **Per diem:** Transportation provided to an individual by provider agencies for non-emergency purposes. This transportation is reimbursed using a day unit.
- **Trip:** Transportation provided to individuals (excluding transportation included in the rate for habilitation services) for which costs are determined on a per trip basis. A trip is either to a service/activity from an individual's home (one-trip) or from the service/activity returning to an individual's home (another- trip).
- Ensure that transportation does not duplicate transportation for which another provider is responsible.
- This service is not for transportation that is an integral part of the provision of activities within habilitation settings, or transportation associated with residential habilitation services. Transportation in these situations is built into the rate for service.

- When transportation is provided to more than one individual at a time, the total units of service that are provided are equitably divided among the individuals for whom transportation is provided.
- Transportation provided through other MA benefits must be applied for before being covered as a waiver service.

Section 8.22: Home Accessibility Adaptations

Service Description:

Certain modifications to the private home of the individual (including homes owned or leased by parents/relatives with which the individual resides) which are necessary due to the individual's disability, to ensure the health, security, and accessibility of the individual, or which enable the individual to function with greater independence in the home.

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- Is the modification included in the exclusive list in the service definitions for this service?
- Is the modification necessary due to the individual's disability?
- Does the modification have a primary benefit to the individual, and not the public at large, staff, significant others or families?
- Was there a recommendation obtained from an appropriate professional?
- Do the modifications meet the applicable standards of manufacture, design, and installation?
- Are these modifications cost effective?

Additional Documentation needed in the ISP:

- The SC will document in the Physical Development field, the adaptation, the purpose of the adaptation, and the formal/informal assessment that identifies the individual's need for the adaptation.
- The SC should document how the modification will be used when there are multiple qualified providers supporting the person.

Service Guidelines:

- The term 'private home' includes homes owned, rented, or leased by the following and not owned, rented, or leased from a provider agency: the individual with mental retardation, parents or relatives with which the individual resides, or family living homes that are privately owned, rented or leased by the host family.
- Home modifications must have utility primarily for the individual with the disability.
- Home modifications would not be expected for a family member without a disability, and are not part of room and board costs as defined in 55 Pa. Code Chapter 6200.

- The modification must be allowable as per the list in the service definition.
- Home modifications consist of installation, repair, maintenance, and extended warranties for the modifications; and when necessary to comply with rental/lease agreements, return of the property to its original condition.
- Adaptations that add to the total square footage of the home are excluded from this benefit. The only exceptions are those adaptations to bathrooms that are necessary to accommodate a wheelchair.
- Durable medical equipment is excluded.
- Modifications or improvements to the home that are of general utility are excluded.
- Modifications must increase accessibility and must not be restrictive.
- Modifications not of direct benefit to the individual are excluded.
- Funding is limited to \$20,000 per individual, per home during a 10-year period.
 - The 10-year period begins at the first utilization of authorized Home Accessibility Adaptations. The 10-year period incorporates the previous 9 fiscal years and the current fiscal year. For FY 2009/2010, the 10-year period started in FY 2000/2001 (that is started on July 1, 2000).
 - A new \$20,000 limit can be applied when the individual moves to a new home.
 - In joint custody situations, total adaptations cannot exceed \$20,000 which includes both homes.

Section 8.23: Vehicle Accessibility Adaptations

Service Description:

Certain modifications to the vehicle of the individual (including a vehicle owned by parents/relatives/legal guardians with which the individual resides) which are necessary due to the individual's disability.

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- Is the modification specifically designed to address the needs of the individual?
- The modification does not benefit the public at large, staff, significant others or families?
- Was there a recommendation obtained from an appropriate professional?
- Do the modifications consist only of vehicular lifts, interior alterations to seats, head and leg rests, and belts, customized devices necessary for the individual to be transported safely in the community, including driver control devices, and/or raising the roof or lowering the floor to accommodate wheelchairs?
- Are these modifications cost effective?

Additional Documentation needed in the ISP:

- The SC will document in the Physical Development field, the adaptation, the purpose of the adaptation, the cost of the adaptation and the formal/informal assessment that identifies the individual's need for the adaptation.

Service Guidelines:

- Vehicle modifications consist of installation, repair, maintenance and extended warranties for the modifications only.
- This service can be used to fund the portion of a new or used vehicle purchase that is related to the cost of accessibility adaptations (in order to fund this type of adaptation, a clear breakdown of the purchase price versus the adaptation is required).
- The service cannot be used to purchase vehicles for waiver participants, their families, or legal guardians.
- Regularly scheduled upkeep and maintenance of the vehicle, including warranties that cover the entire vehicle, are excluded.
- Maximum state and federal funding participation is limited to \$10,000 per individual during a 5-year period.
 - The five year period begins with the first utilization of authorized Vehicle Accessibility Adaptations or when the individual transfers to a different ODP waiver. The 5-year period incorporates the previous 4 fiscal years and the current fiscal year.
 - For FY 2009/2010, the 5-year period started in FY 2005/2006 (that is, started on July 1, 2005).
 - Only modifications listed in the service definition may be funded through the Waivers.

Section 8.24: Assistive Technology

Service Description:

An item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve an individual's functioning.

Questions for determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- Is the assistive technology device necessary to address the needs of the individual?
- Was a recommendation obtained from an independent evaluation of the individual's assistive technology needs?

- Is the organization or professional providing the evaluation credentialed, licensed, or certified in an area related to the specific type of technology needed?
- Does the individual not have a fiduciary relationship with the assistive technology provider recommending the device?
- Does the device meet the applicable standards of manufacture, design, and installation?
- Is the device cost effective?

Additional Documentation needed in the ISP:

- The assistive technology device was recommended by an independent evaluation of the individual's assistive technology needs.
- The specific necessary equipment must be defined.
- Verification is documented that MA state plan and/or private insurance limitations have been exhausted prior to funding with annual updates recorded in the ISP, as well as in service notes in HCSIS or in the individual's hard copy file.
- A summary of the documentation must be included in the service details page of the ISP.

Service Guidelines:

- There must be a recommendation by the team or a person that is part of the team that identifies the need for an assistive device evaluation.
- An evaluation to support the need for the assistive device must be documented.
- Assistive technology services include direct support to an individual in the selection, acquisition, or use of an assistive technology device.
- Items reimbursed with waiver funds shall be in addition to any medical supplies provided under the MA state plan and shall exclude those items not of direct medical or remedial benefit to the individual.
- Repair and maintenance of devices and purchases of extended warranties are limited to those devices purchased through the waivers.
- If a participant receives behavioral therapy services or behavioral support services, the assistive technology must be consistent with the ISP.
- The device does not benefit the public at large, staff, significant others or families.
- This service excludes durable medical equipment, as defined by Title 55 PA code Chapter 1123 and the MA state plan.
- Assistive technology may only be funded with waiver or base funds when the service may not be provided under the MA state plan or private insurance because limitations have been reached, or when the service is not covered under the MA state plan or private insurance.

Section 8.25: Homemaker/Chore Services

Service Description:

Homemaker/chore services are indirect services including household cleaning and maintenance and homemaker activities.

Homemaker services enable the individual or the family with whom the individual resides to maintain their private residence. These include cleaning and laundry, meal preparation, and other general household care.

Chore services include services needed to maintain the home in a clean, sanitary, and safe condition. Examples of chore services include: heavy household activities such as washing floors, windows, and walls; and providing safe egress from the ice/snow.

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- For Homemaker services, is there any other household member who manages the home or provide homemaker activities?
- For Chore services is the individual, family member or friend, or anyone else in the household, capable of performing and financially providing for the function? Is any other relative, caregiver, landlord, community/volunteer agency, or third party payer is capable of or responsible for their provision?

Additional Documentation needed in the ISP:

- Homemaker/Chore services: The ISP team must also determine and the SC will document in the Outcome Summary Section of the ISP whether a person is temporarily or permanently unable to perform and financially provide for the homemaker functions.
- Homemaker services: The SC will document what the homemaker will be doing and continue to monitor that the tasks are occurring.
- Chore services: The SC will document what the chore service provider will be doing and continue to monitor that the tasks are occurring.

Service Guidelines:

- Services are limited to a total of 40 hours of services per fiscal year unless the inability to perform and financially provide for these functions is permanent.
- Services are limited to 40 hours per individual, per fiscal year when the person and everyone else in the household are temporarily unable to perform or financially provide for the homemaker/chore function. A person is considered temporarily unable when the condition or situation that prevents them from performing and financially providing for the homemaker/chore functions, is expected to improve.

- Services are not available to people residing in agency-owned, rented/leased or operated homes.
- Services do not include maintenance in the form of upkeep and improvements to the individual's residence.
- Financial inability to provide homemaker/chore services can be calculated at the same threshold as waiver service (at or less than 300% of the Social Security Income maximum with less than \$8,000 in resources).

Homemaker service

- The service must be provided by a qualified homemaker and may include cleaning and laundry, meal preparation, and other general household care.
- The service has no limit when the individual lives independently or with family members or friends who are permanently unable to perform and financially provide for the homemaker service. A person is considered permanently unable when the condition or situation that prevents them from performing and financially providing for the homemaker functions is not expected to improve.

Chore service

- In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of the chore service.

Section 8.26: Education Support Services

Service Description:

Educational support services consist of special education and related services as defined in sections 15 (elementary and secondary education) & 17 (higher education) of IDEA to the extent that they are not available under a program funded by IDEA or available for funding through OVR. Educational support services may consist of general adult education services including community college, university or other college-level courses, classes, tutoring to receive a general education development (GED) degree, and assistance necessary for the person to participate in apprenticeship programs.

Determining the need for services:

The following additional questions should be used to establish a determination of need for this service:

- Does the educational support services relate directly to the Outcome selected by the individual?
- Is the individual age 21 or below? If yes, they should have this service provided for them through the Department of Education.

- Did the individual graduate before the age of 21? If yes, OVR should be contacted prior to payment for this service under the Waivers.

Additional Documentation needed in the ISP:

- Documentation of verification that services are not available for funding through OVR or available through IDEA for individuals still in school.
- A summary of the documentation must be included in the service details page of the ISP.
- Documentation to support the continued need for service re-authorization i.e.; to train on a new skill, or progress demonstrated on current outcomes to date.

Service Guidelines:

- May consist of general adult educational classes, including community college, university or other college-level courses, classes, tutoring to receive a general educational development (GED) degree, and assistance necessary for the person to participate in apprenticeship programs.
- Services may not be provided through ODP funding if they are available through IDEA or OVR.

Section 8.27: Specialized Supplies

Service Description:

Specialized supplies consist of incontinence supplies not available through the MA state plan or private insurance. Specialized supplies are limited to diapers, incontinence pads, cleansing wipes, underpads, and vinyl or latex gloves. This service is limited to \$500 per individual per FY.

Determining the need for services:

The following additional question should be used to establish a determination of need for this service:

- Is the person incontinent?

Additional Documentation needed in the ISP:

- Documentation that the services are not available through the MA state plan and/or private insurance must be maintained in the individual's file and updated on at least an annual basis.
- Annual documentation may be placed in the ISP, a Service Note in HCSIS or in the individual's file.
- The summary of the documentation must be included in an Outcome section of the ISP.

Service Guidelines:

- Specialized supplies may only be funded when the service may not be provided under the MA state plan or private insurance because limitations have been reached, or when the service is not covered under the MA state plan or private insurance.

Section 9: Monitoring of Services

SC monitoring verifies that the individual is receiving the appropriate type, amount, duration, and frequency of services to address the individual's assessed needs and desired outcomes as documented in the approved and authorized ISP. For waiver participants, SC monitoring must take place at the minimum frequency outlined in Appendix D-2 (Service Plan Implementation and Monitoring of the Approved Waivers), in the current, approved Consolidated or P/FDS Waivers. For other individuals, SC monitoring must take place at least annually, or at a frequency necessary to ensure the health and welfare of the individual. In addition, the SC and ISP team gather information and review the Outcomes and selected services on an ongoing basis to ensure that the ISP continues to reflect what is important to and for the individual and that it continues to address the individual's needs, as described above. The ISP is revised or updated as needed based on these reviews. All revisions and updates are discussed with the individual and his or her family, surrogate, or advocate and plan team.

ODP exercises oversight of ISPs through its AE Oversight Monitoring Process to ensure that ISPs are implemented as written, including implementation of services and Outcomes as well as to ensure that ISPs for Waiver participants are developed in accordance with the current approved Waivers.

Supports Coordination Monitoring Requirements as Described in Appendix D-2 Service Plan Implementation and Monitoring of the Approved Waivers:

The AE and ODP are responsible to ensure that monitoring is conducted by SCs at a frequency and duration necessary to ensure services are provided in accordance with the waiver participant's ISP, and to ensure the waiver participant's health and welfare.

For Consolidated Waiver participants who receive a monthly service, the AE is responsible to ensure the following minimum monitoring requirements are met in accordance with the approved waivers.

Deviations (statutory vs. non-statutory) of the minimum monitoring frequency that involve monitoring at a frequency less than what is identified in the approved waivers, must be approved by ODP.

In addition, the individual may be asked to participate in other external monitoring, such as IM4Q surveys and oversight by the AE, County Program, ODP, or Department of Public Welfare.

Section 10: Addressing Changes in Need throughout the Year

If an individual experiences a change in need throughout the year, this change must be reflected in the individual's ISP. Upon verification of a change in need, the SC must document the change in a Service Note in HCSIS, update the individual's PUNS if applicable, and initiate a critical revision to the ISP.

The following guidelines in regard to the funding source should be used when addressing changes in need:

- *Waiver Participants:* Individuals enrolled in one of the Waivers must have their assessed needs addressed within the scope and limitation of the applicable Waiver, and therefore the ISP services must be updated as necessary to address a change in need.
 - If the change in need impacts the currently authorized services and/or funding, the SC must create a critical revision. The critical revision must be created, and submitted for authorization within seven calendar days of notification of the change.
 - If a change in need does not impact services or funding, the SC must create a general update. The general update must be created and finalized within 7 calendar days of verification of the change in need.
 - If the new service(s) or funding is denied by the AE, the AE must provide the individual their due process rights. In addition, the SC must update the individual's PUNS.
 - When a change in need will cause the individual enrolled in the P/FDS Waiver to exceed the P/FDS cap, the individual should be considered for enrollment in the Consolidated Waiver. If capacity is not available, a PUNS should be initiated to assess these needs. In the interim, base funds may be used to augment the services required by the individual in the P/FDS Waiver.
 - If an individual must request an exception to exceed the established limits or service conditions as detailed in the approved Waiver service definitions, a "Request an Exception" Form must be completed by the SCO and forwarded to the appropriate AE who will review it and forward it to the appropriate RPM.
 - The AE must approve and authorize or deny the revised ISP, including the attached funding within 14 calendar days.
- *Base-Funded Individuals:* Base funding is utilized as per the Mental Health and Mental Retardation Act of 1966 (50 P.S. §§ 4101-4704) subject to available funding.
 - If the change in need impacts the current services and funding, the SC must create a critical revision.
 - The County Program must approve and authorize or deny the revised ISP, including the attached funding within 14 calendar days.
 - If the new service(s) or funding is denied, the individual must be provided with their due process rights. In addition, the SC must update the individual's PUNS.

Section 11: Updating ISPs At Annual Meeting And As Needs Change

ISP Teams should review services at least annually and as needs change throughout the year. ISP Decisions made by teams, BHA or the Secretary of Public Welfare, are specific to the circumstances or needs of the participant at the time the decision was made and, in most cases, are not considered permanent or life time decisions. It is expected that these types of ISP decisions are revisited at least annually at the ISP Annual Review update meeting. If at any time, the team or AE who is expected to authorize services based on individual needs determines the services that were included in the ISP as a result of previously made decisions are not needed, it is expected that the ISP be revised to reflect the current needs.

Section 12: Helpful References

Annotated ISP (attachment)

Attached to this manual and located in the Learning Management System (LMS) is the annotated ISP which is a valuable tool for SCs to use when creating, updating, and/or revising plans. It provides clear and concise description summaries for each section of the ISP that will help all team members assist in the development of a quality ISP. The annotated ISP has been revised to provide more direction regarding what type of information is needed, what section of the plan the information should be captured in, in order to prevent duplication of effort.

ISP Timeline (attachment)

Attached to this manual and located on the ODP consulting website, www.odpconsulting.net, is an ISP timeline that will assist all team members with identifying ISP roles and the activities associated with the plan process.

The intention of the timeline is provide guidance to all team members involved in all activities of the plan process. ODP will not use the timelines as a basis for compliance but as measures to help ensure that the ISP is completed timely.

Travel Policy

- The travel policy allows specific services to be paid for in PA, or anywhere in the 50 Continental United States, the District of Columbia, and the American Territories during temporary travel. The American territories include the following: Guam, Northern Mariana Islands, Puerto Rico, United States Virgin Islands, and American Samoa.
- The following services can be provided during travel: Unlicensed home and community habilitation, residential habilitation (licensed or unlicensed), respite, nursing, therapy, supports coordination, Supports Broker, Behavioral Support, Companion, Specialized Supplies, and Transportation. (Transportation would include the mileage required to deliver the service while traveling).
- Travel plans must be reviewed and discussed by the ISP team and documentation of this discussion must be documented in a service note.
- Roles and responsibilities for individual and staff for Home and Community Services are the same during travel.
- Services are limited to previously authorized hours for vacations and other optional travel.
- All service definitions, program and provider criteria, and documentation of services apply during travel. For licensed residential services, the permanent residential setting must be located in PA.
- The provision of Home and Community Habilitation services during travel is limited to no more than 30 consecutive calendar days.
- Travel cost for individual and staff person are not covered.
- Individuals may choose to pay the cost of the staff persons travel from their personal funds as long as the individual's choice is documented and the team is in agreement.

Section 13: How to Process and Review Waiver Service Requests

Purpose: To provide a standardized process for SCs and AEs to assist, communicate and respond to requests without team concurrence to change an existing waiver service, to make an ISP modification, to request a new service and also to record requests for general waiver information.

SCs are the primary contact for all questions or service requests regarding the Waivers, therefore it is important that the communication between the individual or their family and the SC be clear and defined. It is important for the SC to document in a Service Note, all communication between them and the individual or their family. It is also important for SCs to differentiate between providing general waiver services information and the approval or denial of a request to change services or qualified providers. To improve communication and understanding of this process, the SC will:

- Answer each question raised by the individual, family or team member to the best of their ability. If necessary, research the answer and get back to the individual, family or team member as soon as possible.
- Provide a basis for the answer (the service definition bulletin, or the Waivers would be excellent sources). Explain that approval of waiver eligible services is specific to individual need and situation and may vary due to these factors.
- If the individual, family or team member is making a request on behalf of the individual, remind the individual or person making the request that the AE must authorize or disapprove services. Volunteer to help them submit a formal request for the service or change discussed. Submit the request to the AE as described below.

Request for New or Additional Services or Change in Provider:

When an individual/surrogate requests a change to an existing waiver service, a plan modification, request for information and new service requests that did not result in team concurrence, the SC and AE should follow the procedure outlined below:

Procedure (see chart below):

1. Clarify the request:
 - Clarify the request with the individual, his or her family, and/or provider.
 - What specific new service, additional service, or provider change is requested by the individual?
 - Document receipt and details of this request in the Service Notes in HCSIS.
 - Completion of DP22 initiates the 30 day requirement within which a written response to the request is required from the AE.
2. Identify what has changed in the individual's life by gathering the necessary information that has prompted this request. Some questions to ask include:

- Was there a change in the individual's physical health or behavioral health?
 - What is the progress the individual is making towards the desired Outcome?
 - Has there been a change with the primary caregiver?
 - Does the individual receive the currently authorized level of services?
 - Does the individual receive the authorized level of services from other service systems (EPSDT (medical/behavioral), education, children and youth, etc.)?
 - Is the request for the service related to services authorized but not received through other service systems (i.e. EPSDT or Therapeutic Staff Support)?
 - Is the requested service related to a specific health or welfare need for the individual?
 - Does the service require an evaluation from a specialist/physician?
3. Explain in detail the specific need and how the requested services will support this need.
 4. Complete the Waiver Service Request Form (DP1022). A copy of this completed form must be provided to the individual/family.
 5. Submit the request for supervisory review.
 - The SC supervisor/manager must review the form for completeness and accuracy and verify that Service Notes regarding this request have been entered in HCSIS.
 6. Formally submit the request to the AE for authorization or disapproval.
 - The SC supervisor/manager should submit the waiver service change request to the AE within 10 calendar days of receiving verification from the individual/family of the request.
 7. Notify the individual and/or legal representative of the AE's decision.
 8. Notify the individual and/or legal representative of their rights (if applicable).

Services requiring an evaluation from other specialists/physician:

If the requested new or additional service requires a physician's order or an evaluation from another specialist, the SC is required to complete the Waiver Service Request and Review Form, and include the requested health related service and the written instructions for obtaining this service. The request for this service is not a formal request and cannot be processed until the following is obtained: a physician's order, documentation that the service is not available through the MA state plan or private insurance, or an evaluation from another specialist is obtained.

- The SC is required to assist the individual/family in this process, if needed.
- The SC is not required to issue rights to fair hearings and appeals at this time since there has been no denial of service. However, necessary documentation is required prior to the consideration for the expenditure of base or waiver funds.
- The SC is required to document these activities in Service Notes in HCSIS.
- If the requested new or additional services require a physician's order, submission to MA or private insurance and/or an evaluation, the 30 day timeline will begin when the additional information is obtained and the formal request can be submitted.

The Formal Response:

1. The SC Supervisor/Manager electronically submits the Waiver Service Request and Review Form to the designated staff person at the AE within 10 calendar days. If necessary, supporting documentation should be received by the AE within 3 calendar days of the electronic submission. The AE will review the request within 10 calendar days.
2. The AE is required to review and respond to the request within 20 calendar days. If the form or documentation is incomplete, the AE shall notify the SC Supervisor in writing of the needed information.
3. The AE will complete, sign and date the form in all applicable sections.
4. If during the review a “no” response is indicated in any question in the *What needs to be completed to approve the request or provide a basis on which to deny the request* section, the AE will provide instructions to the SC (with a copy to the individual/family within 30 calendar days of the team meeting) of what is needed to move forward with the request or issue a denial, the reason for the denial and rights to due process and fair hearings and appeals.

If additional information cannot be obtained within this time frame, the AE shall consider this a denial and follow the rest of this procedure.

The AE Decision: Approval

1. If the AE approves the request in full, the decision should be communicated to the SCO within 3 calendar days of receiving the request.
2. Within 5 calendar days of receiving the decision, the SC shall complete a critical revision to the ISP, the SCO submits the ISP to the AE, and the change is authorized by the AE.
3. If the AE approves the request in part or on a time limited basis, the AE shall send a letter to the individual/person making the request and the SCO. The letter must describe the AE actions, the basis for the partial or limited approval and include a notification of the individual’s due process rights. Additionally, the SC shall make changes to the ISP and service authorizations must be entered into the ISP as a critical revision.
4. If the change involves a currently authorized service in HCSIS, the old authorization must be end-dated and a new authorization reflecting the approved change in units must be entered.
5. The Department may establish prior authorization for specific services and has the final authority for the content of ISPs, including directing the content of the services and supports in an ISP.

The AE Decision: Denial

1. If the AE denies the request, the decision should be communicated to the SCO within 3 calendar days of receiving the request.
2. Within 5 calendar days, the AE sends a letter to the individual/person making the request and the SCO detailing specifically what is being denied and the basis for the

denial. Specific references to the AE Operating Agreement, the approved Waivers and/or applicable ODP bulletins must be included in the denial letter.

3. If the AE denies a waiver participant’s request or gives a waiver participant partial or limited approval, the basis for this partial or limited approval must be provided.
4. The AE must provide due process and fair hearing information when services are denied in whole or in part situations.
5. If the individual pursues a fair hearing, then the AE will submit a copy of this denial letter with the fair hearing request.

Appeal of requested waiver services

Service requests and their decisions are subject to fair hearings and appeals review. All waiver service requests that are appealed will also be subject to a service review as outlined in bulletin 00-08-05, *Due Process and Fair Hearing Procedures for Individuals with Mental Retardation*, or any approved revisions.

Appeals of service requests for base-funded services

Each AE shall have service eligibility and determination processes for non-waiver services.

Waiver Service Request Process		
Calendar Days	Activity	Actions
Day 1:	Information Gathering	<ul style="list-style-type: none"> ● The SC is notified by the individual/team that there is a need to request a service, additional units of service, or a change in provider.
Within 2 days of request for service:	Documentation	<ul style="list-style-type: none"> ● SC completes the waiver service request form. ● SC documents confirmation of request in service notes. ● SC submits form to SC Supervisor.
Within 10 days of request for service:	Review at SCO level	<ul style="list-style-type: none"> ● SC Supervisor ensures form is completed and accurate and service note is completed. ● SC Supervisor submits form to AE electronically and documents date.
Within 10 days of receipt of the request:	Review at AE level	<ul style="list-style-type: none"> ● AE reviews request for service form (AE will alert SCO Supervisor if form is not complete).

Within 3 days of reviewing request:	Approve, disapprove or Authorize	<ul style="list-style-type: none"> ●AE completes, signs and dates the form in all applicable sections and electronically sends form back to SC Supervisor.
Within 5 days of receiving the approved/authorized form:	Critical Revision of ISP	<ul style="list-style-type: none"> ●SC must update ISP. ●SCO must submit ISP to AE.

Section 14: ISP Key Terms

Abbreviated Plan – A shortened ISP that may be used for someone who receives under \$2,000 in non-waiver services.

Administrative Entity – A county/joinder or non-governmental entity that performs waiver operational and administrative functions delegated by the Department, under the Department's approved Consolidated and P/FDS Waivers and Administrative Entity Operating Agreement.

Amount (of services) – The total volume of funded services (measured in units) that are authorized in the ISP and furnished to the individual.

Annotated ISP – An ISP template that contains ODPs expectations of required documentation and recommended best practices for each section of the ISP located in LMS.

Annual Review Meeting – The team meeting that is held annually to review the ISP.

Annual Review Process – Part of the ISP process that includes the review of information gathered, outcome development, identification of services and choosing a provider.

Annual Review Update – An ISP category that is used to document the results of annual review meetings.

Annual Review Update Date – The date by which the ISP will be reviewed, updated, approved, and authorized (if applicable) every year.

Bi-Annual Review – A process to review the ISP twice a year, or every six months. A bi-annual review is a requirement for Pennhurst Class members only. This bi-annual review starts 6-months after the annual review update date.

Bridge Plan – An individual's initial ISP, which has a timeline shorter than the FY to accommodate varying timelines for initial annual review meetings.

Community Supports – Services or organizations available within the individual's community.

Consent To Share ISP – The individual and his or her family, guardian, surrogate, or advocate provide consent to share the ISP with qualified providers online in HCSIS after it is approved.

Critical Revision – A revision to the ISP when there is a change in services, a change in provider or in the amount of funding required to address the needs of the individual.

Distribution of ISP – The distribution of the ISP, critical revisions and annual updates to individuals, family members and qualified providers prior to the effective dates of service.

Draft Plan – An ISP in HCSIS that can be edited or used by adding, deleting or revising information in that ISP.

Duration (of services) – The length of time that a service will be provided.

Eligibility – The functional qualification of an individual to receive services funded by ODP.

Fiscal Year Begin Date – For a FY renewal ISP, the FY begin date coincides with the beginning of the FY, July 1. Note that the FY begin date for initial ISPs should reflect the anticipated start date of the ISP.

Fiscal Year End Date – The FY end date of an ISP coincides with the end of the FY, June 30.

Fiscal Year Renewal – An ISP in HCSIS that is used to renew the ISP for the following fiscal year. The ISP will have a FY begin date of July 1 and a FY end date of June 30.

Frequency (of services) – How often a service will be furnished to an individual (ex. 3 times per week).

General Update – A revision to the ISP that is used to update information such as medical information, when not modifying services in the ISP. A general update is completed throughout the year when information changes.

Independent Monitoring for Quality (IM4Q) – Part of ODP’s quality initiative to collect and track outcome measures from the Core Indicators Survey and the Independent Monitoring Survey.

Individual Monitoring Tool – The regularly scheduled and ongoing monitoring of an individual's ISP to ensure that ISPs are implemented as written, including that services are provided as indicated on the ISP.

Individual Support Plan (ISP) – An individual’s summary of their planned services, identified as a result of review by the individual, family, and of preferences, outcomes, health, safety, and medical information.

Intermediate Care Facility for persons with Mental Retardation (ICF/MR) – A state-operated or non-State operated facility, licensed by the Department in accordance with Chapter 6600 (relating to intermediate care facilities for persons with mental retardation), providing a level of care specially designed to meet the needs of individuals who have mental retardation, who require specialized health and rehabilitative services.

Invitation to ISP – The letter sent by the SC which invites members of the individual’s plan team to the plan meeting.

Legal Guardian – A person not affiliated with a provider agency who has legal standing to make decisions on behalf of a minor or adult (for example, a guardian who has been appointed by the court).

Legally Responsible Individual – A person who has legal obligation under the provisions of the law to care for another person, including parents of minors (natural and adoptive), spouses, and legally-assigned relative caregivers of minor children.

Natural Supports – Unpaid assistance to an individual such as friends, family, neighbors, businesses, schools, civic organizations, and employers as well as other non-Waiver funding streams such as the Pennsylvania Medical Assistance State Plan, Behavioral Health, OVR and the Department of Education.

Non-statutory – Deviations of the minimum monitoring frequency that involve monitoring at a frequency less than the Waivers specifies.

Outcomes – Goals, levels of achievement and personal preferences the individual chooses to acquire, maintain or improve.

Participant Directed Services – The list of identified services in the service definitions and approved Waivers that are available to self direct.

Plan Creation – An ISP being created for the first time in HCSIS or if there is a time-span between two ISPs.

Pennsylvania Guide to Participant Directed Services – Is a guide developed to help people understand what PDS means and what PDS you can self direct. It is located on the odpconsulting.net website under ODP Topic Information.

Prioritization of Urgency of Needs for Services (PUNS) – PUNS is the current process for categorizing an individual's need for services. PUNS focuses on the existing services and supports received by the individual, the prioritization of urgency of need for requested services, and the categories of services needed. This information is used by AEs, County Programs, and ODP to prioritize waiting lists and for budgeting. The following are the PUNS categories of need:

- *Emergency Need* - Indicates a need for services within the next six months.
- *Critical Need* - Indicates a need for services greater than six months but less than two years in the future.
- *Planning Need* - Indicates a need for services greater than two years but less than five years in the future.

Quarterly Review – A quarterly review is used to edit or update an existing ISP when no changes to the existing services and supports are required at least every 3 months. The 4th quarterly review date originates from the date of the annual review and therefore, is the annual review

update. This option will not allow the Supports Coordination role to modify plan start and end dates.

Relative – Any of the following who have not been assigned as legal guardian for the individual with mental retardation: a parent of an adult, a stepparent of an adult child, grandparent, brother, sister, half-brother, half sister, aunt, uncle, niece, nephew, adult child or stepchild of a parent with mental retardation and adult grandchild of a grandparent with mental retardation.

Self Directed Services – This means the participant or their surrogate (representative) manages and directs the supports and services in the participant's ISP. In order to self direct, you must become either a Common Law Employer or Managing Employer, use one of the FMS options, and you must live in your own private residence or the residence of family.

Services and Supports Directory (SSD) – An online database of all the qualified service providers registered in HCSIS that is accessible to families and individuals during the registration process to locate qualified providers within a geographic area. The directory is intended to expand individuals' ability to make informed choices. This is the section of HCSIS where SC's choose qualified service providers from and attach them to the ISP.

Statutory – The monitoring frequency as specified in the Waivers.

Supports Coordinators (SC) – A SCO employee whose primary job functions are to locate, coordinate and monitor services provided to an individual.

Supports Coordination Organization (SCO) – A provider qualified to deliver the services of locating, coordinating and monitoring services provided to an individual.

Total Plan Budget Amount – The total of the authorized units of service for an individual in a FY.

Willing and qualified provider – A provider who meets applicable qualification criteria and agrees to provide services to an individual as stated in his or her ISP. Waiver providers must meet qualification criteria included in the approved Consolidated, P/FDS Waivers.