Person-Centered Service Planning Process In HCBS Authorities
42CFR 441.301 (c)(1)(i-ix)   and

Person Centered Service Plan in HCBS Authorities
42 CFR 441.301 (c)(2)(i-xiii)

Checklists for State Program Offices

Checklist for states **Procedures or Process** related to Person-Centered Service Planning at Minimum:

☐ Includes method for inviting and including people chosen by the individual

☐ Provides method for communicating necessary information and support to ensure that the individual directs the process to the maximum extent possible and shows the person's desired involvement.

☐ Assures the person is enabled to make informed choices and decisions

☐ Allows for the plan to be developed in a timely manner, and occurs at times and locations convenient to the individual and their representatives.

☐ Creates a reliable way to gather and reflect cultural considerations

☐ Assures all discussions are in plain language. Information is available in a manner that is accessible to individuals and their representatives, including those who have limited English proficiency.

☐ Includes strategies for solving disagreement within the process, including clear conflict of interest guidelines for all planning participants

☐ Assures the person centered service plan is developed by a conflict free case manager who is not otherwise a qualified provider of HCBS waiver services to the individual

☐ Offers choices to the individual regarding the services and supports the individual receives and from whom (including eligible and willing providers)

☐ Provides a description of the method for individuals to request updates and that the updates are developed in a timely manner

☐ Demonstrate that the services and supports reflect what is important to the person regarding preferences for delivery of such, and meet the needs identified through an assessment of need.

☐ Demonstrates the plan is commensurate with the level of need and the scope of services and supports available with the HCBS waiver and prevents the provision of unnecessary or inappropriate services and supports.

☐ May include whether and what services are self-directed

☐ Is signed by all individuals and providers responsible for its implementation and how a copy of the plan is provided to individual and his/her representative.

* Person Centered Planning requirements described in this final rule apply only to 1915(c) waivers and 1915(i) state plan options, and are consistent with the expectations described for 1915(k) authorities.

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Checklists for State Program Offices

☐ Describes how the individual and the conflict free case manager can assure the planning process Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual

☐ Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others

☐ Gathers and documents information which reflects what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare

☐ Identifies risk factors and measures used to minimize them, including back up plans.

Checklist for ***document requirements*** related to Person-Centered Service Plans, at Minimum, demonstrate:

The Individual is driving planning documentation:

☐ Individual's goals and desired outcomes are included, show a clear link to strengths and preferences

☐ Indicates how the person was provided opportunities to seek employment and work in competitive integrated setting(s) and the results of the person's decision

Setting documentation:

☐ Must document that the **setting is chosen by the individual** and **supports full access to the community**.

☐ Explains justification for any restrictions or modifications that are not consistent with the HCBS guidelines (e.g., specific choices, roommates, access to food, etc.)

Services and supports are individualized:

☐ Lists or describes services /supports which will be accessed to assist the individual to

- ☐ Engage in community life,
- ☐ Control personal resources, and
- ☐ Receive services in the community.

☐ Shows a link between supports and services and the individual's strengths and preferences.

☐ Shows alignment of supports and services with assessed clinical and support needs.

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Checklists for State Program Offices

☐ Individualized backup plans and strategies are described.

☐ Identifies any self-directed services and supports

☐ Reflects services which are both paid and unpaid, including any natural supports provided and by whom.

The Person Centered Service Plan must also:

☐ Describe how any disagreements which arose during the planning process were addressed, and indicates the agreement of team members, including the person whose plan it is

☐ Describe any risks identified and measures used to minimize the risk

☐ Identify providers of services and supports, including unpaid supports provided voluntarily in lieu of waiver or state plan HCBS

☐ Identify the person responsible for monitoring plan

☐ Show informed consent of the person whose plan it is, in writing

☐ Be signed by all individuals and providers responsible for its implementation. A copy of plan must be provided to individual and his/her representative and others involved.

Person Centered Service Plan Review and update:

☐ Must be reviewed and revised upon reassessment of functional need as required every 12 months or

☐ Must be reviewed and revised when the individual's circumstances or needs change significantly, and/or

☐ Must be reviewed and revised **at the request of the individual**.

Requirements related to any modifications under this section 441.301 (C)(4)(vi)(A) through (D) Home and Community Based Settings: Provider Owned or Controlled Residential Settings:

In those situations where a person lives in a residential setting that is owned or controlled by a service provider, and modifications are requested to the expectations of community settings under the above mentioned section of the rule, then the person centered service plan must document any of the following relative to the modifications requested:

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Checklists for State Program Offices

☐ Identify a specific and individualized assessed need

☐ Document the positive interventions and supports used prior to any modifications to the person centered service plan

☐ Document less intrusive methods of meeting the need that have been tried but did not work

☐ Include a clear description of the condition that is directly proportionate to the specific assessed need

☐ Include a description of the regular collection and review of data used to measure the ongoing effectiveness of the modification

☐ Includes established time limits for periodic reviews to determine if the modification is still necessary or can be terminated

☐ Includes the informed consent of the person for whom the modification is made

☐ Includes an assurance that the interventions and supports will cause no harm to the person.

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