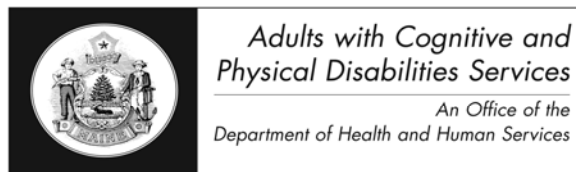


# Instructions for Personal Plan Forms

**June 2009**

**Developmental Services  
Maine Department of Health and Human Services**



*John E. Baldacci, Governor*

*Brenda M. Harvey, Commissioner*

## General Comments

These instructions are intended for use in conjunction with the **Person-Centered Planning Preparation and Procedure Guide**. The **Guide** explains the requirements and procedures for many of the items in these forms. You can read and download the **Guide** at the DHHS Developmental Services web page. <http://www.maine.gov/dhhs/OACPDS/DS/PCP-Action-Plan/guide.html>

Instructions for each item on the forms are *in italics*.

These forms are used to enter data into the DHHS Enterprise Information System (EIS). Please keep these forms together and numbered consecutively. They may be numbered either consecutively with the narrative, or numbered as a separate group.

We do our best to make changes only as needed, and to communicate to planning coordinators when changes are made. Still, we recommend that you check the Developmental Services web page occasionally to see if there are any changes or updates.

## Adult Developmental Services Personal Plan Face Sheet

A Face Sheet must accompany each plan, including interim plans that are developed at a time other than the annual plan.

### Identifiers

<b>Consumer name</b>	Self-explanatory	<b>Region:</b>  ___ 1    ___ 2A    ___ 3B ___ 2R    ___ 3P ___ 2L  Self-explanatory
<b>SS#</b>	Self-explanatory	
<b>MaineCare ID #</b>	Self-explanatory	
<b>EIS ID #</b>	The consumer's ID # in the DHHS Enterprise Information System. Providers may not have this number, in which case it should be added by the ICS/CCM	
<b>ISC/CCM name</b>	ISC = DHHS MR Services Individual Support Coordinator CCM = Community Case Manager contracted by DHHS	

### Facilitator

<b>Name of person writing this plan</b>	Self-explanatory
<b>Organization</b>	Self-explanatory

### Plan

<b>Plan start date</b> This would generally be the date of the planning meeting. Note that all dates are in mm/dd/yy format.	____ / ____ / ____	-	<b>Plan Type</b> ___ Annual    ___ Review/Other ___ Interim <p style="margin-left: 40px;">A <b>Review</b> may be required when MR Crisis Services are involved or when a person's circumstances change significantly. Refer to the Individual Support Team Policy in the MR Crisis Services Manual. (on MR Services web page) and the PCP Preparation and Procedure Guide</p> <p style="margin-left: 40px;">An <b>Interim Plan</b> is required for any unmet need. If an unmet need is identified as part of the annual plan, check both spaces and attach the interim plan. An Interim Plan written at any other time during the year needs its own Face Sheet.</p>
<b>Plan End Date</b> For an annual plan, this will generally be 1 year from the planning date. It could be less than a year if a significant change is expected that would require the team to reconvene and develop a new plan, e.g., the person is currently hospitalized but is expected to recover within 6 months.	____ / ____ / ____		

\* **Next Waiver reclassification date**    \_\_\_\_ / \_\_\_\_ / \_\_\_\_    OR    \_\_\_ No waiver

This is the date when the person is due for annual reclassification for MaineCare waiver services. If the person does not receive waiver funding, check **No waiver**.

**Continued on next page**

**\*Pre-Planning** [Note – this section may be left blank for an interim plan submitted separately from the annual plan]

<p><b>Preplanning start date</b> ___ / ___ / ___ . (see narrative)  <i>There may be more than one pre-planning conversation or meeting. Enter only the date when the pre-planning process started.</i></p>
<p><b>Response Sheet Summary used in Pre-Planning with consumer/guardian to set agenda for the planning meeting</b> ___ Yes ___ No  <i>Yes means the Response Sheet summary was used in setting the agenda</i>  <i>No means the Response Sheet summary was not used in setting the agenda</i></p>
<p><b>Reportable Events reviewed?</b> ___ Yes ___ No ___ No Reportable Events  <i>Yes means Reportable Events were reviewed</i>  <i>No means Reportable Events were not reviewed</i>  <b>No Reportable Events</b> means there were no Reportable Events in the past year</p>
<p><b>IST in past 12 months?</b> ___ Yes ___ No <i>self-explanatory</i></p>

**\*Routine Health**

<b>Date of most recent:</b>	
Physical exam	___ / ___ / ___ .
Dental/oral exam by a dentist <i>This refers only to an exam performed by a dentist. It does not include a dental/oral inspection done as part of the annual physical</i>	___ / ___ / ___ .
IV sedation for dental/oral procedure? ___ Y ___ N <i>Y means the person requires IV sedation in order to have a dental/oral procedure</i> <i>N means sedation is not needed</i>	___ / ___ / ___ <i>If IV sedation was needed, date of most recent use</i>
Vision exam (if needed) <i>This refers only to an exam performed by an optometrist or an ophthalmologist. It does not include a vision screening done as part of the annual physical</i>	___ / ___ / ___ .
Hearing exam (if needed) <i>This refers only to an exam performed by an audiologist. It does not include a hearing screening done as part of the annual physical</i>	___ / ___ / ___ .
Psychotropic meds? ___ Y ___ N <i>Y means the person has one or more psychotropic medications. N means the person has no psychotropics</i> Reviews 1. By psychiatrist? ___ Y ___ N 2. By psychiatrist? ___ Y ___ N <i>Enter the dates of the two most recent reviews.</i> <i>Y means the meds were reviewed by a psychiatrist.</i> <i>N means the meds were reviewed by another practitioner</i>	___ / ___ / ___ . ___ / ___ / ___ .
<b>Mortuary Trust</b> (age 50+ only) ___ Yes ___ No <i>Leave this blank for persons under the age of 50</i>	

<b>Current Medical Providers</b>	
<b>Name</b>	<b>Specialty</b>
<i>Enter the names of the primary care physician and each specialist.</i>	<i>Enter the specialty, e.g., "Family Practice", "Neurology", "Internal Medicine", etc.</i>

Developmental Services Grievance Process insert sent to consumer/guardian   
Check this box to verify that the Grievance insert was sent with the completed plan to the consumer/guardian.

Planning Coordinator signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_.  
This may be the signature of the person who wrote the plan or of an agency planning coordinator who has reviewed the plan.

**Action Plan** (To be completed by ISC/CCM)

Unmet needs are identified?    __ Yes (see narrative)    __ No unmet needs <b>Yes</b> means that unmet needs are described in the narrative and identified on the Need/Desire form <b>No Unmet Needs</b> means that there are no unmet needs., See the PCP Preparation and Procedure Guide for definition of an unmet need
Plan for assessing consumer satisfaction?    __ Yes    __ No <b>Yes</b> means there is a plan for assessing consumer satisfaction <b>No</b> means no plan for assessing consumer satisfaction was found
Planning team monitoring schedule: Enter "monthly", "quarterly" or other schedule for plan monitoring.

This plan accurately reflects the planning process and the person's needs and desires. The recommended services are medically necessary and in compliance with MaineCare rules.

ISC/CCM Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_.

\* These items are required for the annual plan only

## Notification and Attendance

This is a tracking sheet that records involvement in the planning process. It is not a signature sheet. Your agency may require a separate signature sheet.

"Pre-Planning Packet" is a generic term for any material sent out prior to team planning, such as the Response Sheet for Essential Information, assessments, reports, etc.

Relationship	Name (please print)	Check all that apply
<b>Consumer</b> <i>Self-explanatory</i>	<i>PLEASE Print names</i>	<input type="checkbox"/> Pre-planning packet <input type="checkbox"/> Notification <input type="checkbox"/> Invitation Attended meeting: <input type="checkbox"/> In Person <input type="checkbox"/> Via phone or other
<b>Guardian</b>	<i>If there is no Guardian, write N/A in this space.</i> <i>If MR Services is guardian, enter the ISC name here as well as in the ISC space below.</i> <i>If a family member is guardian, enter name here and in Family below</i>	<input type="checkbox"/> Pre-planning packet <input type="checkbox"/> Notification <input type="checkbox"/> Invitation Attended meeting: <input type="checkbox"/> In Person <input type="checkbox"/> Via phone or other
<b>Co-Guardian</b>	<i>If there is no Co-Guardian, write N/A in this space</i>	<input type="checkbox"/> Pre-planning packet <input type="checkbox"/> Notification <input type="checkbox"/> Invitation Attended meeting: <input type="checkbox"/> In Person <input type="checkbox"/> Via phone or other
<b>ISC/CCM</b> <i>Self-explanatory</i>		<input type="checkbox"/> Pre-planning packet <input type="checkbox"/> Notification <input type="checkbox"/> Invitation Attended meeting: <input type="checkbox"/> In Person <input type="checkbox"/> Via phone or other
<b>CAB Correspondent</b> <i>This space is ONLY for Correspondents designated by the Consumer Advisory Board. If there is no CAB Correspondent, enter name of regional CAB representative</i>		<input type="checkbox"/> Pre-planning packet <input type="checkbox"/> Notification <input type="checkbox"/> Invitation Attended meeting: <input type="checkbox"/> In Person <input type="checkbox"/> Via phone or other
<b>Advocate</b> <i>Enter name of DHHS Advocate</i>		<input type="checkbox"/> Pre-planning packet <input type="checkbox"/> Notification <input type="checkbox"/> Invitation Attended meeting: <input type="checkbox"/> In Person <input type="checkbox"/> Via phone or other
Family <input type="checkbox"/> Provider <input type="checkbox"/> Other <input type="checkbox"/> <i>Check the appropriate relationship</i>	<i>Enter the name of the individual</i> <i>You may also enter relationship for Family and Other e.g., "sister", "friend"</i> <i>You may also enter the agency name for service providers</i>	<input type="checkbox"/> Pre-planning packet <input type="checkbox"/> Notification <input type="checkbox"/> Invitation Attended meeting: <input type="checkbox"/> In Person <input type="checkbox"/> Via phone or other
Family <input type="checkbox"/> Provider <input type="checkbox"/> Other <input type="checkbox"/>		<input type="checkbox"/> Pre-planning packet <input type="checkbox"/> Notification <input type="checkbox"/> Invitation Attended meeting: <input type="checkbox"/> In Person <input type="checkbox"/> Via phone or other
Family <input type="checkbox"/> Provider <input type="checkbox"/> Other <input type="checkbox"/>		<input type="checkbox"/> Pre-planning packet <input type="checkbox"/> Notification <input type="checkbox"/> Invitation Attended meeting: <input type="checkbox"/> In Person <input type="checkbox"/> Via phone or other

You may use additional sheets if needed. Cross out or delete the first 6 rows on subsequent sheets. Number each sheet

Page \_\_\_ of \_\_\_

**CONTINUING SERVICES**

CONTINUING SERVICE	ASSIGNED TO	TARGET DATE
<b>Case Management</b>	<p><i>Name of <b>person</b> (not agency, not job title) who has responsibility for ensuring that the service is provided. This may be different than the person who actually provides the service. For example, a residential supervisor may be responsible for a person's medical care, even though a direct support staff may make the appointment for someone's annual physical, another DSP may accompany the person to the appointment, and the physician performs the actual examination.</i></p> <p><i>Responsibility will generally to assigned only to planning team members. In the example above, the residential supervisor would be assigned responsibility for the annual physical.</i></p> <p><i>Enter only <b>one</b> name for each service. If there is shared responsibility, enter the name of the person who has primary responsibility</i></p>	<p>____/____/____</p> <p><i>Enter the date in mm/dd/yy format. For Continuing Services, this would generally be a year from the planning date, unless there is reason to believe a service will end within the year</i></p>
<b>Representative Payee</b>		____/____/____
<b>Medical/Dental Monitor</b>		
<b>Critical Information updates to ISC/CCM monthly, or more frequently as changes occur</b>		____/____/____
<i>Enter the names of any other Continuing Services in this space and below. Detailed descriptions of the service should appear in the narrative, not on this form</i>		____/____/____
		____/____/____
		____/____/____
		____/____/____
		____/____/____
		____/____/____

Number each sheet. If more sheets are needed, cross out the first four pre-printed services at the top of each succeeding page.

**DESIRE/NEED AS DETERMINED BY TEAM**

<p><b>#.</b> You may assign any number you wish. The numbers are used only to keep sheets in sequence and to associate actions with Desires/Needs in case sheets get separated. The numbers are not entered into the EIS</p>	<p><b>NAME OF DESIRE/NEED:</b> The name entered here becomes the label displayed on the computer screen to identify the Desire/Need. Since a Desire/Need may encompass several actions, it is recommended to use the domains from the Response Sheet for Essential Information as names for Desires/Needs</p>	
<p><b>DESIRE/NEED DESCRIPTION:</b> A brief description of the Desire/Need                  ___ Projected date exceeds 90 days because: A brief statement explaining why the desire/need cannot be accomplished within 90 days(if applicable)</p>		
<p><b>START DATE:</b> ___/___/___ Date the Desire/Need is identified, usually the annual planning date.</p>	<p><b>PROJECTED DATE:</b> ___/___/___ Date the Desire/Need is expected to be accomplished, up to one year from planning date. If the Desire/Need is expected to take more than a year, check the long term goal box below.</p>	<p>___ DESIRE ___ NEED ___ UNMET Indicate if this is a Desire or a Need (cannot be both). If the Need (not Desire) is unmet, check the Unmet box. An unmet Need requires a separate face sheet and Interim Plan</p>
<p><b>PERSON RESPONSIBLE:</b> Name of <b>person</b> (not agency, not job title) with overall responsibility for this Desire/Need. Enter only <b>one</b> name. If there is shared responsibility, enter the name of the person with primary responsibility</p>		
<p><b>REASON:</b> ___ Continuing ___ New Most Desires/Needs will be New. A Continuing Desire/Need is one carried over from the previous year as a Long Term Goal</p>	<p><b>LONG TERM GOALS FLAG:</b> ___ Check if this Need/Desire is projected to take more than a year</p>	

<p><b>ACTION #:</b> Label each action with the number you gave the Desire/Need and a letter, e.g., 1A</p>	<p><b>ACTION NAME:</b> Identify the action. As with Plan name and Desire/Need, the action name becomes the label which identifies the action in the EIS</p>	
<p><b>ACTION DESCRIPTION:</b> A brief description of the action that will be taken. :</p>		
<p><b>ACTION START DATE:</b> ___/___/___ The date when the action is expected to start. This may be the planning date or any other time within the year</p>	<p><b>TARGET DATE:</b> ___/___/___ The date when the action is expected to be completed, up to a year from the planning date.</p>	
<p><b>PERSON RESPONSIBLE:</b> The name of the <b>person</b> (not agency, not job title) responsible for this action</p>		
<p><b>RESOURCES NEEDED:</b> Use this space to identify resources such as funds, staff, training, etc. which may be needed to accomplish the action. This need not be a descriptive narrative; a simple list is sufficient</p>		

<p><b>ACTION #:</b> If the action above is 1A, this would be 1B, etc.</p>	<p><b>ACTION NAME:</b></p>	
<p><b>ACTION DESCRIPTION:</b></p>		
<p><b>ACTION START DATE:</b> ___/___/___</p>	<p><b>TARGET DATE:</b> ___/___/___</p>	
<p><b>PERSON RESPONSIBLE:</b></p>		
<p><b>RESOURCES NEEDED:</b></p>		

If there are more than 4 Actions, use another Desire/Need sheet. On the new sheet cross out the Desire/Need block at the top and complete as many action blocks as needed, continuing the numbering for each action (e.g., 1E, 1F etc.)

<b>INTERIM PLAN</b>
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*Each Interim Plan needs a separate Action Plan face sheet with Interim Plan checked in the Plan Type space*

<b>#</b> Use the same number for the Interim Plan as the Desire/Need in the Annual plan. If this Need was not in the Annual plan, use a new number	<b>INTERIM</b> Use the same name as for the original Desire/Need	
<b>NEED DESCRIPTION:</b> Brief description of the Unmet Need		
<b>START DATE:</b> ____/____/____ Date the Need was identified as unmet	<b>PROJECTED DATE:</b> ____/____/____ Date the Unmet Need is expected to be met, up to a year from the original Plan Date	
<b>PERSON RESPONSIBLE:</b> Name of <b>person</b> (not agency, not job title) with overall responsibility for this Need. Enter only one name. If there are shared responsibilities, name the person who has primary responsibility.		

<b>ACTION #:</b> Use the number you gave the Interim Plan above plus a letter, e.g., 1A	<b>ACTION NAME:</b> Identify the action. As with Plan Name and Desire/Need, this name becomes the label identifying the action in the EIS
<b>ACTION DESCRIPTION:</b> Brief description of the action that will be taken to address the unmet need	
<b>ACTION START DATE:</b> ____/____/____ Date the action is expected to begin.	<b>TARGET DATE:</b> ____/____/____ Date the action is expected to be completed, up to a year from the Annual Plan date
<b>PERSON RESPONSIBLE:</b> The name of the <b>person</b> (not agency, not job title) responsible for this action	
<b>RESOURCES NEEDED:</b> Use this space to identify resources such as funding, staff, training, etc. that may be needed to accomplish this action. This need not be a descriptive narrative; a simple list is sufficient	

<b>ACTION #:</b> If the Action above is 1A, this would be 1B, etc.	<b>ACTION NAME:</b>
<b>ACTION DESCRIPTION:</b>	
<b>ACTION START DATE:</b> ____/____/____	<b>TARGET DATE:</b> ____/____/____
<b>PERSON RESPONSIBLE:</b>	
<b>RESOURCES NEEDED:</b>	

*If there are more than 4 Actions, use another Interim Plan sheet. On the new sheet write in the consumer's initials, cross out the block at the top and complete as many Action blocks as needed, continuing the numbering for each Action (1E, 1F, etc.). Number each page*

**Team Recommendation of Supports Waiver Services ( Section 29 )**

The planning team recommends the following service categories. See plan narrative for details.

*This form is used for persons who are eligible for services funded by MaineCare Home and Community-Based Services waiver Section 29. For complete service definitions see the MaineCare Benefits Manual, Chapter II, Section 29.*

*Check (✓) each service that the team recommends. Note that an individualized justification for the service and an individualized description of how the service will be provided for the person must be in the plan narrative*

\_\_\_\_\_ **Community Support** is Direct Support provided in order to increase or maintain a member's ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well-being. This is a habilitative service with a focus on community inclusion, personal development, and limited support in areas of daily living skills if necessary.

Estimated average \_\_\_\_\_ hours per week

*Teams should estimate the **average** number of hours per week the person will need the service over the course of a year. This estimate will be used in calculating the authorized hours of service for the year.*

\_\_\_\_\_ **Employment Specialist Services** include services necessary to support an individual in maintaining Employment. Services include: (1) periodic interventions on the job site to identify an individual's opportunities for improving productivity, minimizing the need for formal supports by promoting natural workplace relationships, adhering to expected safety practices, and promoting successful employment and workplace inclusion; (2) assistance in transitioning between employers when an individual's goal for type of employment is not substantially changed, including assistance identifying appropriate employment opportunities and assisting the individual in acclimating to a new job.

Estimated average \_\_\_\_\_ hours per week

\_\_\_\_\_ **Work Support** is a therapeutic and supportive service provided to improve a member's ability to independently maintain productivity and employment. This service is commonly provided after a period of stabilization and encompasses adherence to workplace policies and productivity. It may also include training and assistance in areas such as hygiene, self-care, dress code, and related issues. Work Support is provided in a member's place of employment and may be provided in a member's home in preparation for work.

Estimated average \_\_\_\_\_ hours per week

\_\_\_\_\_ **Home Accessibility Adaptations** are those physical adaptations to the home, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home

\_\_\_\_ (Describe in narrative)

\_\_\_\_\_ **Transportation service** offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170 (a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, are utilized.

(Describe in narrative)

\_\_\_\_\_ **Respite Services** provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the participant. Respite may be provided in the participant's home, provider's home or other location as approved by a respite agency or DHHS. Expenditures for this service may not exceed \$1,000 per year.

\_\_\_\_ (Describe in narrative)

**Planning Team Recommendation for Waiver Services (Section 21)**

The planning team recommends the following service categories. See plan narrative for details

*This form is used for persons who are eligible for services funded by MaineCare Home and Community-Based Services waiver Section 21. For complete service definitions see the MaineCare Benefits Manual, Chapter II, Section 21.*

*Check (✓) each service that the team recommends. Note that an individualized justification for the service and an individualized description of how the service will be provided for the person must be in the plan narrative.*

\_\_\_\_\_ **Home Support** is direct support provided to improve and maintain a member's ability to live as independently as possible in his or her home. Home Support may be provided in a Licensed or unlicensed residential setting, in a Shared Living arrangement, or in any other residential setting. Home Support is direct support to a member and includes habilitative training and/or personal assistance (self-care, self management), development and personal well-being. Home Support may be provided as either a regularly scheduled "round the clock" service or as less intensive individual hours, or blocks of hours, of service.

(\_\_\_ Per Diem) (Hourly, \_\_\_ hrs/week) (\_\_\_ Shared Living) (\_\_\_ Family-Centered, \_\_\_ persons served)

*Per Diem is group living. Hourly is for a person living in their own home and receiving occasional hours of home support during the week. Shared Living is a person living with a qualified caregiver under contract with a provider agency.*

*Family-Centered Support is a person living with a provider family in the provider's home. For Family-Centered Support, indicate the total number of persons served in the home.*

\_\_\_\_\_ **Community Support** is Direct Support provided in order to increase or maintain a member's ability to successfully engage in inclusive social and community relationships and to maintain and develop skills that support health and well-being. This is a habilitative service with a focus on community inclusion, personal development, and limited support in areas of daily living skills if necessary.

Estimated average \_\_\_ hrs./week

*Teams should estimate the average number of hours per week the person will need the service over the course of a year. This estimate will be used in calculating the authorized hours of service for the year*

\_\_\_\_\_ **Employment Specialist Services** include services necessary to support an individual in maintaining Employment. Services include: (1) periodic interventions on the job site to identify an individual's opportunities for improving productivity, minimizing the need for formal supports by promoting natural workplace relationships, adhering to expected safety practices, and promoting successful employment and workplace inclusion; (2) assistance in transitioning between employers when an individual's goal for type of employment is not substantially changed, including assistance identifying appropriate employment opportunities and assisting the individual in acclimating to a new job.

Estimated average \_\_\_ hours per week

\_\_\_\_\_ **Work Support** is a therapeutic and supportive service provided to improve a member's ability to independently maintain productivity and employment. This service is commonly provided after a period of stabilization and encompasses adherence to workplace policies and productivity. It may also include training and assistance in areas such as hygiene, self-care, dress code, and related issues. Work Support is provided in a member's place of employment and may be provided in a member's home in preparation for work.

Estimated average \_\_\_ hours per week

\_\_\_\_\_ **Home Accessibility Adaptations** are those physical adaptations to the home, required by the participant's service plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home.

(Describe in narrative)

\_\_\_\_\_ **Specialized medical equipment and supplies** include devices, controls, or appliances, specified in the plan of care, which enable participants to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and nondurable medical equipment not available under the MaineCare Benefits Manual. Items reimbursed with waiver funds are in addition to any medical equipment and supplies furnished under the MaineCare Benefits Manual and exclude those items that are not of direct medical or remedial benefit to the participant

(Describe in narrative)

Continued...

\_\_\_\_\_ **Communication Aids** are devices or services necessary to assist individuals with hearing, speech impairments to effectively communicate with service providers, family, friends, and other community members. Communication Aids include:

- a) Communicators (including repair and maintenance) such as direct selection, alphanumeric, scanning and encoding communicators;
- b) Speech amplifiers (includes hearing aids), aids and assistive devices (including repair and maintenance) if not otherwise covered for reimbursement under other sections of the MaineCare Benefits Manual;
- c) Facilitated communication. Providers must submit a written plan for DHHS's approval defining the facilitated communication services that will be offered to the Member. The provider of this service must have a Certificate of Clinical Competence-Speech Pathology (CCC-SP)  
(Describe in narrative)

\_\_\_\_\_ **Non-Traditional Communication Consultation** is provided to members and their direct support staff and others to assist them in to maximize communication ability as determined from assessment. The goal is to allow for greater participation in the service planning process and to enhance communication within the member's environment. The provider of this service must be a Certified Visual Gestural Communicator.  
(Describe in narrative)

\_\_\_\_\_ **Non-Traditional Communication Assessments** determine the level of communication present via gesture, sign language or unique individual communication style. The assessment examines signed or gestured vocabulary for every day objects or actions and. the ability to combine gestures, as well as the ability to understand similar communication. Assessment recommendations are made to optimize communication to maximize social integration. The provider of this service must be approved by The Department of Health and Human Services Office of Deaf and Multi-cultural Services.  
(Describe in narrative)

\_\_\_\_\_ **Consultation Services** are services provided to persons responsible for developing or carrying out a member's Personal Plan. Consultation Services include:

- a) Reviewing evaluations and assessments of the member's present and potential level of psychological, physical, and social functioning made through professional assessment techniques; direct interviews with the member and others involved in the Personal Plan; review and analysis of previous reports and evaluations, and review of current treatment modalities and the particular applications to the individual member.
- b) Technical assistance to individuals primarily responsible for carrying out the member's Personal Plan in the member's home, or in other community sites as appropriate.
- c) Assisting in the design and integration of individual development objectives as part of the overall Personal Planning process, and training persons providing direct service in carrying out special rehabilitative strategies identified in the member's Personal Plan.
- d) Monitoring progress of a member in accordance with his or her Personal Plan and assisting individuals primarily responsible for carrying out the member's Personal Plan in the member's home or in other community sites as appropriate, to make necessary adjustments.
- e) Providing information and assistance to the member and other persons responsible for developing the overall Personal Plan.

\_\_\_ OT      \_\_\_ PT      \_\_\_ SLP      \_\_\_ Psych

*Check the appropriate profession or professions.*

\_\_\_\_\_ **Counseling** is a direct service to assist the member in the resolution of the member's behavioral, social, mental health, and alcohol or drug abuse issues. Counseling services, as recommended in the Personal Plan, are approved by DHHS. The provider of this service must be a Licensed Clinical Social Worker (LCSW) or a Licensed Clinical Professional Counselor (LCPC).  
(Describe in narrative)

\_\_\_\_\_ **Crisis Intervention Services** are direct intensive support provided to individuals who are experiencing a psychological, behavioral, or emotional crisis. The scope, intensity, duration, intent and outcome of Crisis Intervention must be documented in the Personal Plan. Crisis intervention is commonly provided on a short-term intermittent basis.  
(Describe in narrative)

continued

\_\_\_\_\_ **Crisis Assessment** is a comprehensive clinical assessment of a member who has required intervention by the state Crisis Team on at least three occasions within a two-week period. The assessment includes: a clinical evaluation to identify causes or conditions that may precipitate the crisis, specific crisis prevention activities, and to develop a plan for early intervention and stabilization in the event of a crisis. The required members of a clinical team are a psychiatrist or licensed psychologist and a clinical liaison. Depending upon client need other team members may include: physician, occupational, physical or speech therapist.  
(Describe in narrative)

\_\_\_\_\_ **Transportation Service** offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State plan, defined at 42 CFR §440.170 (a) (if applicable), and does not replace them. Transportation services under the waiver are offered in accordance with the member's service plan. Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, are utilized.  
(Describe in narrative)

## Personal Plan Approval

*You may modify the format of this form, (e.g., use agency letterhead) as long as the text is not changed.*

Date: *fill in date*

Dear; *Name of guardian. If the person has no guardian, fill in name of person*

A copy of the Person-Centered Plan for person's name dated plan date is enclosed for your approval. Please check the appropriate box below to show if you approve the plan, or do not approve the plan. Return this letter to me in the enclosed self-addressed envelope within ten (10) business days. If you do not respond within 10 days, this may result in disruption of services.

- I approve the plan. I understand that I may revoke my approval of any or all parts of the plan at any time
- I do NOT approve the plan and will get in touch with you to discuss it.

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Service Recipient or legal guardian

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date

Thank you for your assistance.

Sincerely,

*If the guardian/person's signature cannot be obtained within 30 days of the planning date, send the plan to the Regional Office with a note explaining what attempts were made to obtain the signature.*