

Individual Support Plan (ISP) Instruction Manual

Updated 7/2014- for plans submitted
8/1/2014 forward

The following changes are included in this manual
<i>Updated ISP template pages</i>
<i>MMCP info (Medicare Medicaid Coordinated Plan)</i>
<i>Updated Supported Employment info</i>
<i>Updated pro-ration guidelines</i>

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Instructions for Completing an Initial or Annual Individual Support Plan

Purpose of the Individual Support Plan (ISP) Manual

The purpose of the Individual Support Plan (ISP) Instruction Manual is to help plan developers complete all of the forms required for an ISP.

Required Forms

Plan developers must complete each of the following required forms and submit them **completed** before an initial or annual ISP can be processed for authorization:

- Supports and Services Authorization worksheet (Excel version)
- Signature Page
- Personal Summary/Assessed Needs page
- Supports and Services page
- **ISP Supplemental Information Page- includes the Transition Plan (if applicable), Plan Monitoring questions, Safety Concern questions, and Alone Time in a CFH questions**
- **Supported Employment form**
- **Exception Review form(s) only in the following cases: the plan is requesting High or Intense Supported Living AND/OR Supported Employment and the request for these services will exceed the calculated budget**
- Safety Plan (if applicable, for Supported Living only)
- **Intense Blended Staffing Request form (if applicable)**
- **SME PA request form (if applicable)**
- **Medical Care form that is current within 365 days of submission (this form may indicate the participant was last seen on a previous date)**

For **ISP addendums**, **only** the following documents must be submitted:

- ISP Supports and Services Addendum worksheet (Excel version)
- Additional justification for services (if requested)
- **Exception Review form(s) only in the following cases: the addendum is requesting High or Intense Supported Living AND/OR Supported Employment and it will put the plan over the calculated budget or it will remain above their calculated budget**
- **Intense Blended Staffing Request form (if applicable)**

Important: Before submitting the forms listed, a plan developer should ensure the following requirements are met:

- All forms must be on the current version and typed. **Please do not change formatting or formulas.**
- All required forms must be submitted.
- All fields within the forms must be completed correctly.

Note: Plan developers will be notified if the forms do not comply or are filled out incorrectly, and an incomplete notice will be generated, as applicable.

Assessments and documents initiated by the Idaho Center for Disabilities Evaluation (ICDE) include:

- **Medical Care Form (sent to the participant for them to take to their physician)**
- Eligibility Determination Letter
- Medical, Social and Developmental Assessment Summary
- SIB-R report

Assessed needs for the ISP can be obtained from:

- History and Physical
- SIB-R (report only)
- Medical, Social, and Developmental Assessment Summary
- Developmental evaluations- including comprehensive and specific skill assessments
- Functional assessments
- Psychological evaluations
- Physical therapy/occupational therapy/speech assessments from independent therapy providers

Supports and Services Authorization Instructions

Note: **You can find an example ISP Authorization worksheet on the Adult DD Care Management website**

Participant Name: Type the name of the participant exactly as it appears on their Idaho Medicaid card.

Medicaid #: Type the participant's Medicaid identification number as it appears on their Idaho Medicaid card.

This form is broken down into 3 areas: DD services, Ancillary services, and Targeted Service Coordination services. As information is filled into each of these areas, each area will have an auto-populated annual cost total.

This form is able to have more lines added into it, however, the formatting and formulas may not always carry through.
DOUBLE-CHECK FOR ACCURACY

For those participants who have chosen to participate in the Medicare Medicaid Coordinated Plan (MMCP) program, service coordination professional and paraprofessional services are still costed against their budget but are not prior authorized.

Provider Name Column: List in this column all DD waiver and state plan service providers who are delivering services (that need to be costed) to the participant. All routine costs that support a participant in the community, and that are related to their disability, must be listed. Costs can be found at www.healthandwelfare.idaho.gov. Select Providers>Medicaid Providers>Medicaid Fee Schedule.

****Behavioral Health services (formerly known as mental health clinic, psychosocial rehabilitation and substance abuse services) are managed and paid for by the State's contractor, Optum Idaho and do not need to be costed against the participant's budget. Behavioral Health services must continue to be included in the Supports and Services. For more information on Optum's processes, visit www.OptumIdaho.com**

****For medical transportation service provision questions, contact American Medical Response (AMR) at 1-877-503-1261. This service can be included on the Supports and Services page. It is a Per Member Per Month service, so there is no cost to the participant's budget.**

****For Residential Habilitation Program Coordination services for Certified Family Home providers, contact Community Partnerships of Idaho at pcdata@mycpid.com. There is no cost to the participant's budget for this service.**

****Dental services have been reinstated for those participants on the enhanced plan. Dental services do not need to be included on the Supports and Services page.**

****For PD and TSC services covered under the MMCP program (True Blue Special Needs Plan) and other questions, see the FAQs posted on the Health and Welfare website. These services are costed at the rate shown on the most current fee schedule.**

Procedure Code Column: List the service code that corresponds with the DD waiver or state plan service. This service code can be found under the "Procedure Code" and "Modifiers" columns of the most current fee schedule (see Web site listed above).

Start Date and Stop Date Columns: Type the proposed start and stop date for each service being delivered.

Units Column:

Based on the service's unit time value, list the total number of units being requested for a particular service. Use the most current fee schedule for this information.

Examples of units and their time value are as follows:

- 1 unit = 15 minutes/1 day/1 mile/1 visit/1 per year, etc.

Reminder: When a service provider is requesting hours and the service unit's time value is 15 minutes, the number of hours requested must be multiplied by 4 to determine the total number of units. For example: 10 hours x 4 units per hour = 40 units

Unit Cost Column: Refer to the "Amount Allowed" column of the fee schedule for the dollar value of each unit. List this dollar value in this column. **Example:** For code H2032: 1 unit = \$3.02

Frequency Column:

Service units being requested must also have a frequency. To determine frequency, list how often the units of service are being delivered.

Examples of frequency to enter are:

- 365 for daily services (e.g. supported living: Daily rate, CFH)
- 52 for weekly services (e.g. developmental therapy, adult day health)
- 12 for monthly services (e.g. service coordination)
- # of units for yearly services (e.g. plan development)
- # of units for 1 time services (e.g. speech evaluation)

Annual Cost Column: This column will populate automatically based on a formula for each section. **DOUBLE-CHECK FOR ACCURACY**

Annual Units: This column will populate automatically based on a formula. **DOUBLE-CHECK FOR ACCURACY**

IPA # Column: This column is for Department of Health & Welfare use only. If the box for the "Service Type" contains a number, the service has been prior authorized.

Annual Total: This cell will populate automatically based on a formula and should show the sum from the 3 areas at the top of the form. **DOUBLE-CHECK FOR ACCURACY**

Calculated Budget Amount: Type the authorized budget amount from the participant's Eligibility Notice.

+/- Medicaid Annual Total: This cell will populate automatically based on a formula. **DOUBLE-CHECK FOR ACCURACY**

Final Plan Amount: Type the final amount requested. The Care Manager will review, approve, or negotiate and update the "final plan amount" as needed.

Instructions to pro-rate plans

When plans are extended due to an appeal or some other valid reason determined by the IAP or Care Manager (i.e. an initial plan is unable to be submitted and approved prior to the 90 days after the assessment), confirm with the Care Manager the dates needed to complete the pro-ration.

Instructions to pro-rate a plan— Based on the highest budget amount (for waiver participants) or the calculated budget (non-waiver) subtract the Plan Development amount for the year (\$290.16) and divide the rest

of the calculated annual budget by the 12 months in the year. This amount is then multiplied by the number of months left in the plan year to get the new pro-rated budget and the PD (\$290.16) is then added back in.

For example: If a \$35,000 budget plan should have started 1-1-2015 but was extended to 2-28-15, this is now a 10 month plan, starting on 3-1-15. $\$35,000 - \$290.16 = \$34,709.84$ divided by 12 = $\$2892.49$ x 10 months left in the plan year = $\$28,924.87$. After adding the PD back in, the new pro-rated total is $\$29,215.03$.

A plan that is extended should be pro-rated and turned in with 45 days to complete the plan review prior to the end of the extension.

Process for Physical, Occupational, and Speech Therapy Services on the ISP

Therapy services for adults with a developmental disability must be discussed as prioritized needs through the person centered planning process and be included on the ISP as part of the total cost coming out of the participant's annual budget.

Effective July 1, 2013, PT, OT, speech therapy, and all related evaluations are unable to be provided in a DDA. These must be provided by independent therapy providers.

Note: Therapy evaluations completed by independent providers may provide support in developing developmental therapy goals in a DDA.

Effective January 1, 2012, therapy services, when received from an independent therapy provider or outpatient hospital provider, are limited based on the annual Medicare caps below. **Please see Medicaid Information Release MA11-28 for more information on requests exceeding these caps.**

- \$1,870 per calendar year for speech language pathologist (speech therapy) services and physical therapy services combined.
- \$1,870 per calendar year for occupational therapy services.

If these services are required by a participant they need to be included and costed accordingly on the participant's plan; however, Medicaid does not reimburse for services that are duplicative.

For further information on these changes, see rule 16.03.09.732.04.

Signature Page Instructions and Example Form

Note: This form is provided as an example and can not be used as an actual ISP signature page.

Participant Name: Type the name of the participant exactly as it appears on their Idaho Medicaid card.

Medicaid #: Type the participant's Medicaid identification number as it appears on their Idaho Medicaid card.

MMCP: Check this box if the participant is enrolled in the Medicare Medicaid Coordinated Plan program.

Date of Person Centered Planning Meeting (PCP): Type the month, day, and year the PCP meeting was conducted.

Service boxes: Check the corresponding box(es) for the services the participant receives, including MMCP if they are enrolled.

Initial or Annual Plan: Check the corresponding box if this is the first state plan or waiver Individual Support Plan (ISP) being submitted for the participant or their annual plan.

Did the participant attend his/her Person Centered Planning (PCP) meeting?: Indicate whether or not the participant attended their person centered planning meeting by checking the appropriate box. If the "YES" box is checked, the plan developer must include a brief summary of how the participant participated in the process on the Personal Summary page. If the "NO" box is checked, the plan developer must provide information on how the participant participated in the process (e.g., discussion at another time) on the Personal Summary page.

Participant Address and Phone #: Type the participant's current physical address with city, state, and ZIP code. Type the telephone number where the participant can be reached. If needed, designate if the number is for a landline, a cell phone, or a message phone.

Participant Date of Birth: Type the participant's date of birth with month, day, and year.

Gender: Check the box for the participant's gender.

Guardian Name (if applicable): Type the first and last name of the participant's legal guardian or "Self" if the participant is their own guardian.

Note: If a participant is committed to the Department of Health and Welfare, indicate that the Department is the guardian.

Guardian Address: Type the guardian's current mailing address with city, state, and ZIP code.

Guardian Phone #: Type the guardian's phone number with the area code. **Note:** If a guardian is named, verify that a copy of the guardianship papers is on file with the Idaho Center for Disabilities Evaluation (ICDE). If not, obtain the guardianship papers and submit them to ICDE.

Guardian Email: Type the email address of the guardian.

Emergency Contact (if applicable): If no legal guardian is identified, type the name, address, and telephone number of a family member or friend who can be contacted in the event of an emergency.

Plan Developer: Type the first and last name of the plan developer.

Plan Developer Agency and Address: Type the agency's name and mailing address where the plan developer is employed with the city, state, and ZIP code.

Plan Developer Telephone #: Type the telephone number where the plan developer can be reached.

Plan Developer Email: Type the email address of the Plan Developer.

Planning Team Members Present for PCP Meeting: Individuals who are physically present at the PCP meeting must sign here.

Relationship to Participant: Each PCP team member must legibly print the nature of their relationship to the participant whether it be a member of the PCP team or a service provider (i.e. mother, developmental specialist, program coordinator, etc.). If the PCP team member is a service provider, have them also indicate their agency name in this section.

Other Planning Team Members Not Present: List the first and last name of individuals whose input/information was considered when developing the plan but who were not physically present at the PCP meeting.

Relationship to Participant: The plan developer must indicate the nature of the other planning team members' relationship to the participant. If a team member is a service provider, indicate their job title and agency name.

DD Waiver Participant/Guardian Initials: The participant/guardian must indicate by initialing that they have chosen developmental disability (DD) waiver services over intermediate care facility (ICF/ID) placement.

Participant Signature and Date Lines: The participant must sign (or mark or stamp) on this line if they are their own guardian. Write the month, day, and year the participant signed their plan.

- If the participant is unable or unwilling to initial/sign their name due to “individual special circumstances” (e.g., refusal to sign at that time, participant is tactile defensive), the plan developer must document the case specific reasons why with the submission of the plan.

Guardian Signature and Date Lines: The guardian's signature on the ISP Supports and Services Authorization page indicates the guardian's request for identified services on behalf of the participant. In the event the guardian is not physically present at the person centered planning (PCP) meeting, documentation must exist that verifies the plan developer forwarded a copy of the entire ISP Supports and Services Authorization worksheet to the guardian for review.

If a plan developer is unable to obtain the guardian's signature before submitting the ISP Supports and Services Authorization worksheet for authorization, the plan developer has the option of obtaining confirmation from the guardian by e-mail or telephone that they agree with the plan. The plan developer must then document in the guardian signature section the guardian's approval of the plan, the means by which the plan developer received approval from the guardian (e-mail or telephone), and the date the approval was received.

Although the ISP Supports and Services Authorization form can be submitted for authorization without the guardian's signature when the above mentioned documentation is present, the plan developer must still require the guardian to sign, initial, and forward a copy of the ISP Supports and Services Authorization form to the plan developer by mail or fax to support the request for services. The plan developer must then maintain the ISP Supports and Services Authorization form signed and initialed by the guardian in the participant's file for quality assurance review purposes.

Plan Developer Signature and Date Lines: The plan developer must sign here. Write the month, day, and year the plan developer signed the plan.

Plan Developer Acknowledgement ():** By signing this page, the plan developer acknowledges that any modifications to the Individual Support Plan (ISP) that was initially developed by the person-centered planning team will only be made with the agreement of the participant, guardian, and any applicable providers.

**For participants in a CFH, this ISP, along with current medical information and CFH implementation plans must be kept in the home.

ICT Care Coordinator Signature and Date Line: For those participants enrolled in the MMCP program, once the ISP has been written, the Plan Developer should forward the plan to the ICT Care Coordinator for them to review and assure non-duplication of services. Be sure and allow enough time for review to allow for initial/annual plan submission guidelines of 30/45 days.

Participant Name: Sally Jones	Medicaid #: XXXXXXX	MMCP <input type="checkbox"/>	Date of PCP Meeting: 8/1/2014
DD Waiver: <input checked="" type="checkbox"/> A&D/DD: <input type="checkbox"/> DD State Plan: <input type="checkbox"/>	Initial Plan <input type="checkbox"/>	Annual Plan <input checked="" type="checkbox"/>	Did the participant attend his/her Person Centered Planning meeting? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

Participant Address and Phone #: 001 Main Street Anytown, ID 80000 (208) 123-4567 Participant Date of Birth: 1/1/1901 Gender: M <input type="checkbox"/> F <input checked="" type="checkbox"/>	Guardian Name (if applicable), Address and Phone #: Nancy Jones 002 West St. Anytown, ID 80000 (208) 000-5555 E-mail: nancy@email.com	Plan Developer: Susie Planwriter Plan Developer Agency and Address: XYZ Service Coordination 003 North St. Anytown, ID 80000 Plan Developer telephone#: (208) 901-2345 Plan Developer email: sp@tsc.com Agency Administrator e-mail: ab@tsc.com
	Emergency Contact (if applicable): Deena Little (sister) (280) 891-0123	

Person Centered Planning Team Members

Planning Team Members Present for PCP Meeting	Relationship to Participant	Other Planning Team Members Not Present	Relationship to Participant
<i>Susie Planwriter</i>	Plan Developer/TSC- XYZ Service Coordination	Dan Driver	L:MNOP Transportation
<i>Nancy Jones</i>	Mother/Provider/Guardian	Nelly Needle	Nurse- QRS Services
<i>Shannon Jones</i>	Sister	Billy Banter	CBRS worker – Healthy Steps
<i>Debbie Data</i>	DS- EFG Developmental	Tawny Talker	Therapy, Inc.
<i>Gary Goal</i>	PC- ABC Agency		
<i>Wendy Work</i>	Job coach- EFG Developmental		

DD Waiver Participant/Guardian Initials: ND I have been informed of and understand my choice of waiver services. I choose to receive waiver services rather than to accept placement in an ICF/ID. I understand that I may, at any time, choose facility admission.

Authorization is requested for the services listed on the Authorization page by the following people:

_____	_____	_____
PARTICIPANT SIGNATURE	GUARDIAN SIGNATURE (if applicable)	PLAN DEVELOPER SIGNATURE
_____	_____	_____
DATE	DATE	DATE

****By signing this page, I am acknowledging as the plan developer that any modifications to the Individual Support Plan (ISP) that was initially developed by the person-centered planning team will only be made with the agreement of the participant/guardian and/or any applicable providers.**

For individuals living in Certified Family Homes, this ISP, accompanied by current medical information and CFH Implementation Plan(s) must be maintained in the home.

For Participants enrolled in Medicare-Medicaid Coordinated Plan (MMCP), this signature is required to ensure no duplication or contraindicated services.

ICT CARE COORDINATOR SIGNATURE DATE

Personal Summary Instructions

Participant Name: Type the name of the participant exactly as it appears on their Idaho Medicaid card.

Medicaid #: Type the participant's Medicaid identification number as it appears on their Idaho Medicaid card.

Participant Involvement in the Person Centered Planning (PCP) Process: Describe how the participant participated in the PCP process. Include a brief summary of statements and choices made regarding their services.

Additional information that has occurred since the ICDE assessment: Provide any further information related to the participant that was not captured in the ICDE assessment and/or has occurred since the assessment meeting at ICDE. This could be in relation to assessed needs, medical issues, critical incidents, etc. This can give the plan reviewer a more complete picture of what has happened in that time with the participant.

Assessed Needs:

An assessed need is identified through documented, professional, objective observation and testing. It is relevant to the participant's current situation and is determined by identifying which assessed deficits are necessities based on information that they impact or are barriers to the participant's independence. Assessed needs can be addressed through the use of available supports and services. They are skills the participant needs help with, not services they are to receive. A deficit may not necessarily be a need. If there is a need in an area based on assessment information, and the team would like to **defer** that need for the current plan year, indicate it as **"deferred"**.

During an ISP meeting, the following categories should be discussed and information **updated yearly**. Indicate **"Yes"** or **"No"** if an assessed need(s) exists in that area. There may be more than one assessed need in each area.

- **Physical/Mental Health:** Consider the primary and co-occurring diagnoses and health conditions of the participant (e.g., high blood pressure, allergies, specialized medical equipment, bipolar disorder, treatments, diabetes). **Do they need DME items to address their DD needs? Therapies?**
- **Living Situation:** Consider the participant's current living situation (e.g., in own home/apartment with or without roommates, certified family home with or without relative providers, residential assisted living facilities (RALF), activities of daily living, housekeeping skills). **Do they want to make any changes in this situation? What skills do they need to maintain their living situation?**
- **Family/Social Relationships:** Consider family members or natural supports which are involved in the participant's personal life and any family needs. **Do they need to build these relationships and their social skills?**
- **Behavioral Issues:** Consider behaviors that impact the participant's health and safety and the safety of others in the community. **What types of services would best address their behaviors (med mgmt., counseling, CBRS, etc.)**
- **Employment:** Consider where the participant works, what the participant does, and whether it is paid or unpaid employment. Consider if the participant is interested in employment. **What skills do they need to maintain or get employment?**
- **Legal Status:** Consider whether or not the participant is their own guardian or has a guardian. **Do they need a guardian? Are they involved in the legal system in any way? Do they have probatory guidelines?**
- **Communication:** Consider the participant's primary method of communication (e.g., verbal, sign language, communication devices, interpretive services) **What skills do they need in expressive/receptive language?**
- **Ambulation/Mobility:** Consider what adaptive equipment is necessary for mobility and what methods the participant uses to navigate through the community (e.g., bicycle, public transportation, drives own car, motorized wheelchair). **What skills do they need to be more independent and safe in their community/home?**

- **Financial:** Consider if the participant has a representative payee or conservatorship, trusts, personal checking and/or savings account(s), sources of income, and the participant's ability to manage funds or if assistance is required. **What types of skills do they need to handle financial transactions or decisions?**
- **Community Access:** Consider where/how often the participant accesses the community, their educational needs, interests, religious preferences, etc. **What activities would they like to be involved in to enhance their skills?**
- **Long Range Goals:** These are goals that the participant would like to achieve over time (not within the current plan year) with the help of their PCP team. These could include marriage, children, getting a driver's license, moving out of mom and dad's house in 10 years, pre-planning for end of life issues, etc. **The current year's assessed needs and objectives may contribute to achievement of these goals in the future.**
- **Personal Goals (NEW AREA):** Consider the goals of the participant based on their preferences, choices, and interests. See Section II of the MSDAS. **How is the team able to facilitate movement towards these goals during the current plan year, if possible?**

Correlate Assessed Needs to Goals to be Addressed Within the Plan Year: After identifying the assessed needs of the participant as identified during the PCP team meeting and in looking at other assessment tools, a direct relationship must always exist between each assessed need and the current plan year's participant goals and provider based goals/supports listed on the Individual Support Plan (ISP) Supports and Services page(s).

- For each area that is checked "Yes", give a brief description of the assessed need and list the corresponding goal/support on the Supports and Service page(s).
- For each area that does not have an assessed need or is not being addressed this current plan year, check "No" or "Deferred". There is no further response needed.

Supplemental Information Instructions (including transition planning, plan monitoring, safety concerns, and alone time)

Participant Name: Type the name of the participant exactly as it appears on their Idaho Medicaid card.

Medicaid #: Type the participant's Medicaid identification number as it appears on their Idaho Medicaid card.

Transition Planning - The transition plan is the process that is anticipated to meet the transition goal. It must facilitate independence, personal goals, and personal interests while helping the participant move toward fewer paid services and greater natural supports in community environments. The transition plan must include a transition into one or more of the following environments:

- An alternative setting
- Vocational training
- Supported or independent employment
- Volunteer opportunities
- Community based organizations and activities
- Less restrictive settings

There are **two instances** when a transition plan is required for a participant:

- A transition plan must be developed and included on the ISP when a participant has been notified that they are borderline eligible for waiver or state plan services at the beginning of the plan year on their eligibility notice.
- A transition plan must be developed when a participant is anticipated to transition to a lower intensity or frequency of any service they receive during the upcoming plan year.

The criteria in which a transition plan is required are stated on the form, as are the accepted transition areas.

- For **all** participants, mark the appropriate box indicating if a transition plan is needed.
- If a transition plan is required:
 - As a PCP team, discuss and write in the first column which transition area(s) are anticipated for the participant.
 - Assign each area with a number for purposes of tracking across the table.
 - In the second column, write the transition goal and planning steps for the identified transition area within the plan year. These goals and planning steps should be structured and progressive
Examples: a reduction in the amount of hours of a more restrictive service, increase in time with natural supports for supervision, use of other non-Medicaid funded resources, etc.
 - In the third column, write who is going to ensure the goal and steps are accomplished for each transition area.
 - In the fourth column, write the expected completion date for each transition area.
Note: Service Coordination notes should document the progress made toward each transition area.
 - For those transition steps where a service is decreased or discontinued and the annual budget is affected, **submit an addendum.**
- If the PCP team determines the participant needs a behavior/safety plan for one of the goals and planning steps, write "Refer to attached _____ plan".
- For participants who are moving out on their own or getting off probation, they still need to meet the criteria to have a transition plan.
- If the participant is expected to move between hubs or regions during the plan year, refer to the Transfer Protocol on the Developmental Disability (DD) Care Management website.
- Unexpected transitions throughout the year can be handled with an addendum, if necessary.

Plan Monitoring-

- Answer the 3 questions in this section using "Yes" or "No". For those questions with a "No" answer, the Plan Monitor/TSC (PM) should give an explanation. Provider Status Reviews are required to be submitted to the PM at 6

month and annual intervals, but do not need to be submitted with the plan. Care Managers may request this information if they feel it is necessary during plan review.

Safety Concerns and Alone Time -

- Answer the 6 questions in this section using “Yes” or “No”. Give an explanation for all answers, as needed.
- **Safety Plans for participants who are in Supported Living are submitted with the ISP**
- **For Alone Time in a CFH, please see the “Home Alone Guidelines for Adults with Developmental Disabilities” on the DD Care Management website. These safety plans are not turned in with the ISP.**

Safety Plan Information - A safety plan should be in place in the event that the participant requires immediate help at a time when a paid support is normally in place and is not available. A safety plan is needed when any of the following criteria are met:

- A “YES” answer for the following Safety Concern question is identified **and** the participant lives in a supported living environment:
 - “Within the last plan year have there been any situations that could re-occur that would put the participant or others in danger?” If a ‘yes’ response, a safety plan is required.
- **Any** requests for home alone time on an ISP for participants accessing High Supported Living services
- There is a transition to fewer paid supports indicated by a ‘yes’ for either situation on the transition section of the ISP. (i.e. a participant moving from ‘Intense’ to ‘Hourly’)

A safety plan generally includes the participant’s own knowledge of what to do in emergency situations, and the availability of natural supports and/or other paid supports or devices such as:

- Co-workers at a job site
- Roommate or neighbors at home
- Family, friends and good community acquaintances
- A Personal Emergency Response System (PERS)

A safety plan would need to include the following information:

- What support is in the plan to reduce risk?
- What will be done to resolve a risk due to loss of support?
- How has the participant demonstrated their ability to implement any part of the identified safety plan?
- How would the participant evacuate their residence?
- What mobility, functional and communication skills does the participant have to protect themselves?
- What back-up supports are in place?
- What ability does the participant have to recognize the need for and seek emergency help?

Supporting documentation, including but not limited to, staffing and activity schedules, progress notes, and incident reports may be necessary to determine if the safety plan is adequate. These can be requested by the Care Manager during plan review.

Supported Employment Instructions

Include the participant name and Medicaid number. Add the start and stop dates of the supported employment services that will be provided.

Questions 1-3 are for participants that ARE NOT currently employed and questions 4-6 are for participants that ARE currently employed.

If the responses for questions 1-3 indicate that DD Waiver Supported employment could potentially be pursued in the current plan year, and if the participant has not utilized supported employment before, the initial or annual plan will need to identify the intent for the participant to obtain a job and use supported employment, by including the following language on the plan. This assessed need should be addressed within the Personal Summary and the statement below should be added to the Supports and Services page.

“I have identified employment as a priority for my plan. When an employment opportunity has been identified, an addendum to my Individual Support Plan will immediately be submitted by my Plan Developer. The addendum will identify the provider I have chosen and the necessary units per week needed for supported employment”

This form should also come in with an addendum adding supported employment services. If the plan/addendum is over budget, the supported employment Exception Review Request form must also be submitted.

**Idaho Department of Health and Welfare
PERSONAL SUMMARY EXAMPLE**

(Including Assessed Needs, Transition Planning, Plan Monitoring, Safety Concerns)

Participant Name: Sally Jones		MID: XXXXXXX		
Participant Involvement in the PCP process: Sally identified who she wanted at her PCP meeting. While at the meeting, Sally stated what goals she wanted to work on at the center and that she wanted to do more job tasks independently. She agreed that she needs some work on her behavior and wants to work harder on that this year.				
Additional information that has occurred since the ICDE assessment: Since the ICDE assessment, Sally was hospitalized for 5 days with pneumonia. The PCP team is monitoring her health and may evaluate having her stay indoors more in winter and not go out in the community with the DDA group due to her susceptibility. Sally also has elected to try a new center closer to her home.				
<u>Assessed Needs</u> - Review the ICDE assessments and provider evaluation tools to identify the participant's assessed needs.	<i>Is there an assessed need(s) in this area?</i>			<i>If yes, give a brief description of the assessed need(s)- below your description list the corresponding goal(s)/support(s) from the Supports and Services page (a service, support(s), and or goal(s) on the Supports and Services pages should correlate to the assessed need(s) identified).</i>
	<i>Yes</i>	<i>No</i>	<i>Deferred</i>	
Physical/Mental Health	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sally has been diagnosed with Mild MR and Bipolar Disorder. She takes medication to help with her cycling. Sally also has nighttime incontinence on occasion. She is able to us the restroom during the day. Goal(s)/Support(s): symptom management, incontinence supplies
Living Situation	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sally lives with 2 roommates who she gets along with. Sally needs cues throughout her day to maintain a clean home. Sally needs assistance in learning ADLs, personal care skills Goal(s)/Support(s): make bed, take meds on time, complete a load of laundry, load dishwasher, cook a simple recipe, brush hair after showering
Family/Social Relationships	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sally is close with her family. Sally needs assistance in not interrupting others. Sally also would like assistance to meet new friends. Goal(s)/Support(s): wait turn when speaking, asking questions of others, plan new community activity 2 times a month
Behavioral Issues	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sally will sometimes hit others when asked to do something she does not want to do. Sally does engage in self-injurious behaviors such as scratching herself when she is upset. She could benefit from training in replacement behaviors. Goal(s)/Support(s): med mgmt., talking with staff when upset

Employment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sally just got a new job cleaning office a few nights a week so will need a job coach to help her maintain her employment.
				Goal(s)/Support(s): following list of items to clean, refilling window spray, cleaning bathroom items, asking for help when she can't locate a cleaning item
Legal Status	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
				Goal(s)/Support(s):
Communication	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sally is verbal but currently has difficulty with expressive communication skills due to slurring her speech.
				Goal(s)/Support(s): speech evaluation
Ambulation/Mobility	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sally is ambulatory, however, she does have decreased mobility on her right side due to seizure activity. Sally could benefit from PT to strengthen her right side.
				Goal(s)/Support(s): PT
Financial	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
				Goal(s)Support(s):
Community Access	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sally needs to work on using appropriate social skills in different environments and how to access different locations near her home.
				Goal(s)/Support(s): ordering in a restaurant, learning to ride the bus
Long Range Goals	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sally would like to be able to live alone in an apartment in 5-10 years. Sally's family would also like to do some planning for when they are no longer living.
				Goal(s)Support(s): link to funeral home to discuss burial planning, link to classes that discuss independent living
Personal Goals				Sally would like to take a trip to San Diego, learn how to ride horses, and take swimming lessons.

Idaho Department of Health and Welfare

Supplemental Information Form EXAMPLE

Participant Name: Sally Jones	MID: XXXXXXXX
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Transition Planning- A transition plan must facilitate independence, personal goals and personal interests. The transition plan must also meet the health and safety needs of the participant.

Based on the eligibility notice, is this a participant who may no longer qualify for DD waiver services at the end of the plan year?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Based on the PCP team discussion, is this a participant who will need to transition to a lower intensity/frequency of any services they receive during the current plan year?	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

If either question is marked “Yes”, describe the transition plan below in terms of where and how the transition will take place: It must be a transition into one or more of the following: An alternative setting, vocational training, supported or independent employment, volunteer opportunities, community based organizations and activities and/or less restrictive setting

Transition Area	Goal & Planning Steps (reduction of services)	Responsible Party	Expected Completion Date
1. Less restrictive setting	1. Reduce use of Supported living: A. Allow alone time beginning now for 4 hours during night. B. Increase activities with natural support, Julie C. Add visiting mom 2 weekends a month	1. Sally, RH, TSC, Julie, mom	1. 6-1-15
2. Community based organizations and activities	2. Increase community activities alone: A. Get/learn to use a bus pass to go to work, bowling, SO, ARC, and grocery store. B. Set up time to go alone to the community center where planned activities are taking place 2 hours a day 4 days a week	2. Sally, TSC, RH, mom	2. 7-1-15
3. Volunteer opportunities	3. Increase volunteer opportunities A. Volunteer at Idaho Youth Ranch(work up to 3 mornings/week, 2 hours each) *See attached safety plan	3. Sally, TSC, Idaho Youth Ranch, RH	3. 9-1-15 4. 6-1-15

4. Supported/ind. Emp.	4. Increase hours at work. A. Use a checklist & timer for independent guidance B. Ask co-workers for feedback on quality	4. Sally, job coach, McDonald's supervisor, TSC	
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<i>Plan Monitoring</i>	<i>Yes</i>	<i>No</i>	
Over the last plan year, were services provided to the participant according to the authorized plan?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>If no, what action was taken?</i>
Did you receive completed Provider Status Reviews for required services that show progression, regression, and/or maintenance of skills?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If no, please list the agency and the action taken</i> EFG Developmental. Plan Monitor contacted the agency at the 6 month time frame for this document. Agency did not respond, but did submit the document at the PCP meeting.
In the past year, was/is the participant satisfied with the quality and quantity of services received from all providers?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>If no, what action was taken?</i>

<i>Safety Concerns</i>	<i>Yes</i>	<i>No</i>	
Within the last plan year have there been any situations that could re-occur that would put the participant or others in danger?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If yes, describe the situation(s) in detail, how this is being addressed and by whom? <u>Include a safety plan for SL participants only</u></i>
Are there structural, physical, emotional, or environmental risks (i.e., evacuation during an emergency, etc.) that would present concerns related to the well being of the participant?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>If yes, describe the risks in detail, how this need will be addressed and by whom?</i> If there was a fire, Sally is able to evacuate on her own. Sally does not like loud noises. For her to access the community, those with her should prepare her for any unexpected noise she may encounter and offer her options to work through the situation.
Are there significant health and well being issues not addressed on the ISP?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If yes, describe them in detail and, in detail, how these needs are addressed and by whom?</i>

<i>Alone Time in a CFH</i>	<i>Yes</i>	<i>No</i>	
Does the participant/guardian want to utilize alone time?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>If yes, describe how much alone time is desired by the participant, when the participant would like to be alone, where the alone time will likely occur. If no, then do not answer further questions.</i> Sally would like to be alone for an hour a day when she returns home from the DDA (5 hours per week). She uses this time to listen to music.

Does the PCP team agree the participant's functional age and cognitive skills would allow the participant to follow a home alone safety plan to reduce risk and address health and safety concerns?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>If no, describe the risks or issues that the PCP team has identified that prevent the participant from utilizing alone time.</i>
Does the PCP team agree there are no issues (e.g. behavioral issues or impulse control) which would impact the participant's ability to follow a home alone safety plan to reduce risk and address health and safety concerns?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>If no, describe the risks or issues the PCP team has identified that prevent the participant from utilizing alone time.</i>

Idaho Department of Health and Welfare
Supported Employment Form **EXAMPLE**

Participant Name: Sally Jones	MID: XXXXXXXX	Start Date:	Stop Date:
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<i>Supported Employment</i>	<i>Yes</i>	<i>No</i>	
Please fill out this section if the participant is not currently employed			
1. Has the participant considered work as a goal?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<i>If no, give reason for not considering work as a goal:</i>
2. Has the participant gone through the Vocational Rehabilitation process?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>If no, please explain:</i> Sally is working on pre-vocational skills in DT prior to applying with VR.
3. What are the current goals that would increase the participant's ability to work?			<i>List goals here:</i> staying on task, following directions, personal hygiene, asking clarification questions
Please fill out this section if the participant is currently employed			
4. Does the participant require support on the job?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If yes, describe the type of Supported Employment supports needed for the participant to be successful at work (such as number of hours per week, if supports are needed for part of the work day or throughout the work day).</i>
5. Is it anticipated that Supported Employment Services will be accessed this year?	<input type="checkbox"/>	<input type="checkbox"/>	<i>If no, please explain:</i>
6. Describe the plan to transition the participant to greater independence while at work (such as a decrease in the number of Supported Employment hours, coordination with the job site supervisor)			<i>Describe here:</i>

Supports and Services Instructions and Example Form

Note: This form is provided as an example and is not representative of actual ISP Support and Services pages. The services below are not intended to be a comprehensive list. For services not listed here, refer to the fee schedule.

Participant Name: Type the name of the participant exactly as it appears on their Idaho Medicaid card.

Medicaid #: Type the participant's Medicaid identification number as it appears on their Idaho Medicaid card.

Supports and Services column: List in this column all of the supports and services that will be delivered to the participant during the plan year.

Some of the services listed in this column provide supports that have the participant's responsibilities and expectations listed in IDAPA code or their Provider Agreement and do not need to be copied here. These services include (see example Individual Support Plan (ISP) pages):

- Residential habilitation - supported living agency - include emergency number
- Plan development

Some of the services below have goals that may correlate to an assessed need and/or do not have measurable participant objectives associated with them. These supports are accomplished by the provider. If the participant receives any of the following services, please include a list of the supports being provided in the first column (see example ISP pages):

Service	Support to be listed
Residential Habilitation Program Coordination	Program Coordination Plan and Program implementation Plans (PIPs): Develop, implement and monitor **Indicate the number of hours of home alone time being requested per week (if applicable)
Residential Habilitation Certified Family Home	Supports of the home, frequency of doctor and dentist visits, and if substitute care/alternate care/alone time is being requested
Adult Day Health	Supports of the provider
Non- Medical Transportation	Pick up site and ending destination (including address and city for both)
Medical Transportation	Refer to AMR as the support for this service to/from DDA services.
Behavioral Consultation	Supports of the provider
DD Waiver Nursing services	Goals of the provider from their care plan-submit care plan
Durable Medical Equipment (DME)	Supplies/items
Service Coordination and Emergency Plan	Specific goals of the provider, frequency/mode of contact/who is being contacted, emergency and non-emergency situations, how to coordinate services after an emergency
Behavioral Health Services (psychotherapy, CBRS, med management, etc.)	Behavioral health goals are identified on provider treatment plan - double check there is no duplication with other services (16.03.10.513.04)
Natural Supports	Locations in the community that are accessed
OT/PT/Speech Therapy- Independent Providers	Goals to be addressed during the plan year

Lesser used services such as chore services, respite, home modifications, specialized medical equipment, personal emergency response systems (PERS), home delivered meals, and interpretation can be listed in the Supports and Services column, along with the frequency and provider in the appropriate columns.

Goals to be Addressed Within the Plan Year column: Based on assessed needs, include in the second column any short-term goals that the participant will work to accomplish within the plan year for the following service types:

- Residential Habilitation Certified Family Home (CFH)
- Residential Habilitation Supported Living
- Developmental Therapy
- Supported Employment (if an annual plan and has already been receiving the service)

Accessing Behavioral Health Services: The plan developer must obtain behavioral health assessments and/or treatment plans for use during the person centered planning process. When the initial/annual plan is written, assessed needs related to the participant’s behavioral health should be identified within the Personal Summary and goals should be included in the Supports and Services. Behavioral health services are not costed on the cost page. Regional Care Managers will review the ISP has no duplication of services, addresses health and safety and provides for the right care, in the right place, at the right price with the right outcomes. If through this clinical review, the care manager believes that developmental disability and behavioral health goals on the Supports and Services page are duplicative, the care manager may request behavioral health assessments and/or treatment plans can be requested from the Developmental Disability (DD) plan developer for more detailed information.

Requests for Supported Employment: If a participant has not utilized supported employment before, the initial or annual plan will need to identify the intent for the participant to obtain a job and use waiver supported employment by including the following language on the plan. This assessed need should be addressed within the Personal Summary and the statement below should be added to the Supports and Services page.

- **“I have identified employment as a priority for my plan. When an employment opportunity has been identified, an addendum to my Individual Support Plan will immediately be submitted by my Plan Developer. The addendum will identify the provider I have chosen and the necessary units per week needed for supported employment”**

During plan review, Regional Care Managers may request other documentation to see data or for clarification if the goals on the Supports and Services page appear to be too broad and/or duplicative.

Frequency Column: Identify how often each service or support is being delivered (e.g., 20 hours/week, 1 time/year, etc.) This frequency should correlate with what is on the authorization page.

- For durable medical equipment (DME), identify the quantity of the product (e.g., 3 boxes). If the product is also being requested on a regular basis (e.g., weekly, monthly), this information must also be included (e.g., 3 boxes per month, etc.). Refer to the DME fee schedule for pricing.
- For developmental therapy, identify whether it is home and community-based individual, home and community-based group, center-based individual, or center-based group developmental therapy.
- For non-medical transportation, include the miles per trip, trips per day, and the number of days per week it is occurring (e.g., 4 miles/ trip x 2 trips/day x 3days /wk).
- For natural supports, include the frequency the activities are completed.
- For the emergency plan, include the frequency, as needed.
- **For High Support, include the breakdown of how many hours of group and individual is receiving each week**

Agency or Provider Column:

- Type the name of the CFH provider, if the participant receives CFH services.
- Type the agency responsible for providing the service and/or support. Do not include the staff names from the agency. However, Residential Habilitation Program Coordination must include the name and contact information of the Program Coordinator.
- Type the name of the person or organization responsible for helping the participant during an emergency or for natural supports.

**Idaho Department of Health and Welfare
Supports and Services Form
EXAMPLE FORM**

Participant Name: Sally Jones

MID#: XXXXXXXX

*These are examples below- goals, supports, emergency objectives, etc. need to be specific to the participant the plan is being written for

Supports and Services	Goals to be Addressed Within Plan Year	Frequency	Agency or Provider
<p>Residential Habilitation Program Coordination</p> <p>If an “Alone Time” request to the right is approved, a Home Alone Time Program Implementation Plan (PIP) will be developed by the PC</p>	<p>Program Coordination Plan and Program implementation Plans (PIPs): Develop, implement and monitor</p> <p>**Participant will be safe for <u>7</u> hours of Alone Time a week.</p>	<p>365 days/year 52 weeks/year</p>	<p>Community Partnerships of Idaho</p> <p>Program Coordinator- Gary Goal 208-999-9999</p>
<p>Residential Habilitation (CFH)</p> <ul style="list-style-type: none"> -See Dr. Johnson (physician) 1x/ year -See Dr. White (dentist) 2x/ year -Assist with medications -Assist with scheduling appointments and transportation -Assist with daily living skills -Assist with finances -Assist with recreational opportunities <p>Alternate Care: None</p>	<p>Sally:</p> <ul style="list-style-type: none"> Will initiate taking medications Will increase independence with bathing skills Will increase social skills during meals Will increase shopping skills Will increase opportunities for community integration Will pick up own place and setting after meals 	<p>365 days/year</p>	<p>Nancy Jones, Provider</p>
<p>Residential Habilitation- Supported Living</p> <p>Emergency contact number: 111-1111</p>	<p>Sally:</p> <ul style="list-style-type: none"> Will increase independence with bathing skills Will increase shopping skills Will increase budgeting skills Will increase opportunities for community integration Will pick up own place and setting after meals 	<p>40 hours/week</p>	<p>ABC Agency</p>
<p>Adult Day Health</p> <ul style="list-style-type: none"> Assist with ADLs Monitor social opportunities Provide recreational activities 		<p>4 hours/week</p>	<p>EFG Developmental</p>
<p>Non-Medical Transportation</p> <p>From home (001 Main Street Boise) to Adult Day Health at EFG Developmental</p>		<p>1 mi/one way 2 miles/day 4 days/wk</p>	<p>LMNOP Transportation</p>

Supports and Services	Goals to be Addressed Within Plan Year	Frequency	Agency or Provider
(234 Foothill St. Boise) and back			
<p>Supported Employment I have identified employment as a priority for my plan. When an employment opportunity has been identified, an addendum to my Individual Support Plan will immediately be submitted by my Plan Developer. The addendum will identify the provider I have chosen and the necessary units per week needed for supported employment.</p>		TBD	TBD
<p>Behavioral Consultation Provide staff training Provide emergency back-up as needed Consult with direct care staff regarding behavior management techniques</p>		30 min./month	QRS Services
<p>Nursing Monitor prescription needs Monitor dietary needs Monitor blood pressure</p>		1 visit/month	QRS Services
<p>DME-gloves</p>		2 boxes/month	QRS Services
<p>Plan Development</p>		6 hours/year	XYZ Service Coordination
<p>Service Coordination and Emergency Plan By phone or in person the para-professional will: -Link to Special Olympics events in the area -Explore the guardianship process -Assist in locating appropriate transportation to DDA services By phone or in person the professional will: -Explore alternate care when Nancy is on vacation - Link to energy assistance</p>		Para- 1 hour/month Pro- 3 ½ hours/month As needed As needed	XYZ Service Coordination

Supports and Services	Goals to be Addressed Within Plan Year	Frequency	Agency or Provider
<p>-Conduct a face to face meeting with Sally at least every 90 days to review the plan</p> <p>-Monitor Sally’s satisfaction in the DDA and at her job every 90 days</p> <p>-Identify an emergency plan in the case of Sally injuring himself during a behavior</p> <p>-Complete 180 day review of TSC goals</p> <p>- By phone or in person the professional or paraprofessional will contact: Sally, mom, relevant providers, etc.</p> <p>-Discuss barriers to service provision</p> <p>-In the event of a medical emergency: Contact 911, and call Sally’s mother Nancy at 123-4567.</p> <p>-In the event of a non-medical emergency: Contact Nancy at 123-4567, sister Shannon at 891-0213. Susie can be contacted at 901-2345</p> <p>-In the event of an emergency, Susie will assist in contacting any applicable service providers if Sally is unable to attend services. Susie will also contact applicable members of the PCP team to discuss prevention and resolution of recurring emergencies.</p>		<p>As needed Every 90 days</p> <p>Every 90 days</p> <p>As needed</p> <p>Every 180 days Monthly</p> <p>As needed</p>	<p>Nancy Jones</p> <p>Shannon Jones</p> <p>XYZ Service Coordination</p>
<p>DDA</p>	<p>Sally:</p> <p>Will increase communication by using full sentences</p> <p>Will request assistance from store employees</p> <p>Will stay on topic in conversations</p> <p>Will follow multiple part instructions</p> <p>Will learn to make change using bills and coins</p> <p>Will learn to write a complete check</p> <p>Will learn to maintain an accurate check book</p> <p>Will tell time on a clock</p>	<p>Ind Center 2 hours/ week</p> <p>Group Center 2 hours/week</p> <p>Ind community 2 hours/week</p> <p>Group community</p>	<p>EFG Developmental</p>

Supports and Services	Goals to be Addressed Within Plan Year	Frequency	Agency or Provider
		2 hours/week	
Community Based Rehabilitative Services Provide training to build and maintain stabilization in mood, behavior Provide training to use medical resources appropriately		1 hour/week	Healthy Steps
Natural Supports -Church -Spend time with family -Special Olympics bowling		Every Sunday 1 wknd a mo. Weekly	Nancy Doe Shannon Sister Shannon Sister, George
Speech Therapy Improving speech production when asked a question Speaking clearly Enunciation		40 units/year	Therapy, Inc.
Medical Transportation To and from XYZ Agency for DT		5 days a week	AMR

Supports and Services Addendum Instructions

Note: **You can find an example addendum page on the Adult DD Care Management website**

Participant Name/Address/Phone: Type the name of the participant exactly as it appears on their Idaho Medicaid card. Type the participant's name current physical address with city, state, and ZIP code and their phone number.

Medicaid#: Type the participant's Medicaid identification number as it appears on their Idaho Medicaid card.

Guardian Name/Address/Phone Number/Email (if applicable): Type the first and last name of the participant's legal guardian or "Self" if the participant is their own guardian. Type the guardian's current mailing address with city, state, and ZIP code. Type the guardian's phone number with the area code. Type the guardian's email address.

ISP Start Date: Type the month, day, and year the current Individual Support Plan (ISP) was authorized for which an addendum is being submitted.

Plan Developer Agency/Name/Phone/Email: Type the Plan Developer's agency name where they are employed, name, phone number with area code, and email address.

Provider Requesting Addendum: Type the name of the individual/provider who is requesting the addendum on this line, if it is someone other than the plan developer.

Date Requested: Type the month, day, and year the ISP Supports and Services Addendum form is completed.

Reason for Addendum Request: Identify which of the options listed below is the reason for submitting the addendum.

Note: The reason must be based on the participant's need or want and must be clearly identified. More than one option can be listed. **Additional pages can be attached when justification is needed. ** An addendum is not needed for goal changes.**

- Adding or deleting services (e.g., supported living, supported employment, DDA).
- Changing the type of service (e.g., community DT to center DT).
- Changing the amount of service
- Changing the agency identified on the ISP Supports and Services form
- Change of participant address

Service boxes: Check the corresponding box(es) for the services the participant receives, including MMCP if they are enrolled.

For demographic changes for a participant (i.e. address, phone number, etc.)- the participant will also need to send an email to Self Reliance at MyBenefits@dhw.idaho.gov. This information will then be updated with Molina.

Adding Supported Employment with an addendum:

- **An addendum should be submitted with the Supported Employment form (see page 22).**
- **The addendum should be submitted at least 15 days in advance of the start date of supported employment being requested.**

- **If supported employment is being added to a plan or additional supported employment units are being requested that put the participant over budget, the Supported Employment Exception Review Request form must also be submitted**
- **If non-medical transportation is required to get the person to and from the job it must also be identified on the plan/addendum, costed, and this service must be within the assigned budget.**
- **An addendum cannot be used to add supported employment as an initial waiver service.**

Provider Name Column: Type the name of the provider of the service that a change is being requested for.

Procedure Code Column: List the service code that corresponds with the DD waiver or state plan service. This service code can be found under the “Procedure Code” and “Modifiers” columns of the most current fee schedule (see Web site listed above).

Start Date and Stop Date Columns: Type the stop date for the service that is being ended. Type both the start and end date for the service that is being added/modified. **Submission should allow for plan review and authorization at least 15 days in advance of the start date being requested.**

Units Column: See page 6 for how to list the Units in this column. For those service that are being decreased/ended, include a minus sign (-) in this column only.

Units Cost Column: Refer to the “Amount Allowed” column of the fee schedule for the dollar value of each unit. List this dollar value in this column. **Example:** For code H2032: 1 unit = \$3.02.

Frequency Column: See page 6 for how to list the Frequency in this column.

Annual Cost Column: This column will populate automatically based on a formula for each section. **DOUBLE-CHECK FOR ACCURACY**

Annual Units: This column will populate automatically based on a formula. **DOUBLE-CHECK FOR ACCURACY**

IPA # Column: This column is for Department of Health & Welfare use only. If the box for the “Service Type” contains a number, the service has been prior authorized.

Addendum Sub-Total: This cell will populate automatically based on a formula. **DOUBLE- CHECK FOR ACCURACY**

Previous Annual Plan Total: Type this amount here.

Calculated Budget Amount: Type the authorized budget amount.

New Medicaid Annual Total Line: Type this new amount here.

Participant Signature and Date Line: The participant must sign (or mark or stamp) here if the participant is their own guardian. If the participant is unwilling or unable to sign due to “special circumstances” (e.g., refusal to sign at that time, participant is tactile defensive), the plan developer must document the case specific reasons why with the submission of the plan. Write the month, day, and year the participant signed the ISP Supports and Services Addendum.

Guardian Signature and Date Line: Refer to page 9 of this manual for directions on how to get a guardian signature. Write the month, day, and year the guardian signed the ISP Supports and Services Addendum or the month, day, and year the guardian gave confirmation by e-mail or telephone of their agreement with the ISP Supports and Services Addendum.

Plan Developer Acknowledgment Signature and Date Line: The plan developer must sign here. Write the month, day, and year the plan developer signed the ISP Supports and Services Addendum.

Plan Developer Acknowledgement ():** By signing this page, the plan developer is acknowledging that any modifications to the Individual Support Plan (ISP) that was initially developed by the person-centered planning team will only be made with the agreement of the participant/guardian and/or any applicable providers.

ICT Care Coordinator Signature and Date Line: For those participants enrolled in the MMCP program, if they want to reduce/increase their TSC units, the ICT Care Coordinator will need to sign off on the addendum.

If a participant chooses to access the MMCP program mid-year and decides to change to a different TSC agency during that same plan year, the ICT Care Coordinator will need to sign off on the addendum. Once the addendum has been written, the Plan Developer should forward the addendum to the ICT Care Coordinator for them to review. Be sure and allow enough time for review to allow for addendum guidelines of 15 days.

THIS FORM IS ONLY FOR THOSE PARTICIPANTS NOT SELECTING THE MMCP PROGRAM

Plan Development Authorization Cover Sheet

Date	Assessor	Participant
Prior Authorization Start Date (Date provided by the plan developer)	Prior Authorization End Date	MID #
Plan Developer and Agency Name: (please print or type)		Provider Number (preferable):

Agency Notes (if needed):

Plan Development Services Have Been Authorized:
(for regional office use only)

Service	Frequency	Prior Authorization #
G9007 Plan Development	hours / year	

Department Notes (if needed):

Instructions: The Plan Development Authorization Cover sheet can be completed at the time of the person centered planning meeting or after. It can be turned in directly to the Regional Support Staff for prior authorization. **Note: The Prior Authorization Start Date should not be a day/month (date) earlier than last year's prior authorization date.**

Exception Review Instructions and Forms

DO NOT TURN THE INSTRUCTIONS IN WITH THE ISP

The Department will complete an exception review and negotiate additional funding in **only** the following circumstances:

This process is supported by the following rules:

IDAPA 16.03.10.515.03 Exception Review

High Supported Living:

Persons accessing **High Supported Living** and requesting additional funding must provide documentation to support that the service is required for health and safety and meets Medical Necessity criteria identified at IDAPA 16.03.10.012.14. The documentation should also include a start and end date for a projected time period the over budget plan costs will be needed.

Intense Supported Living:

Please submit supporting documentation and/or information according to the guidance below:

1. For participants who were determined to meet one (1) or more of the Intense Supports criteria during the eligibility determination and budget calculation process, it is only necessary to submit documentation and/or information to support a request for additional dollars to purchase services other than Intense Supported Living (i.e. Nursing Services, Behavioral Consultation, etc.). It will not be necessary to re-submit documentation that supports the request for Intense Supported Living services. OR
2. For participants who requested their budget be calculated using Intense Supports as their living situation but who were determined not to meet one (1) or more of the Intense Supports criteria during the eligibility determination and budget calculation process, it will be necessary to submit any additional documentation and/or information not submitted as part of the eligibility determination and budget calculation process that supports a request for additional dollars to purchase Intense Supported Living services and any other service(s) (as applicable). OR
3. Participants who did not request their budget be calculated using Intense Supports as their living situation during the eligibility determination and budget calculation process, documentation and/or information must be submitted to support a request for additional dollars to purchase Intense Supported Living services and any other service(s) (as applicable).

Submitting Documentation for Intense Supported Living:

1. A participant and the person centered planning team may request an Exception Review for individuals when they require **Intense Supported Living**. The participant's plan must include a request for Intense Supported Living services and supporting documentation must verify that the participant requires a type, frequency or intensity of support that is not addressed by the Inventory of Individual Needs. To qualify for additional funding there must be documentation submitted to support one or more of the following:
 - a. The participant has recent felony convictions or charges for offenses related to serious injury or harm of another person. ***These participants must have been placed in a supported living setting directly from incarceration or directly after being diverted from incarceration.***

- b. The participant has a history of predatory sexual offenses and is at a high risk to re-offend based on sexual offender risk assessments completed by appropriate professional.
- c. The participant has a sustained history of serious aggressive behavior showing a pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes that person fear bodily harm. The participant must also have the capability to carry out such a threat. The frequency and intensity of this type of aggressive behavior must require continuous monitoring and regular and routine intervention to prevent injury to themselves or others.
- d. The participant has chronic or acute medical conditions that are so complex or unstable that one-to-one staffing is required to provide frequent interventions and constant monitoring. Without this intervention and monitoring, the participant would require placement in a nursing facility, hospital or ICF/ID with twenty-four (24) hour on-site nursing. Verification of the complex medical condition and the need for this level of service requires medical documentation.

Supported Employment:

A participant and person centered planning team may request an Exception Review for **Supported Employment** as defined in IDAPA 16.03.10.703.04 when services are needed for the participant to obtain or maintain employment. Exception Review requests related to Supported Employment will be reviewed and approved based on the following:

- A Supported Employment service recommendation including the recommended amount of service, level of support needed employment goals and a transition plan. The Supported Employment recommendation shall accompany the Exception Review Request and must be completed by the Idaho Division of Vocational Rehabilitation (IDVR) when the participant is transitioning from IDVR services or by the Supported Employment Agency identified on the plan of service or addendum.
- A participant's plan of service has been modified by the participant and their person centered planning team to support employment as a priority. If no service modifications are made to accommodate the addition or increase of Supported Employment services, the person centered planning team will identify the reasons for the ongoing need for the requested mix of services.
- Acknowledgement that additional budget dollars approved to purchase Supported Employment services may not be reallocated to purchase any other Medicaid service signed by the participant and legal guardian if one exists.

All other participants requesting additional funding must do so as part of a budget appeal when they do not believe their assigned budget meets their assessed needs.

**** All other participants requesting additional funding must do so as part of a budget appeal.**

**** Care Managers may request additional information if they feel it is necessary during plan review.**

EXCEPTION REVIEW REQUEST FORM
FOR HIGH OR INTENSE SUPPORTED LIVING

Established Standards and documentation requirements identified below:

This process is supported by the following rules:

IDAPA 16.03.10.515.03 Exception Review

High Supported Living:

Persons accessing High Supported Living and requesting additional funding must provide documentation to support that the service is required for health and safety and meets Medical Necessity criteria identified at IDAPA 16.03.10.012.14.

PROJECTED TIME PERIOD the over budget plan costs will be needed:

Start Date: _____ End Date: _____

Intense Supported Living:

Please submit supporting documentation and/or information according to the guidance below:

1. For participants who were determined to meet one (1) or more of the Intense Supports criteria during the eligibility determination and budget calculation process, it is only necessary to submit documentation and/or information to support a request for additional dollars to purchase services other than Intense Supported Living (i.e. Nursing Services, Behavioral Consultation, etc.). *It will not be necessary to re-submit documentation that supports the request for Intense Supported Living services.*
OR
2. For participants who requested their budget be calculated using Intense Supports as their living situation but who were determined not to meet one (1) or more of the Intense Supports criteria during the eligibility determination and budget calculation process, it will be necessary to submit any additional documentation and/or information not submitted as part of the eligibility determination and budget calculation process that supports a request for additional dollars to purchase Intense Supported Living services and any other service(s) (as applicable).
OR
3. Participants who did not request their budget be calculated using Intense Supports as their living situation during the eligibility determination and budget calculation process, documentation and/or information must be submitted to support a request for additional dollars to purchase Intense Supported Living services and any other service(s) (as applicable).

The need to provide exceptional support to address health and safety issues associated with the following circumstances will be considered for additional funding. Documentation to support the services requested must demonstrate they are required, based on medical necessity described in 16.03.10.012.14.

Please check all of the criteria below that apply to the participant.

- The participant has recent felony convictions or charges for offenses related to Serious injury or harm of another person.

Documentation: The documentation must describe the incident(s) and outcome. The documentation must support that as a result of the incident(s), the participant will access Intense Supported Living directly from incarceration or directly after being diverted from incarceration. Information must be provided by the Supported Living agency indicating the reasons why additional funding is required to maintain the participant's health and safety, what type of additional support will be provided and the anticipated cost of providing the support.

- The participant has a history of sexual offenses and is at high risk to re-offend.

Documentation: The documentation must identify the type and frequency of the offenses. If there are current issues, data and incident reports must be provided to describe the status of the individual in relation to these offenses. There must also be a recent psychosexual risk assessment completed by a qualified professional that identifies the person's propensity to re-offend, why this level of support is required to maintain health and safety, and a treatment and supervision plan to manage or address any identified risk(s).

- The participant has a sustained history of serious aggressive behavior that shows pattern of causing harm to themselves or others. The serious aggressive behavior must be such that the threat or use of force on another person makes the person fear bodily harm and the participant has the capability carry out such a threat. The frequency and intensity of this type of aggressive behavior must requires continuous monitoring and regular and routine interventions to prevent injury to themselves or others.

Documentation: The documentation must include the data and incident reports to support frequency and intensity of the aggressive behavior(s). The Supported Living agency must include a current psychological evaluation and behavior management plan developed by a professional to address and manage the identified behaviors and the agency's plan for implementing this level of support in order to maintain the participant's health and safety.

- The participant has chronic conditions that are so complex or unstable that requires frequent interventions and constant monitoring and/or the participant has an acute medical condition that is so complex or unstable they require frequent interventions and constant monitoring.

Documentation: The documentation must include a current physician's order that supports the chronic or acute condition and any medical, behavior or psychiatric assessments and notes. The documentation must also include a physician plan or nursing plan for intervention. The professional's plan must indicate whether there is a need for around the clock up and awake monitoring, and if not, what frequency, intensity and type of support is required to maintain participant's health and safety.

PROJECTED TIME PERIOD the over budget plan costs will be needed:

Start Date: _____ End Date: _____

EXCEPTION REVIEW REQUEST FORM FOR SUPPORTED EMPLOYMENT

Participant Name: _____	Proposed Start Dates: _____
Supported Employment Agency: _____	
Request submitted by: _____	Job title: _____
The frequency of the additional Supported Employment being requested: _____	
Additional budget dollars requested: _____	

Supported employment consists of competitive work in integrated work settings for individuals with the most severe disabilities for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a severe disability. Because of the nature and severity of their disability, these individuals need intensive supported employment services or extended services in order to perform such work. (IDAPA 16.03.10.703.04)

The Department will complete an exception review of plans or addendums requesting services that exceed the assigned budget authorized by the assessor. The process for Exception Review Requests for Supported Employment is supported in IDAPA 16.03.10.515.03

Check (X) each of the criteria below has been met and supporting documentation is attached to the request:

- A Supported Employment service recommendation completed by the Idaho Division of Vocational Rehabilitation (IDVR) when the participant is transitioning from IDVR services or, when the participant is in an established job, by the Supported Employment Agency identified on the plan of service or addendum.
Documentation: The documentation must include a service recommendation which includes the recommended amount of service, level of support needed, employment goals and a transition plan.

- A comprehensive review of all services of the participant’s plan has taken place.
Documentation: The documentation must include a copy of the participant’s plan that includes a goal for supported employment. Additionally, for exception reviews submitted with an addendum, the plan developer should indicate that a review of services has taken place in the “Reason for Addendum Request” section. The combination of supports and services on the participant’s plan and the addendum must support the increase or addition of supported employment services.

- Acknowledgement that additional budget dollars approved to purchase Supported Employment services may not be reallocated to purchase any other Medicaid service.
Documentation: Participant and Guardian signature is included in the *Person-Centered Planning Team Endorsement* below.

Person-Centered Planning Team Endorsement:

By signing below, I acknowledge that additional budget dollars approved to purchase Supported Employment services may not be reallocated to purchase any other Medicaid service. I am also indicating that I believe the additional hours requested meet the Supported Employment needs of the participant and represent the participant's choice.

Participant Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Employment Agency Representative: _____ Date: _____

Plan Developer/TSC: _____ Date: _____

Other: _____ Date: _____

Other: _____ Date: _____

Supported Employment
Employment Agency Exception Review recommendation SAMPLE

Date:

Client:

Referral Source:

Employment Specialist/Employment Agency:

Employer/Location:

Client's Scheduled Hours:

Client's Current Wage:

Client's Employment Benefits:

Progress Summary:

(Support hours have been used to maintain the following performance/discuss client's progress on the job detailing successes and limitations)

Employment Goals/Objectives:

(List client's goals and discuss the client progress on the goals)

Recommended Amount of Service/Level of Support:

The client has learned the position and the job tasks and is meeting the employer's expectations with the support of a job coach. From the Employment Specialist observation and evaluations made during this training period the following level of support is recommended:

The client is currently working ____ hours per week

The client will require ____ (full, moderate low) level of support for ____ hours per week of Supported Employment to maintain employment.

Examples:

- The client is currently working 20 hours per week and will require full support for 20 hours per week of Supported Employment to maintain employment.
- The client is currently working 20 hours per week and will require moderate level of support for 12 hours per week of Supported Employment to maintain employment.
- The client is currently working 20 hours per week and will require a low level of support for 8 hours per week of Supported Employment to maintain employment.

Rational:

(Discuss the rational to justify the number of hours recommending)

Transition Plan:

(Discuss plan to transition the client to fewer hours of Supported Employment or to a different level of support during the upcoming year. If the participant is unable to transition to fewer hours or level of support, discuss why a transition plan is not feasible.)

Thank you,

ES name
Employment Specialist

Plan Developer ISP Checklist

Participant Name:

Plan Developer Name:

Date Submitted:

Plan Due Date (30 days prior to the requested start date for initials/45 days before the expiration of the existing annual plan)

- ISP forms: Authorization Worksheet, Signature Page, **Personal Summary/Assessed Needs page, Supplemental Information page(s), Supported Employment form, Supports and Services Page(s)**
 - Double-check Medical Care form was received by ICDE or submitted with plan
 - Check for participant/guardian/plan developer/**MMCP signatures** as applicable
 - Waiver box initialed (*) on Signature Page
 - Signature page indicates type of plan and MMCP, if applicable**
 - Goals and supports** are consistent with participant's assessed needs identified from assessments
 - Participants who have serious general maladaptive behavior index scores (below -22) and/or are requesting Intense Supported Living Services (based on IDAPA 16.03.10.514.02.b.i., ii., or iii.) should have at least 1 formal behavioral goal to be addressed within the plan year
 - Participants who have a GMI of -17 in combination with their age equivalency of 8-8y6m should have goals to address any behavioral issues
 - Participants who take prescription psycho-active drugs and who have Axis I diagnoses should have services or supports which address any behavioral and/or medication assistance or medication administration issues
 - Transition plan for participants who are borderline waiver plan eligible as noted on their annual eligibility notice or are expected to need less intensity/frequency of supports during the year
 - Goals (formal) for Certified Family Home, Supported Living, Developmental Therapy, Supported Employment** are listed on the Supports and Services page and link to an assessed need
 - Goals are specific enough to adequately determine what is being worked on and ensure there is no duplication of services, however, they are not so specific as to list individual objectives
 - CFH Provider enrollment letter is attached to initial plans and addendums requesting to start CFH Services
 - Plans indicating intent to receive supported employment show statements to this effect**
 - Services/supports (informal) for Adult Day Health, Behavioral Consultation, DD Waiver Nursing, Service Coordination, transportation, DME, behavioral health, and PT/OT/Speech therapies, etc.** are listed on the Supports and Services Page
 - PT/OT/Speech (independent provider) are on the cost page and cost caps do not exceed Medicare amounts
 - Assessment requests in a DDA do not exceed **4 hours for the year**
 - Behavioral Health services do not duplicate other services on the ISP
 - Frequency of services and programs are consistent with the participant's needs and current situation
 - Emergency contacts/objective listed on plan
 - Exception Review (*) form(s) to justify a request for plan cost above the authorized budget for High/Intense Supported Living or **Supported Employment only**
 - Risk Assessment (*)
 - Safety Plan for participants in Supported Living. 'Safety Concerns' and 'Alone Time in a CFH' sections of the Personal Summary must be completed for a participant requesting alone time in a CFH.
 - Nursing Plan of Care (*)
 - Provider Status Reviews are received by the TSC/Plan Monitor for required services (**DO NOT TURN IN WITH THE PLAN-KEEP IN FILE AND SEND IF REQUESTED BY THE CARE MANAGER**)
 - Participant is making progress or maintaining skills or new ISP indicates adjustment
 - Implementation plans for CBRs and DT/RES HAB (*) **NO DUPLICATION**
 - There is no duplication of services and services do not exceed 168 hours per week
 - Services are listed and costed accurately in units using the correct codes on the Authorization Page
 - DME/SME is identified on Authorization Page with the correct code and cost (*)
 - Non-medical transportation is identified on Authorization Page (*)- verify type (i.e. commercial, agency, or individual) and rate with transportation provider prior to costing
- (*) = if applicable

How to Initiate an Addendum

When a situation arises that requires a current service or support provider to request a modification to the existing Individual Support Plan (ISP) based on participant preference or assessed need, an ISP Supports and Services Addendum form must be submitted for authorization. The process for initiating an ISP Supports and Services Addendum for submission is as follows:

- Step 1. A plan developer and/or service or support provider may initiate an addition, deletion, or modification to the existing ISP.
- Step 2. The requesting provider then completes the ISP Supports and Services Addendum form according to the ISP Instruction Manual.
- Step 3. The requesting provider reviews the completed ISP Supports and Services Addendum form with the participant or guardian (if applicable).
- Step 4. The requesting provider (if not the plan developer) forwards the ISP Supports and Services Addendum to the plan developer.

If two or more service and/or support providers submit separate ISP Supports and Services Addendums for the same participant at the same time, the plan developer can create one overall ISP Supports and Services Addendum to encompass all requests for change, if the service and support providers agree with this arrangement. The plan developer will then be responsible for obtaining all required signatures on the one overall ISP Supports and Services Addendum.

- Step 6. Once the plan developer receives an ISP Supports and Services Addendum from a service or support provider, the plan developer evaluates whether it is necessary to convene a person centered planning (PCP) meeting to discuss the proposed request and verify the participant's or guardian's (if applicable) agreement with the request as stated in the ISP Supports and Services Addendum.
- Step 7. Once it has been verified by the plan developer that the participant/guardian is in agreement with the ISP Supports and Services Addendum request, the plan developer determines the financial impact of the request relative to the participant's annual budget.

For each service, numbers for costing should only be put into the unit, unit cost, and frequency columns. The addendum sub-total will auto-populate based on a formula. Complete the previous annual plan total, calculated budget amount, and new Medicaid annual total boxes.

If the ISP Supports and Services Addendum request puts the plan over the participant's assigned budget, the plan developer should collaborate with the PCP team to discuss alternatives to bring the plan within budget. If the PCP team is requesting High/Intense Supported Living **and/or Supported Employment** and the plan is over budget, the plan developer, together with the PCP team, must complete an Exception Review form.

- Step 8. The plan developer will then submit the ISP Supports and Services Addendum form along with the Exception Review form (if applicable) to the Information Coordinator (IC) who then forwards it on to the appropriate regional Care Manager for review and authorization. The requested start date of the plan should allow for 15 days to review, approve, and PA the addendum.

GUIDELINES FOR DURABLE MEDICAL EQUIPMENT AND SUPPLIES (DME) AND SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES (SME) FOR ADULTS WITH DEVELOPMENTAL DISABILITIES (2010)

PLAN DEVELOPERS AND DEPARTMENT STAFF

Plan Developers are responsible for assisting individuals requesting developmental disability services to obtain needed medical equipment and supplies and to submit Individual Support Plan (ISP) service authorization requests and addendums for costing as needed.

It is important to remember that if the participant you are providing services to is enrolled with Healthy Connections, a primary care provider referral is necessary for Medicaid reimbursement of Durable Medical Equipment and Supplies (DME) or Specialized Medical Equipment and Supplies (SME). You are responsible for assuring that this referral is obtained prior to requesting Medicaid reimbursement for DME or SME.

Durable Medical Equipment and Supplies (DME)

- Copies of DME rules are available through the IDAPA rules at 16.03.09.752
- If it has been determined that a participant needs any medical equipment or supplies during their Person Centered Planning (PCP) meeting or at any other time, the Plan Developer will need to consult with a chosen medical equipment vendor to determine whether or not the requested equipment/supplies are covered under Medicaid's DME limits and require prior authorization.
- If the DME does not require prior authorization the item and the cost will be included on the Individual Support Plan or addendum and reviewed by Regional Care Managers as part of their clinical review for cost and meeting assessed needs.
- If the DME requires a prior authorization, the plan developer works with the vendor to provide a copy of the final authorization to be submitted with the plan or addendum. The item and cost of the item will be identified on the plan or addendum. When DME has been authorized by the Medical Care Unit, the Regional Care Manager must negotiate other services to bring the plan within budget if applicable.
- If the equipment/supplies are not covered under the State Plan and the individual is either receiving or applying for waiver services, follow the procedure for Specialized Medical Equipment and Supplies (SME) listed below. The Medical Care Unit is currently reviewing SME, using CMS criteria and medical necessity. The Medical Care Unit will contact the vendor and request the Prior Authorization request form to follow the SME process below.
- When requests for non-covered equipment and/or supplies are submitted to the Medical Care unit, they will automatically consider any equipment/supplies under SME.
- If a participant is currently living in an ICF/MR or is applying for waiver services and will need either DME or SME immediately upon discharge onto the DD waiver, the vendor will need to provide the discharge order along with the PA request to the Medical Care Unit. The date of the PA may not be sooner than the date of the discharge.

- The authorization of the plan and/or the discharge from the facility should not be delayed waiting for authorization of DME or SME, unless the item is required to maintain health and safety for that participant in a community setting.

Specialized Medical Equipment and Supplies (SME) - DD Waiver

- Specialized medical equipment and supplies include devices, controls, or appliances, specified in the ISP. The equipment and supplies must enhance the participants' daily living, and enable them to control and communicate within their environment. This also includes items necessary for life support, ancillary supplies, and equipment necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the State Plan.
- Items covered under the DD waiver are in addition to any medical equipment and supplies furnished under the State Plan and shall exclude those items that are of no direct medical, adaptive, or remedial benefit to the participant. All items must meet applicable standards of manufacture, design, and installation, including Underwriter's Laboratory (UL), Federal Drug Administration (FDA), and Federal Communication Commission (FCC) standards. Items available under the Medicaid program may only be billed by a medical vendor provider.
- Prior to requesting SME, the Plan Developer or Service Coordinator must first attempt to access these services through all other resources including State Plan Medicaid coverage.
- SME does not include convenience items or devices to assist the provider in fulfilling their responsibilities as outlined in rule due to a disability or deficit of the provider.
- The code for SME can not be used to bill for DME or for participants that are not eligible for services on the DD waiver.
- If there are questions in regards to SME on the ISP, contact the Regional Care Manager.
- Vendors must have the appropriate Medicaid provider agreement in order to bill for the DME or SME types and specialties.
- The vendor submits a request for SME using the Specialized Medical Equipment Prior Authorization Request Form to the Idaho Medicaid Medical Care Unit.
- The Medical Care Unit will review the request and determine if it meets medical necessity criteria.
- If they approve the request, the Medical Care unit will fax a copy of the authorized vendor request to the vendor. The Plan Developer works with the vendor to get a copy of the authorized vendor request to submit with the plan or addendum. The request form includes information attempts to use natural supports and all efforts to find other funding.
- The Regional Care Manager uses the Medical Care unit authorization when reviewing addendums and plans to verify the plan cost request is within the assigned budget including the costs for SME.
- The Regional Care Manager will negotiate budget discrepancies as needed with the Plan Developer. Since the SME has already been authorized in MMIS, the Care Manager will need to negotiate other services to bring the plan within budget.

- If the Medical Care unit denies the request, they will send a denial notice to the vendor. The Plan Developer works with the vendor to determine which requests have been approved for inclusion on the plan or addendum.

Idaho Medicaid Specialized Medical Equipment Prior Authorization Request Form - Developmental Disability Waiver

*Return to: Idaho Medicaid Medical Care Unit
Fax: (800) 352-6044 Phone: (866) 205-7403 Mail: PO Box 83720, Boise, ID 83720-0036*

Please complete entire form and submit all required documentation

Medicaid Provider Information				
Provider Name:	Provider Number:	Phone:	Fax:	
Contact Person:				
Medicaid Participant Information				
Last Name:	First Name:	Initial:	Medicaid ID:	
Date of Birth:	Phone Number:	Healthy Connections Referral Number:		
Physician Information				
Physician Name:		Phone:	Fax:	
Diagnosis:			ICD-9:	
Requested Equipment				
HCPCS Code(s) Requested:		Start Date:	End Date:	
Monthly Rental Price: (Ten month rental to equal purchase)		<input type="checkbox"/> Required for hospital discharge, date:		
Required Documentation for Initial Request (please provide all required documentation for review)				
<input type="checkbox"/> Current, signed and dated physician order with diagnosis and length of need. Note: Verbal orders, signature stamps, or electronic signatures are not accepted.				
<input type="checkbox"/> For mobility equipment, a seating and mobility evaluation completed by a physical or occupational therapist. See www.dme.idaho.gov for the mobility evaluation form.				
<input type="checkbox"/> Documentation that shows that the equipment will 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.				
<input type="checkbox"/> Documentation that shows all natural supports have been exhausted and all efforts to find other funding. Attach documentation to this request or use comment section below.				
Notes or Comments: 				
(Department Use Only) Do not Write in Area Below				
Received Date:	Eligibility:	LTC:	TPOI:	Urgent:
Authorized: Yes No	Denied: Yes No	PA Number:		
Reviewer:	Date:	Keyed By:	Date:	

Guidelines for Developing Person Centered Plans that Encourage Independence

Every effort must be made to develop services and supports that meet the participant's identified assessed needs in the most independent manner. Participants should be encouraged and helped to find activities and develop relationships in their community. In considering the questions below, you succeed in helping the participant realize independence, identify natural supports, and reduce dependence on services. This in turn helps provide the paid services they need within their approved budget.

Here are some questions you can ask:

- Are the activities on the plan based on the participant's choice?
 - Do they support their life goals or slow them down?
- Do they need to learn skills to succeed in the activities, or do they just need assistance to access the activity?
 - Do they need training or just assistance in finding/accessing transportation?
 - Are the goals achievable?
- How much time are they able to focus on what is being taught?
- How often do they need to practice the skill in order to learn the skill?
- Is the skill being taught in the setting where they need to use it to be successful independently?
 - Should it be taught in a community activity of interest?
 - Should it be taught individually instead of with a group of other people?
- Are there duplicative services? If so, eliminate all duplications.
- How much supervision is required for the participant to be safe and the services effective?
 - Do they need a job coach through their entire working shift?
 - Do they need night supervision?
 - Do staff need to be up and awake?
 - Do they need supervision during all waking hours or could they be left alone for periods of the day?
 - Could they share a staff that could supervise both of them at the same time?
- Would services such as personal emergency response systems and home delivered meals make them more independent yet still provide for their safety and needs?
- What natural (unpaid) supports or goods can take the place of paid supports?

Adding Waiver Services When There is an Existing "State Plan Only" ISP

If a participant is on a state plan only ISP and wants to access DD waiver services before the next annual ISP, they must submit an application to the Regional Medicaid Services office. If the participant has been seen within 120 days, the assessor does not need to see them. If it is over 120 days, they will need to be seen and the SIB-R re-administered if it falls within the guidelines requiring a more current SIB-R. Following the determination for waiver, the assessor will send out a new eligibility letter which may have a new calculated budget. If the participant is determined eligible for waiver services, the plan developer must then convene a person-centered planning (PCP) team meeting to initiate a new initial waiver ISP. **An addendum cannot be used to add initial waiver services. The date of the new initial waiver ISP becomes the new annual re-determination date.**

Each of the following forms must be submitted before an initial waiver ISP can be processed for authorization:

- Supports and Services Authorization worksheet, Signature Page form, Personal Summary/Assessed Needs form, Supplemental Information form (includes Transition Plan (if applicable), Plan Monitoring questions, Safety Concern questions, Alone Time in a CFH questions, and supported employment questions), Supports and Services form(s)
- Exception Review form(s) (only in cases where the plan is requesting High or Intense Supported Living and/or Supported Employment and it is over budget)
- Current medical care form
- Safety Plan (if applicable, for Supported Living only)

Change in Plan Developer/TSC Agency Within the Plan Year

If a participant chooses to change their plan developer within the current plan year and the new plan developer is employed by a different service coordination agency, the request for the change in plan developer and plan development hours (if there are any within the 6 hours left) must be submitted on an Individual Support Plan (ISP) Supports and Services Addendum form by the new plan developer.

If a participant chooses to access the MMCP program mid-year and decides to change to a different TSC agency during that same plan year, the ICT Care Coordinator will need to sign off on the addendum. Once the addendum has been written, the Plan Developer should forward the addendum to the ICT Care Coordinator for them to review. Be sure and allow enough time for review to allow for addendum guidelines of 15 days.

Statewide Bureau of Developmental Disabilities Phone List

Regional Medicaid Services	
For assistance not found in this manual, review of crisis requests, application for services, and the plan submission process	
Region 1	(208) 769-1567 Select Regional Medicaid
Region 2	(208) 799-4430 or (877) 799-4430 Select Adult Developmental Disabilities Program
Region 3	(208) 455-7150
Region 4	(208) 334-0960
Region 5	(208) 736-3024 or (800) 826-1206
Region 6	(208) 239-6260
Region 7	(208) 528-5750

Independent Assessment Providers	
For eligibility determination and assessment	
Region 1	(208) 772-8502
Region 2	(208) 799-5044
Regions 3 and 4	(208) 373-1730
Region 5	(208) 736-5711
Region 6	(208) 282-5465
Region 7	(208) 525-7050

Adult Protection Services	
For reporting of suspected abuse, neglect or exploitation	
Area 1 (Region 1)	(208) 667-3179 or 1-800-786-5536
Area 2 (Region 2)	(208) 743-5580 or 1-800-877-3206
Area 3 (Regions 3 and 4)	(208) 332-1745 or 1-844-689-7562
Area 4 (Region 5)	(208) 736-2122 or 1-800-574-8656
Area 5 (Region 6)	(208) 233-4032 or 1-800-526-8129
Area 6 (Region 7)	(208) 522-5391 or 1-800-632-4813

Web Site Links

General Health and Welfare information:

<http://healthandwelfare.idaho.gov/Home/tabid/55/Default.aspx>

Adult DD Care Management: Forms, DD Application information, etc:

<http://healthandwelfare.idaho.gov/Medical/DevelopmentalDisabilities/AdultDDCareManagement/tabid/211/Default.aspx>

Self-Direction information:

www.selfdirection.idaho.gov

Administrative Rules:

<http://www.adm.idaho.gov/adminrules/>

Idaho Statute:

<http://www3.state.id.us/idstat/TOC/idstTOC.html>

Federal Regulations:

<http://www.gpoaccess.gov/cfr/>

Medicaid Provider Handbook

<https://www.idmedicaid.com/Provider%20Guide/Forms/AllItems.aspx>

DME Information

www.dme.idaho.gov

Medicaid Fee Schedule:

<http://healthandwelfare.idaho.gov/Providers/MedicaidProviders/MedicaidFeeSchedule/tabid/268/Default.aspx>

Molina:

<https://www.idmedicaid.com/Default.aspx>