VI. Supported Living

Family Outreach, Inc. contracts with State and community agencies to provide an array of Supported Living services. The following policies and procedures apply to Supported Living services provided through a variety of funding sources.

A. Intake and Referral

Intake and referral services for persons entering Supported Living includes a variety of activities to assist in the identification of individual needs and utilization and development of individualized resources and supports.

1. Program Admission

a. Policy

When requested by the DDP Program, a case manager, a family or individual, the Supported Living Program Manager or designee (satellite office) will develop a proposal for services.

b. Procedure

(1) The Program Manager or designee will review an individual's referral for services.

(2) When a referral is received the Supported Living Program Manager may assign an Individual Support Coordinator to participate in further review of details of the referral or participate in any meetings to gather and share information about requested Family Outreach services.

(3) The Supported Living Program Manager or assigned Individual Support Coordinator should develop a written proposal that outlines the details of services to be provided and the associated costs.

(4) The written proposal will be submitted to the person, their representative or the requesting case manager for consideration.

2. Program Capacity

a. Number of Persons Served

(1) Policy

The number of individuals enrolled monthly will be determined through contract. Family Outreach, Inc. may maintain more than the contracted number of individuals on the caseload. The total number of enrolled individuals is dependent on the frequency of contact with the individuals. The total caseload should not exceed 10% of maximum caseload number without approval of the Board.

(2) Procedure

(a) Each Individual Support Coordinator (ISC) will have a minimum and a maximum limit on the number of individuals on his/her caseload. The limit will be arranged between the Director, the Program Manager, and the ISC.

(b) The Director will monitor on a monthly basis the number of individuals receiving services and the total number of individuals on a caseload. The Director will obtain this information from the monthly contact report, the monthly census reports, and personal communications.

(c) Individual Support Coordinators will be encouraged to maintain their caseloads within their specific limits. If an Individual Support Coordinator desires to change his/her maximum limit, however, she/he can make a request to the Director through the Program Manager.

(d) If changing an ISC's maximum limit, puts the total caseload over the maximum limit then the Director must request permission at the next Board meeting.

(e) The Board will determine if the maximum caseload should be exceeded.

(f) In an emergency situation, the Director may submit the request to the Board President for temporary approval. The request will be discussed at the next Board meeting.

b. Caseload Size

(1) Policy

The maximum number of enrolled individuals per caseload is eight. Caseload size will be prorated according to the percent time for the position. (Example a 50% time position would have a caseload of 4 individuals). Depending on reimbursement of costs and stated contract individual to staff ratios, different funding sources may provide for an adjusted caseload size. Caseload adjustments due to contract requirements will be set for the terms of the contract agreement.

Factors such as the amount of travel and number of individuals on different funding sources could influence the total number of a caseload.

(2) Procedure

(a) According to the above policies, each Individual Support Coordinator will have a specific caseload (number of enrolled individuals) determined by the Director and the Program Manager. Caseload size may change according to the above policies.

(b) When an ISC is aware that a vacancy may occur on his/her caseload, the information should be referred to the Director through the Program Manager.

(c) The Director will notify the contract representative of any potential program exit. The ISC, as appropriate, will plan needed transition activities.

(d) The Director will notify contractor representatives of program vacancies.

c. Caseload Coverage During Absence

(1) Policy

Individual Support Coordinator's caseloads will be covered during an absence (for any reason) of three days or longer.

For absences of three weeks or less, another staff member will be designated as the contact person and will be responsible for any prearranged tasks/objectives that need to be completed during the leave.

For absences of longer than three weeks, services to individuals on the caseload will be prioritized according to number and type of contacts, and Personal Support Plan (PSP) objective/action responsibilities.

A staff member who assists individuals on another caseload may have to adjust the number and type of contacts and the Personal Support Plans of his/her caseload until the additional caseload is no longer his/her responsibility.

(2) Procedure

(a) If an Individual Support Coordinator's absence will be three weeks or less, she/he will review each client on caseload to prioritize contacts by type and frequency and identify PSP task/objective responsibilities. The ISC will recruit assistance with his/her caseload from staff in that office as soon as the leave is planned. If possible, the specific information regarding contacts and tasks will be arranged at least one week before the absence and reviewed with the Supported Living Program Manger.

(b) If the ISC's absence will be greater than three weeks, she/he will review with the Program Manager the service needs during the absence. The ISC will review each individual on the caseload to prioritize contacts by type and frequency, and specify essential PSP responsibilities. The Program Manager and ISC will determine the distribution of the caseload during the absence. Staff who may take on additional caseload responsibilities will be informed as soon as possible after the leave has been discussed with the Program Manager. If possible, the specific plan for the caseload distribution and service priorities will be arranged no later than one week before the leave. This may require that the Staff who takes on the additional individuals may have to adjust contacts and Plans for his/her regular caseload.

(c) The Individual Support Coordinator will notify the team in writing of who to contact during her/his absence.

3. Program Entry and Initial Contacts

a. Policy

The admission date for any Supported Living (Title XIX, Community Supports, etc) is the date on which billing can begin. This date is contingent on the procedures for a specific funding source.

The Individual Support Coordinator (ISC) will meet with the individual enrolled in Supported Living, the individual's guardian (if applicable), and any others the individual invites, to review the following: policies on confidentiality, program exit and grievances; explanation of support coordination; and explanation of program funding.

If a guardianship exists the enrolled individual is still the primary contact for the ISC.

b. Procedure

(1) After program admission the Individual Support Coordinator should immediately call the Administrative Assistant with individual's name, start date, and program, and enter the individual's name and other requested information on the Change of Service form. The Change of Service form is forwarded to the Administrative Assistant by the end of each month for census tracking.

(2) The ISC should determine if a guardianship exists for the enrolled individual, and the extent of any guardianship by requesting a copy of the guardianship decree for the individual's file. If a guardian has been appointed, the guardian will be contacted as appropriate for areas specified.

(3) The ISC should contact the enrolled individual to schedule an admission meeting.

(4) During the admission meeting the ISC will review with the individual the program information stated in policy and funding regulations. The ISC will also complete the Intake Information form, review screening information for accuracy and completion and determine the need for any additional assessments.

(5) All contacts with, or on behalf of, the enrolled individual will be documented in the Contact Records or Home Visit/Meeting Minutes reports.

B. Individual Records

1. Content

a. Policy

Each client will have two files which will be maintained by Family Outreach, Inc. in a confidential manner. One file is the Individual Support Coordinator's and the other is maintained by the Administrative Assistant. The Individual Support Coordinator's file will be made up of a current or working file and a file of past information.

The Individual Support Coordinator's working file for a full time or `active' client will contain:
(* = contained in client's central file also)

1. Intake information
2. Referral information*(including any guardianship decree)
3. Individual interview form
4. Latest psychological report
5. Personal Support Plan
6. Needs assessments including but not limited to Relationship Map, Ecological Assessment, and Compadre Self Assessment of Life Situation
7. Reports or records from agencies, therapists, doctors
8. Authorization for Release of Information* (when applicable)
9. Correspondence
10. Contact record
11. Meeting reports/minutes (individual and team)
12. Budgeting information* including copies of budget, DSP agreements, DSP timesheets, support requests
13. Teaching programs (individual and family/ friend)
14. Written statement of program exit (when exited from the program)*

For a client enrolled in a `limited' service the file will contain: (* = contained in client's central file also)

1. Intake form*
2. Eligibility Determination/verification Form* or referral record
3. Respite Care Services Agreement (if applicable)*
4. Annual Agreement Form*
5. Authorization for Release of Information (when applicable)*
6. Correspondence
7. Contact Record
8. Meeting Report (individual or team)
9. Support Requests* (if applicable)
10. Respite Receipts (if applicable)
11. Written statement of program exit (when exited from the program)*

For a client enrolled in Community Supports services the file will contain:
(* = contained in client's central file also)

1. The latest Community Supports Annual Risk/Needs Planning Assessment Form (RPA)*
2. DPHHS Community Supports Agreement and Authorization *
3. Family Outreach Category Justification Form*
4. Family Outreach Limited Agreement*
5. Authorization for Release of Information (when applicable)*
6. Correspondence
7. Contact Record
8. Meeting Report (individual or team)
9. Support Requests* (if applicable)
10. Copies of DSP invoices. (if applicable)
11. Written statement of program exit (when exited from the program)*

The file will be developed within five working days after the individual has entered the program.

The individual's file will be updated by the Individual Support Coordinator with each new Personal Support Plan. Completed items from 5 to 13 will be filed in a Past Information File.

Individual files are reviewed randomly.

b. Procedure

(1) The Individual Support Coordinator who is assigned intake forwards the original file information to the Administrative Assistant and maintains a copy for the working file. This should occur on the day the individual enters the program.

(2) The Administrative Assistant will assemble a central file after receiving information from the Individual Support Coordinator.

(3) The assigned Individual Support Coordinator will assemble the individual's working file. This will be completed within five working days after the individual has entered the program. The order of the file should follow an order similar to that described for a Past Information file.

(4) The Individual Support Coordinator is responsible for updating the materials in the individual files minimally with each new PSP and forwarding appropriate material to the Administrative Assistant.

(5) The Administrative Assistant is responsible for updating the materials in the individual's central file and forwarding materials that should be included in the Individual Support Coordinator's file.

(6) All entries into individual files will be legible, dated, and signed by the person making the entry (initials may be used as long as the individual's name is in the file).

(7) Individual's files are reviewed randomly to assure that the records are current, accurate, and complete. The Program Manager is responsible for the review.

(8) Upon completion of an Personal support Plan, the Individual Support Coordinator will file all documents related to that Personal Support Plan in chronological order in a Past Information File. Documents should be filed in the following order with item (a) appearing first, etc:

(a) PSP
(b) Teaching Plans for the individual and family/friend and documentation of completion. Teaching plans should be filed in the order they appear in the PSP.
(c) Contact forms and meeting minutes
(d) Budget information

2. Release of Information

a. Policy

Persons requesting specific information from an individual's file must obtain written approval from the individual and guardian, as applicable, and forward the request to Family Outreach, Inc.

Information in the individual files is confidential and information will not be released without proper authorization.

b. Procedure

(1) When an appropriately authorized consent for release of information is received, the original request should be sent to the Administrative Assistant to be filed in the individual's central file.

(2) A copy of the release will be filed by the Individual Support Coordinator in the individual's working file.

(3) The Individual Support Coordinator (or in some cases Administrative Assistant) will copy the requested information and forward it to the person requesting the information.

3. Access to Files

a. Policy

Family Outreach, Inc. Staff Members will have access to individual's files.

Individuals and guardian(s) will have access to the individual's file.

Persons requesting access to an individual's file must obtain written approval from the individual and guardian as appropriate and forward the request to Family Outreach, Inc.

Only Family Outreach, Inc. staff members can remove an individual's working file from a Family Outreach, Inc. office. The individual's central file can not be removed from the administrative office.

b. Procedure

(1) If an individual or guardian requests access to the individual's file, access should be given immediately during normal working hours.

(2) If a person with authorization requests access to an individual's file, the person should be given access immediately during normal working hours.

(3) Anyone requesting access should be advised that the most appropriate time to review an individual's file would be when the Individual Support Coordinator could be available to answer questions and clarify certain information.

(4) Anyone reviewing a file will be required to sign the Family Outreach, Inc. Disclosure Tracking Log kept in each file.

4. Obtaining Information

a. Policy

Family Outreach, Inc. staff will obtain written authorization from the individual and guardian as appropriate. The individual will be informed as to the specific information being requested and the agency or person having the information.

b. Procedure

(1) The Individual Support Coordinator will obtain the authorized signature (individual and guardian, as appropriate) on a Request for Release of Information form specifying the agency or person having the information and the information being requested.

(2) The Individual Support Coordinator will forward a copy of the signed Request for Release of Information form to the agency or person if requested. The original will be retained in the enrolled individual's central file.

(3) When the information arrives, the Individual Support Coordinator will file it in the individual's file and if appropriate forward a copy to the Administrative Assistant for filing in the individual's central file. (See B. 1. Content).

5. Maintenance of Individual Files

a. Policy

Family Outreach, Inc will file all individual files in filing cabinets. After an individual has exited from the program, the individual files will be maintained for five years. The individual's files will then either be forwarded to the individual or guardian, or will be destroyed.

If for any reason Family Outreach, Inc. terminated all services, the individual or guardian should be contacted regarding disposition of the file.

b. Procedure

(1) Staff will file all individual files in a filing cabinet.

(2) The Administrative Assistant will maintain all of the individual's files after program exit.

(3) When an individual exits from the program, the individual or guardian, as appropriate should be asked whether they want the file forwarded to them or destroyed at the end of five years. The Individual Support Coordinator will note any files which should be forwarded at the end of five years.

(4) The Administrative Assistant will send a letter to the individual or guardian, as appropriate at the end of five years to verify which files need to be forwarded and which files need to be destroyed.

(5) All files not requested to be forwarded, will be destroyed.

C. Assessment and Information Gathering

Information gathering refers to individualized procedures used to gather information about an individual enrolled in Supported Living and his or her environment including naturally occurring supports (other involved persons) for the purpose of making decisions regarding needed supports and program planning related to the Personal Support Plan (PSP). Information gathering specifically refers to a process of exchanging information between the individual, involved others and the Individual Support Coordinator (ISC). A variety of techniques (i.e. interviews, checklists, observations) may be used to help an individual determine areas of needed support; alternative methods for addressing needed supports; and alternative resources which may assist in addressing those needed supports. Information gathering is therefore an ongoing, multidimensional process which provides information regarding:

- The individual's unique strengths, abilities, and needs;
- The involved others (team) concerns and wants for the individual and their unique strengths and resources related to those concerns and wants;
- The supports and services needed to address the individual's and team's priorities.
- Additional information about Lifestyle, Wellness, Support Information, Personal Finance and an Annual Healthcare Checklist will be obtained as per PSP guidelines.
- Additional information compiled in the annual Quality of Life and Quality of Services survey will be summarized in the Lifestyle section and considered in PSP planning.

1. Schedule

a. Policy

Information gathering should begin as soon as a referral is received and be ongoing throughout enrollment.

Information gathered will be summarized at least once annually in preparation of the Personal Supports Plan.

The enrolled individual or enrolled individual's team may request a summary of all or parts of the information gathered on a schedule more frequent then the annual planning.

Information gathering activities may be limited due to the funding source (i.e. Community Supports).

b. Procedure

(1) Information gathering should begin during initial contacts with the individual and involved others.

(2) Information gathering is considered an ongoing process which occurs during all contacts with the individual and involved others.

(3) Information gathering on a more formal basis (medical, skill development, etc) may be initiated at any time a new concern, need or want is expressed by the individual or involved others.

(4) Information gathered will be summarized at least annually in preparation of the PSP.

(5) The enrolled individual or with the individual's approved release of information, involved others may ask for a summary of all or parts of information gathered at any time throughout the PSP cycle.

(6) Information gathering for individuals served by funding sources such as 'Community Supports' may be limited to the specifications of the Consumer Support Agreement.

2. Team

a. Policy

Information gathering is a multidimensional process in which information and ideas are exchanged between the individual, involved others and the ISC with the individual participating at the level he/she chooses.

The nuclear team for the purpose of information gathering includes the enrolled individual and the ISC.

An enrolled individual will be involved in all information gathering unless they choose not to be directly involved and indicate that the content of the information gathering can be shared with her/him at a later date.

The enrolled individual and the ISC will jointly determine others who may assist in the evaluation process. The enrolled individual will have final authority in deciding on participants.

b. Procedure

(1) The nuclear team for the purposes of information gathering will include the ISC and the enrolled individual.

(2) For information gathering to be a multi-dimensional process, other professionals, care-givers, and support persons may be involved in sharing information as requested by the enrolled individual.

(3) In initial contacts and, at least, annually in preparation of the PSP, the ISC with the individual will determine other persons who may have information for the development of the PSP. Sources of information may include physicians, therapists, social workers, family members, care-givers (such as PCA's),

employers, and friends. The ISC will document this information on a Home Visit Record. As requested the ISC will obtain an appropriate release of information for gathering the identified information.

(4) Information gathering from team participants is not limited to meetings and may include sharing information through reports, telephone contacts, and letters.

3. Information Gathering Process

a. Policy

Information gathering procedures are administered in the native language or communication form of the enrolled individual.

Information gathering procedures that are used are administered so as not to be racially or culturally discriminatory.

Information gathering is conducted by qualified personnel.

Information gathered (verbal or written) should be free of jargon and terms that are subject to misinterpretation by individuals involved in the process.

Information gathered, including reports, consent for release of information, approval of the process, and contact records will be maintained in an individual record for each enrolled individual.

b. Procedure

(1) During initial contacts with the individual or referral source, the ISC will gather information such as language or cultural differences which may affect information gathering procedures.

A review of the individual's history should also be used to determine any possible cultural or language considerations.

(2) For an individual with a primary language other than spoken English, the ISC will contact the Program Manager to determine the availability of possible resources for providing translation and interpretation services. The ISC will

then offer the enrolled individual resources identified by Family Outreach as well as review resources with which the individual may be familiar. The final decision should be mutually agreed upon with potential cost being considered.

(3) Cultural differences should be considered when interpreting information gathering results.

(4) Information gathering reports prepared by the ISC should be free of professional jargon and terms which could be subject to misinterpretation.

(5) Information gathering procedures are conducted by personnel qualified to utilize the appropriate instruments, methods or procedures.

4. Required Information

Information gathering in the following content areas is required for funding sources other than 'Community Supports'. Some of this information may be gathered and maintained by the individual or another person chosen by the individual and summarized by the ISC prior to the annual PSP or at another designated time.

a. Self Assessment Interviews

(1) Policy

Interview information will be obtained in the following areas; residential history and choices, environmental routines, relation-ships, personal choice-making/preference systems, and health and safety needs

Sharing interview information with the ISC must be voluntary on the part of the individual.

Each individual will be provided with options regarding how he/she would like to share interview information.

Additional interview information may be gathered from involved others with the permission of the enrolled individual.

(2) Procedure

(a) During initial contacts and as part of the PSP development the ISC will complete the information gathering with the enrolled individual. This process will begin by completing the Compadre Self Evaluation of Life Situation interview. And should cover these types of information: strengths, life perspective, advocates, religious activity, daily routine, housing likes, job description, job, travel, support needs, community activities, map important places, home friends, family involvement, housemate likes, care provider likes, home care provider turnover, distant relationships life rating, personal security community belonging, relationship map, relationship difficulties and life crises.

(b) The individual may choose to share requested information in a variety of other forms as appropriate including interview, checklists, surveys or questionnaires.

(c) The ISC should assist the individual in determining other persons who may be appropriate to provide information requested. After obtaining an appropriate release of information the ISC will contact the persons to complete information gathering.

b. Wellness

(1) Policy

Wellness information will include a review of records related to the individual's current health status and medical history, especially information which may influence services and PSP outcomes and actions. As appropriate, this may include but is not limited to information about physical examinations, annual health assessments, and current concerns.

(2) Procedure

(a) The ISC will review with the individual the need for information on health status and medical concerns. The individual may choose to obtain and report the needed information or may request that the ISC or another team member complete this activity.

(b) If the ISC is to gather the information, releases should be obtained, and information gathering should be completed as appropriate.

(c) Information gathered should relate to potential PSP outcomes and objectives/actions and services. Along with an overall Health Summary, PSP guidelines about Wellness require information about Movement, Eating/Nutrition, Hearing/Vision/Dental, Medications, Allergies/Sensitivities, Equipment, Supports and Technology.

c. Financial

(1) Policy

Financial information gathering will include a review of all resources available to the individual particularly those which may influence services and PSP outcomes and objectives/actions. This may include information about government benefits, private resources, and employee compensation and benefits.

(2) Procedure

(a) During initial contacts and as part of the annual PSP development the ISC will gather information on resources available to the individual.

(b) The individual may choose to obtain and report information on financial resources or may request that the ISC or another team member complete this activity.

5. Assessments

Assessment is an individualized process based on the primary functional concerns of the individual and involved others. Assessment processes are directly linked to the development of the PSP. Depending on the enrolled individual's choices, he/she may play a variety of roles in these processes such as information provider and decision-maker.

Assessment activities may be limited under funding sources such as "Community Supports'.

a. Functional Skills

(1) Policy

Assessment of functional skills is an ongoing multidimensional process. Individuals will have a choice as to the assessment process including type of assessments, persons administering assessments, and needed areas of assessment.

(2) Procedure

(a) During the completion of the self assessment information and development of the PSP, an individual may indicate life choices which could involve the need to learn new skills or behaviors.

(b) If the development of a new skill or behavior is requested the ISC should with the individual determine the needed areas of assessment, types of assessments which might be needed, and the persons best able to complete these assessments. Decisions will be documented on the Home Visit Record.

(c) As requested, the ISC will complete or coordinate the completion of assessments.

b. Health and Safety

(1) Policy

An assessment of the health and safety needs of the enrolled individual is required. This assessment information may be available from a variety of sources including the completion of a vulnerability assessment, interviews with the individual or involved others, or ecological inventories.

(2) Procedure

(a) An Annual Health Care Checklist will be completed by the ISC and individual in services at least annually as part of PSP development. In addition an assessment may be needed if some significant change in the living situation of the individual occurs, such as a move.

(b) Information on health and safety needs will be gathered from the individual and the information gathering team through completion of the self assessment (see C. 4. a. Self Assessment Interviews).

(c) The ISC will discuss with the individual and the information gathering team the need for any additional assessment such as a vulnerability assessment or ecological inventory or safety skills assessment.

D. Personal Supports Plans

Personal Supports Plan (PSP) is a written plan for providing supports and services to the enrolled individual and his/her social network(family, friends, etc.)

The Family Outreach or residential component of the PSP is developed with the enrolled individual, the Individual Support Coordinator, and other social network members.

The Case Manager collects preliminary information pertaining to the individual’s vision for themselves, personal introduction and personal profile. The Family Outreach portion of the PSP is based on assessment and information gathering regarding wants and needs and related to strengths and resources of the individual and the social network.

Family Outreach planning includes services needed to directly support the individual's community and residential needs and the social network's capacity to assist and support the individual. This information will be summarized in the Lifestyle, Wellness and Support Information sections of the PSP.

Under limited funding sources such as 'Community Supports' a limited agreement may be developed in place of an PSP (see V. Family Education and Support, G. 8. Limited Services)

1. Development

   The purpose of the meeting to develop potential community and residential visions and outcomes is to synthesize information gathered into a comprehensive plan for delivering supports and services needed by the individual to attain a chosen lifestyle.

a. Schedule

(1) Policy

As appropriate, a transition PSP will be developed for a newly enrolled individual as soon as practical but no later than 30 days after enrollment into Family Outreach services. The purpose of a transitional PSP is the coordination of the transition into Family Outreach services and may include development of a residential setting.

An initial PSP will be developed within the first 30 days after program admission. Program admission is the date on which the individual becomes eligible for Family Outreach Supported Living services.

Personal Supports planning will occur at least annually.

A request for a change in the PSP cycle should be made to the Case Manager whenever there is a significant change in the community or residential needs of the individual.

(2) Procedure

(a) Family Outreach's Personal Supports planning procedures for community and residential needs should be explained to individuals during initial meetings following enrollment into Supported Living services. The date on which an individual is enrolled into services may not be the same as program admission depending on funding source requirements.

(b) The Individual Support Coordinator (ISC) is responsible for coordinating the schedule of the PSP meeting with the Case Manager.

(c) With the concurrence of the individual and the Case Manager, a transition PSP may be developed. A transition PSP should be considered whenever entry into Family Outreach's services will include a change in residence. The purpose of the transition PSP is to define the activities needed to facilitate the move into Family Outreach's Supported Living Program. A transition PSP would be expected to cover a period of no more than 3 months. A transitional PSP may include any or all the components of the PSP, as necessary.

(d) During each PSP the date of the next PSP should be discussed. In most cases that date would be one year later. Due to special circumstances, the ISC may consider a request to adjust those timelines. Special circumstances might include an anticipated residential or community change, a change in the individual's circumstances such as a planned surgery, or changes in the social network such as the move of a parent or other support person.

(e) During the implementation of the PSP special circumstances may arise which necessitate a change in the date of the next scheduled PSP (either sooner or later). With the concurrence of the individual, the ISC should contact the Case Manager and request the change.

b. Participants

(1) Policy

The development of the Family Outreach components of the Personal Supports Plan residential and community supports will occur minimally with the enrolled individual and the Individual Support Coordinator (ISC) in a pre-planning meeting.

The enrolled individual with the ISC will determine any other participants. Other participants might be identified from the completion of information gathering activities describing social and support networks.

Each individual's network is dynamic and membership and roles will change according to the circumstances and priorities of the individual at the time of planning.

(2) Procedure

(a) After completion of information gathering activities identifying individual social and support networks, the individual and the ISC will discuss potential participants in the process to develop community and residential plans. The individual will be encouraged to involve all identified social and support network members.

(b) The individual and ISC will determine a date and place for meeting to develop proposed community and residential plans.

(c) Participants in the pre-planning meeting may fill a variety of roles including sharing information (e.g. reporting history or assessment results), participating in decision making (e.g. screening residences or support staff), or coordinating supports(e.g. providing financial or medical supports).

(d) For the purposes of developing, monitoring, implementing, and evaluating the community and residential supports the ISC is the support coordinator. Support coordination is an active, ongoing process that involves:

Assisting individuals to gain access to supports and services identified in planning.

Coordinating or assisting the individual to coordinate the provision of supports and services (such as medical, financial or residential).

Continuously seeking or assisting the individual in seeking appropriate supports, services and situations.

Facilitating and participating in the development, review and evaluation of community and residential planning.

c. Process

(1) Policy

The meeting to develop community and residential goals may occur with the Personal Supports Plan or prior to the PSP.

Information and ideas are shared and exchanged between the individual and participants to assist the individual in determining the expected outcomes and supports and services needed to attain those outcomes.

Information must be provided in the individual's native language or communication form.

The individual must be given opportunities to choose the role(s) he/she wishes to play in the planning meeting including the decisions she/he wants to make. The individual's role may change over time and the individual must be given an opportunity to choose with each planning meeting.

Planning meeting participants must address ideas for potential back up or crisis residential settings and a back up system for ensuring the delivery of critical supports.

(2) Procedure

(a) Information gathered from reports and assessments should be reviewed by the planning meeting participants. Statements of individual residential and/or community outcomes will be developed and prioritized by the participants.

(b) The participants will brainstorm and prioritize possible strategies and ideas for achieving the stated outcomes as well as back up or emergency residential settings and back up systems for ensuring the delivery of critical supports.

(c) The proposed outcomes and lists of prioritized strategies and ideas will be reviewed and revised as necessary at the PSP meeting.

2. Content

The Personal Supports Plan (PSP)is a written document developed according to contractor rules. Family Outreach's contribution to that PSP include development of residential and community services and supports for the enrolled individual and his or her social network as defined by the contractor.

a. Policy

The ISC will complete the following PSP information:

(1) Individual Information gathered:

ISC’s are responsible for completing the entire Wellness sections, Lifestyle section and Support Section for the services provided to the individual. This information needs to be made available to the Case Manager 45 days prior to the PSP meeting.

The Lifestyle section includes information pertaining to Communication, Home, work/Day/ Retirement and Fun/Relationships. The Family Outreach, Inc. Quality of Life and Quality of Service survey information can be summarized in the relevant topics of the Lifestyle section.

The Wellness section requires an overall Health Summary, information about Movement, Eating/Nutrition, Hearing/Vision/Dental, Medications, Allergies/Sensitivities, Equipment, Supports and Technology.

The Support section requires listing names, addresses and phone numbers of family members, friends and/or the appropriate contact person from provider agencies that support the individual. The Support sections should also include a list of Health Care Provider's names, title, type of service provided, addresses, phone numbers and the facility name or clinic where the provider is located.

(2) Individual Visions:

Individual Visions are the focal point of the Personal Support Plan. Vision statements have a 1 to 5 year outlook and are developed by the individual with assistance from the Case Manager. If the individual is unable to communicate their vision, the team will develop vision statements to be approved by the individual, guardian or legal representative. When complete the Vision should provide a clear picture of what the individual wishes, wants or dreams of doing. The vision statements do not include specific references services.

(3) Individual Outcomes:

Outcomes support the achievement of a Vision and are developed at the meeting with input approval of the individual. They have a one year outlook. Outcomes should be written reflecting the individual's communication style and do not have to be complete sentences. Outcomes relate back to the Vision and clarify what the individual wants to do. Outcomes are not service driven.

(4) Actions

Actions support the achievement of an Outcome and are developed at the meeting by the team. Actions are activities to be completed by the individual or support staff.

Actions require a person or agency responsible be designated and a start and completion date be determined.

If the team believes a particular action should be measured in order to determine progress then it will be written as a behavioral objective and an Implementation Strategy/Plan developed

(5) Implementation Strategies:

Implementation Strategies are developed within 20 days after the PSP meeting by the ISC to support the start date and completion date for the action.

Implementation Strategies will be individualized, detailed, instructional programs which follow the outline found in Family Outreach, Inc.'s prescriptive program format.

Implementation Strategies are developed to gather progress information noting the individual's progress in learning or accomplishing something.

(6) Back Up or Crisis Plans

As determined by the PSP team at least one back up or emergency residential setting will be identified.

As determined by the PSP team at least one process will be identified for ensuring the delivery of critical supports.

Back-up and critical supports will be outlined in the "Lifestyle: Home" section of the PSP document.

b. Procedure

(1) The process and content of the PSP for which Family Outreach is responsible will be reviewed with the individual at initial visits and in preparation for each PSP. Applicable policies and procedures will be reviewed.

(2) Information for the PSP will be obtained from the information gathering and assessment procedures.

(3) Information gathered will be summarized on the appropriate pages of the PSP.

(4) Outcomes will be generated from the PSP procedures. The ISC will assist the individual and the PSP team in developing the outcomes chosen. The ISC will assist the individual and the PSP team to clarify the outcome so that the final outcome meets the criteria described in policy.

(5) The ISC will brainstorm with the individual and the team strategies and ideas for accomplishing each outcome during PSP meetings.

(6) The ISC will define with the individual and the PSP team needs for support coordination in the residential and community areas. Specific areas to be addressed would include minimally Lifestyle and Wellness and Support Information. The individual with PSP team concurrences may choose to assume responsibility for coordination of those areas or choose another person to assist with the coordination of those activities. If the individual or a person other than the ISC chooses to assume responsibility for an area, the ISC is still responsible for monitoring the completion of that coordination.

(7) The ISC will submit completed Lifestyle, Wellness, Support Information forms to the Case Manager.

(8) If Implementation Strategies are required the ISC has 20 working days to submit them to the Case Manager.

3. Implementation

a. Policy

The PSP should be reviewed at least monthly with the individual.

The PSP must be a dynamic document which can be modified to reflect current concerns.

b. Procedure

(1) Once a copy of the completed PSP is received from the Case Manager, a copy should be made for the client file and forwarded to the Program Manager to be placed in the central file.

(2) Services and supports which are the responsibility of Family Outreach are initiated and monitored through visits with the individual. Residential and community services and supports identified as the responsibility of others are monitored through visits with the enrolled individual and regular contacts with the person responsible.

(3) The individual and the ISC will review residential and community PSP actions at least monthly and the review will be documented on the visit record. The review will include:

Assessment of progress made toward completion of implemented outcomes and actions.

Assessment of need for modification, revision, adding, or dropping of outcomes or actions.

Review of procedures for implementation of outcomes and actions.

In addition to the Case Manager, assessment of which PSP team members should be informed of changes in PSP outcomes and actions.

(4) The PSP is dynamic and can be modified to reflect changing needs. ~~IP~~ PSP content areas including but not limited to outcomes and actions can be revised in the following steps:

Revisions to the PSP are made through the Case Manager

The Case Manager contacts the person of their guardian for instructions to call a meeting or give approval to drop or add an action.

Changes in actions require involvement from the involvement from the individual and guardian, case manager and the individual responsible for the action being deleted and/or added.

A meeting may be called if the person does not have a guardian and the person cannot or does not make a decision.

To revise an action:

Strike through the original action and add the new action.

Explain why the old action was deleted in the "Status/Progress" section.

Record the date the action change was made in the "Start/Date Completion Date" beside the newly developed action.

(5) Progress toward each of the actions on the PSP is maintained by the Case Manager. The ISC will submit quarterly progress reports to the Case Manager as required.

Quarterly reports will be completed based on the individual’s PSP date, not the fiscal quarter date.

The first quarterly report will be due the 15^{th} day of the third month following the PSP date and then the third month on the 15^{th} day until the next annual PSP.

4. Evaluation

In addition to the monthly review and monitoring of the PSP, Quality of Life and Quality of Service surveys will be conducted at the completion of the PSP cycle. For the individual and PSP team this information sets the occasion for developing or revising the residential and community outcomes and actions.

a. Policy

The individual and the PSP team must be provided an opportunity to evaluate their quality of life and the quality of services received at the end of the PSP cycle.

The ISC will formally conduct the Quality of Life and Quality of Service survey with the individual at the end of the PSP cycle for each individual. The summarized results will be sent included as the basis for developing or revising outcomes and actions at the PSP meeting.

b. Procedure

(1) Family Outreach's evaluation process should be explained to each individual during the PSP development process.

(2) At the end of the PSP cycle, the Individual Support Coordinator will provide the individual with an opportunity to evaluate and provide feedback regarding the quality of services and supports, and their impressions about their quality of life.

(3) The Individual Support Coordinator will formally record results of the on the survey forms. The survey provides an opportunity to share with the individual and PSP team members, as appropriate, the person’s impressions about the quality of their lives and

services and what modifications or additions and service implementation may be necessary. The survey is especially important for setting the foundation for the development of the new residential and community outcomes and objectives actions. The summary of the results of the survey will be included in the Lifestyle narrative of the PSP.

(4) The evaluation of the residential and community outcomes and objectives at the end of the PSP cycle provides the basis for program accountability between Family Outreach and the contractor. Information about each PSP completed during a three month quarter are summarized and sent to the DDP. The reliability of the reported information is randomly tested on a sample of the PSPs on a periodic basis. (see G. 4. PSP Quarterly Progress Reports)

E. Supported Living

Supported Living is a Family Outreach program which provides individual (consumer) focused educational activities, Caregiver Training and Support, resources, supports, and community coordination. The purpose of Supported Living is to advocate for and empower the independence of adults with disabilities as they live in the community.

1. Individual (Consumer) Focused Education

The objective of individual (consumer) focused education is to teach specific skill acquisition or behavior change techniques which the individual has selected to learn. Instruction may be provided by the ISC, a friend, or a paid support person.

a. Policy

Each individual enrolled will have appropriate information gathering activities completed within the specified timelines (see C. Assessment and Information Gathering).

Each enrolled individual will be informed of the results of the information gathering, specifically indicating the individual's strengths and identified areas of concerns, wants, and needs.

Individuals will be encouraged to participate in individual (consumer) focused activities or PSP-based actions.

Individual (consumer) focused educational activities and actions will be specified on the Personal Support Plan.

Individual (consumer) focused educational activities will be documented in the individual's file and a teaching plan will be developed.

b. Procedure

(1) Individual (consumer) focused education, supported by Actions and accompanying Implementation Strategies, will be explained during initial contacts with the Individual Support Coordinator. The ISC will continue to encourage participation in this area by providing options and strategies relevant to the individual's wants, concerns and needs.

(2) After completing information gathering activities, the ISC will summarize the general results for the individual on the Home Visit form and for the team in the Lifestyle section of the PSP.

(3) Ideas for individual (consumer) focused education related to outcomes will be brainstormed as part of the PSP development (see D. 1. Development) and documented on `brainstorm lists or meeting minutes. The list of outcomes and actions will be basis for planning for the PSP.

(4) The ISC will develop an Implementation Strategy and provide habilitation materials and instruction. The Implementation Strategy will be developed using methods, materials and instructors which are acceptable to the individual. The Implementation Strategy should be specifically tailored to the enrolled individual considering factors such as the functional application of the skill and the naturally occurring opportunities for practice as well as tailoring the strategy to the skill level of the person providing the instruction.

(5) The Implementation Strategy will minimally include: the action as stated in the PSP; a description of the method to be used to meet the action; date of implementation, date of completion, criteria for completion, goal/service schedule and frequency, frequency of documentation, materials required, scoring method and skill building method/reinforcement.

(6) A copy of the Implementation Strategy will be kept in the individual's file. The person conducting the Implementation Strategy, if other than the ISC, will be provided with a copy of the Implementation Strategy. The individual receiving the instruction may have a copy.

(7) The person responsible for the instruction, if other than the ISC, will be taught how to conduct the Implementation Strategy. This may include demonstration, observation and guidance during teaching sessions.

(8) If not providing the instruction directly, the ISC will monitor the Implementation Strategy by observing sessions, interpreting data and making modifications when necessary. The Home Visit report, Meeting Minutes and data collected will document ISC activities.

(9) When an action is completed, it will be documented on the PSP Status/Progress section, the Home Visit form and the teaching plan.

(10) If an action is not met within the specified time the reason for non-completion should be documented at the next PSP.

2. Caregiver Training and Support

Caregiver training and Support are services for people who provide unpaid support, training, companionship or supervision to enrolled individuals. The objective of Caregiver training and Support is to teach appropriate team members the skills and information needed to assume a major role in the support of an individual with disabilities. Examples of skill areas might be: teaching methods, systems management, developing and utilizing generic community resources, and general information.

a. Policy

Family members and friends chosen by the enrolled individual to be PSP team members will be encouraged to participate in Caregiver Training and Support by providing strategies and ideas related to outcome and action statements.

The need for Caregiver Training and Support education will be assessed as part of information gathering for PSP development.

Caregiver Training and Support educational activities and objectives will be specified on the PSP.

Caregiver Training and Support education will be documented in the ISC's client file and a teaching plan will be developed.

b. Procedure

(1) Caregiver Training and Support education will be explained to an enrolled individual and his/her family and friends during initial contacts with the ISC and the ISC will continue to encourage involvement in this area by providing options and strategies relevant to identified concerns.

(2) The ISC and the enrolled individual will assess the need for Caregiver Training and Support education as part of the information gathering process for PSP development(see D.1. c. Process)

(3) The ISC will document areas of possible Caregiver Training and Support education related to outcomes and actions. Ideas for Caregiver Training and Support education will be documented on `brainstorm lists'.

(4) The individual and the PSP team will prioritize ideas. Prioritized areas will be documented on the in meeting minutes. Actions will be documented on the PSP.

(5) The ISC will develop a teaching plan or implementation strategy and provide materials and instruction. The teaching plan for Caregiver Training and Support education will minimally include: the action stated in the PSP; a statement of the method(s) of instruction; a statement of the method used to determine completion of the action; the date the action is completed.

(6) A copy of the teaching plan or implementation strategy will be kept in the enrolled individual's client file. The enrolled individual and the person receiving the instruction may have a copy of the plan.

(7) The ISC will provide instruction using appropriate techniques (e.g. modeling, feedback, etc.).

(8) The ISC and the person receiving instruction will assess the progress towards reaching completion of the action, and will measure indirect consequences of the teaching when

appropriate (For example, after instruction in systems management a caregiver assists an enrolled individual in completing application procedures for a public service).

(9) Caregiver Training and Support education activities will be documented in the client file on Home Visit, Meeting Minutes and Client Contact forms.

(10) When an action(s) is completed, it will be documented on the PSP, the Home Visit Form and the teaching plan.

(11) If an action(s) is not met within the specified time, the reason for non-completion should be documented at the next PSP.

(12) As Caregiver Training and Support objective areas are completed the ISC will encourage the person to practice acquired skills by assuming a larger role in the support of the individual.

3. Support Coordination

The objective of support coordination is to provide individuals with a disability with assistance in obtaining needed services through public and community service systems. These services include location of appropriate housing, working with agencies in the service delivery system to meet an individual's needs, and referral to services to provide needed services.

a. Residential Support Services

The purpose of residential support services is to assist an individual in obtaining the community living situation of her/his choice while addressing the health and safety needs of the individual.

(1) Residential Settings

(a) Policy

Whenever, as a part of information gathering, an individual indicates a choice of residential setting different from his/her current situation, the ISC will develop a PSP outcome addressing the chosen living situation.

The ISC will assist the individual in locating and obtaining community residential options which best match the individual's choice within the individual's given resources. Community living options include the type of shelter (i.e. house, apartment, etc.) as well as the living arrangement (i.e. alone, with roommate, with family, etc.).

(b) Procedure

i) Support services to obtain a residential setting will be explained to an individual as a part of PSP development (see C. Assessment and Information Gathering).

ii) If an individual indicates a choice to change his/her residential setting, the ISC will develop a PSP outcome reflecting the desired change.

iii) As part of PSP development, the team will develop ideas for obtaining the chosen residential setting that best meets the individual's resources and needs. The ISC will develop PSP actions to work towards the stated outcome.

iv) If the individual chooses to move to a different residential setting (i.e. family home to apartment), the ISC may assist the individual in locating and obtaining the preferred community residential setting. This might include activities such as calling realtors, arranging to take the individual to view potential settings, assisting in completing applications, and assisting in rental negotiations.

v) Support services to obtain a residential setting will be documented on Home Visit Records, Meeting Minutes, and Client Contact Records as well as by completion of PSP actions.

(2) Health and Safety

(a) Policy
The ISC will review all residential settings for health or safety issues and address any concerns with the individual and, if needed, with the PSP team. Potential health and safety areas reviewed should be determined from generic housing concerns such as fire prevention as well as issues specific to the individual such as mobility (see C. Assessment and Information Gathering 5. b. Health and Safety).

(b) Procedure
i) The ISC will monitor all residential settings for health and safety issues by observing conditions during routine home visits. The ISC should be particularly aware of potential concerns during consideration of a new residential setting.

ii) The ISC should recommend and provide, if necessary, a smoke detector in all bedrooms and a central location of the residence. The ISC will document in the individual's file at least monthly checks of all smoke detectors.

iii) The ISC should recommend and provide, if necessary, a fire extinguisher for the kitchen area of the residence. The ISC will document in the individual's file an annual check of the fire extinguisher.

iv) The ISC with the individual will develop an emergency evacuation procedure. The ISC will document in the individual's file a practice of the emergency evacuation plan at least once per year.

v) If the ISC becomes aware of a potentially unsafe or unhealthy situation, the ISC should document the concern as well as recommendations for correction of the situation with the individual on a home visit record. If the individual refuses to correct the situation the ISC will contact the Case Manager to request a Supplemental PSP meeting to address the concerns.

(3) Residential Supports

(a) Policy

The ISC, as requested, will assist the individual in locating and obtaining needed residential supports such as housing assistance, utilities, and food assistance.

(b) Procedure

i) During information gathering the ISC will determine the need for assistance in obtaining residential supports such as utilities (phone). The ISC should also review the possible utilization of available government and community programs such as rental assistance, food subsidies, etc. in order to best meet the needs of the individual as well as maximize the individual's resources.

ii) Information on government and community assistance programs will be maintained in office Community Resource files and updated routinely by Family Outreach staff. Information on acquiring local utilities should also be available.

iii) The ISC will review with the individual the availability of potential residential supports and the process for obtaining the needed supports. This information will be documented on the home visit report. The individual will determine with the ISC, the support, the assistance needed to obtain the support and, if needed, a person to provide the assistance. This process may be completed as part of PSP development.

iv) The ISC is responsible for monitoring the completion of the activities to obtain an identified residential support or, as requested, assisting to obtain the support. Activities will be documented on home visit and client contact records.

b. Medical Consultation

(1) Policy

The primary physician is a critical team member involved in providing the supports needed for an individual and should be actively involved in provision of supports.

The individual's primary physician will be consulted under any of the following circumstances:

- behavior changes,
- individual complaints or concerns regarding health, feelings, etc.,
- team or provider observations of changes or concerns,
- any observed changes in body functions, such as eating or weight change,
- medication errors such as missed medication, etc.,
- request for or use of an over the counter medication.

(2) Procedure

(a) The ISC will note any of the above circumstances or any other situations of concern and document the information in the individual's file.

(b) The ISC will discuss the need for a physician consultation with the individual and, if appropriate, any team member(s). Any team member assigned responsibility for coordination of medical care would be notified of concerns. Discussions will be documented in the individual's file.

(c) With the consent of the individual, arrangements will be made for the physician's consultation. Depending on the circumstance, that consultation might range from a phone call to the physician with a specific question to an appointment for a thorough physical.

(d) The physician's report, including any recommendations, will be documented in the individual's file. Any needed follow up will be completed and documented in the individual's file.

(e) If the individual will not consent to a physician's consultation, the PSP team should be notified and a supplemental PSP meeting might be requested to review the situation.

c. Personal Financial Management

(1) Individual Support Coordinator's Responsibilities

(a) Policy

The ISC is responsible for ensuring that the enrolled individual's personal finances are managed to meet his/her needs (room, board, personal needs, etc)

(b) Procedure

i) During information gathering, the ISC will determine resources available to meet the individual's personal needs. As part of information gathering, the ISC may determine that other government or community resources are needed and available to assist in meeting the individual's needs (see E. 3.a.(3) Residential Supports).

ii) As part of the PSP development the ISC with the individual will review whether additional assistance is needed to manage personal finances. The individual may choose to manage her/his own finances, or ask that the ISC or another team member or agency assist with this area.

iii) The ISC will review with the PSP team the plan for management of personal finances. If needed, PSP actions will be identified (i.e. teaching another team member the responsibilities of financial management or applying for additional government resources).

iv) The ISC will determine a regular meeting schedule for monitoring the individual's personal finances. Monitoring of personal finances will be documented on HVRs, meeting minutes, client contacts and, as appropriate, in the completion of PSP actions.

(2) Family Outreach as Manager of Individual's Financial Resources

(a) Policy

Family Outreach will serve as the manager of an individual's financial resources if the individual, team or legal representative makes this request of the agency.

The Business Manager and the ISC will be responsible for following all regulations and completing reporting such as the Representative Payee Report and income tax reporting.

(b) Procedure

i) If during intake or PSP development, the individual team, or representative requests that Family Outreach directly manage the individual's personal finances, the ISC should notify the Business Manager.

ii) The Business Manager will develop a procedure with the ISC to meet the individual's needs. This might include Family Outreach becoming the payee for the individual, planning for the reimbursement of the individual's personal needs, reporting changes to Social Security, and completion of necessary reports, such as income tax returns. The procedure developed will include identifying the person responsible for each activity and a system for coordinating responsibilities.

4. Resource Coordination

The objective of resource coordination is to provide the enrolled individual with the level and intensity of supervision, care, support, training, and guidance needed as determined by the PSP team.

a. Support Fund Budgeting

(1) Individual Cost Plans for Title XIX Medicaid Waiver Funded Services

(a) Policy

Resources and services include:

Habilitation as defined in ARM 37.34.941 including intensive daily care and supervision.

Individual Goods and Services as defined in Appendix C of the 0208 Waiver include supports or goods that enhance opportunities to achieve outcomes related to living arrangements, relationships, inclusion in the community and work as clearly identified and documented in the service plan.

Adult Companion as defined in the 0208 Waiver is non-medical care, supervision and socialization, provided to a functionally impaired individual.

Adult Foster Support as defined in the 0208 Waiver are extraordinary supervision and support by a principal care giver licensed as an adult foster care provider who lives in the home.

Residential Training Supports as defined in the 0208 Waiver is provided to participants with specific, individually designed and coordinated training in a licensed adult foster home setting.

Respite care as defined in ARM 37.34.946. Respite for Title XIX Medicaid Waiver funded services are provided by contracted providers.

Environmental Modifications/ Adaptive Equipment as defined by the 0208 Waiver are physical adaptations to the home, required in the plan of care which ensure health, welfare and safety or greater independence. Minor physical modifications (e.g. ramps, etc.) as defined in ARM 37.34.960. Maximum payment is $3000 per individual. Amounts over this level will require Board approval. Amounts over $4000 require Contractor approval. Adaptive equipment is that which increases independent functioning or obtains or retains employment.

Psychological Services as defined in the 0208 Waiver are those provided by a licensed clinical psychologist or licensed counselor.

Physical therapy as defined in ARM 37.34.954.

Occupational therapy as defined in ARM 37.34.950.

Speech pathology and audiology as defined in ARM 37.34.956.

Homemaker services as defined in ARM 37.34.929.

Personal Care Attendant services as defined in ARM 37.34.933.

Private Duty Nursing as defined in the 0208 Waiver are services to provide medically necessary services when these services exceed the Medicaid limits or are different from the service provided by the State plan.

Dietician Services as defined by the 0208 Waiver are services provided by a registered dietician or licensed nutritionist including meal planning, consultation with and training for care givers education for the individual served.

Meals Services as defined in the 0208 Waiver provides hot or other appropriate meals once or twice per day up to seven days a week.

Respiratory Services as defined in the 0208 Waiver are provided by a licensed respiratory therapist and may include direct treatment, ongoing assessment, equipment monitoring and upkeep and pulmonary education and rehabilitation.

Transportation services as defined in the 0208 Waiver are services offered in order to enable individuals to gain access to waiver and other community services and resources. Transportation is also defined in ARM 37.34.967.

Community Transition Services as defined in the 0208 Waiver are non-recurring set-up expenses for individuals who are transitioning from an institution to a DDP waiver funded HCBS residential service.

(b) Procedure

i) The allowances and limitations of Title XIX Medicaid Waiver funded services will be explained to an individual as a part of entry into those services.

ii) As a part of the information gathering process the ISC will obtain information on resources and services which may be needed to assist the individual.

iii) The ISC, with the individual and the PSP team will brainstorm resources and services related to outcomes and actions. Ideas will be documented on brainstorm lists or meeting minutes.

iv) Resource and service needs will be identified as a Title XIX Medicaid Waiver funded support on the PSP.

v) The ISC is responsible for researching and documenting all other possible funding sources for providing the needed resources and services.

vi) When the PSP team has determined resource and service needs, and the ISC has explored all other possible resources, he/she will refer to the Appendix B Individual Cost Plan (ICP) report from Fiscal as a basis for proposed units of support across service categories as identified in the PSP.

(2) Individual Cost Plan Modifications

(a) Policy

During an individual's PSP cycle, the Individual Cost Plan may need to be modified (the individual's needs change).

Individual Cost Plan modifications to transfer funds from one funding source category to another must be approved by the PSP team.

Individual Cost Plan modifications to amend additional amounts to a category or to add a new funding source category must be approved by the team.

As applicable, service and Individual Cost Plan modifications will be communicated to appropriate subcontractors, the Case Manager, and other PSP team members. DSP employment agreements or contracts may need to be modified or new ones developed.

(b) Procedure

i) Substantial changes in an individual's needs may require PSP modifications.

ii) The ISC will inform the Case Manager regarding the proposed Individual Cost Plan modification.

iii) The ISC will document proposed Individual Cost Plan modifications and team consensus concerning the modifications on a meeting record and/or contact record.

vi) Individual Cost Plan modifications which will impact service delivery will be communicated to the enrolled individual, the Case Manager, and appropriate subcontractors and PSP amendments submitted if needed.

vii) Substantial modifications may require the ISC to renegotiate DSP employment agreements contracts with affected resource/service providers.

b. Use of Individual Goods and Services

The following are general policies and procedures to be applied to the process of using Individual Goods and Services The ISC must refer to the specific funding source guidelines and budget to determine relevant sections.

(1) Purchase of Items and Limited Services

(a) Policy

The ISC will document the use of Individual Goods and Services in the individual's file.

The item or service requested must relate directly to a specific action on the PSP.

Individual Goods and services are services, supports or goods that enhance opportunities to achieve outcomes related to living arrangements, relationships, inclusion in the community and work as clearly identified and documented in the service plan. The item or service is designed to meet the person's functional, medical or social needs and advance the desired outcome outlined in the PSP.

The Program Manager will review and approve requests.

(b) Procedure

i) When the need for an item or limited service (evaluation, therapy consultation, etc.) is determined the ISC should decide what is to be purchased, if it is an appropriate expenditure, what other resources have been checked, the amount required, past expenditures during the current fiscal year, and if the request relates to an outcome and action on the PSP.

ii) For items or limited services to be purchased, the ISC is responsible for filling out the Support Request form by completing: the funding source, enrolled individual's name, the PSP objective the request relates to, what the request is for and where it can be purchased, the specific amount requested, a brief description of how the item or service will benefit the individual.

iii) The ISC forwards the request to the Program Manager.

iv) The Program Manager reviews the request and either approves the request or returns it to the ISC if the form is incomplete or the item is inappropriate. If the request is approved the Program Manager returns it to the ISC for purchase. If the request does not comply with funding source guidelines, the Program Manager may return it to the ISC for reconsideration or forward it to the Director for review.

(2) Respite Services

(a) Policy

Respite services are available to individual's who are living in a family (foster or natural).

An enrolled individual's family may choose a DSP from Family Outreach's applicant pool using the Service Provider Registry.

Respite providers and families may contact Family Outreach staff if there are problems with respite service delivery.

Family Outreach will only provide respite for the enrolled individual in the family.

(b) Procedure

i) ISC's will explain procedures for obtaining respite services during initial contacts and when a need for the service has been identified on the PSP.

ii) In emergency situations, families may contact the ISC if respite care services are needed.

iii) Both respite providers and families are encouraged to contact Family Outreach if there are any problems in service.

c. Direct Service Provision

Purchase of services is a means to make available Resources/Services to children and families. The provision of services includes activities such as:

1. Recruiting and orientation of subcontractors and Direct Service Providers
2. Developing appropriate subcontracts or employment agreements;
3. Assisting the subcontractor or Direct Service Provider in making necessary program changes;
4. Accounting for the costs of the subcontracted services provided to children and families;
5. Approving payments to the subcontractor or Temporary Service Provider.

See Cost Plans for Title XIX Medicaid Waiver

(a) Recruiting and Orientation

i) Policy

Direct Resource/Service provision will occur through subcontracts with qualified individuals/ agencies or through employment agreements with Direct Service Providers (see IV. C DSP Hiring).

Subcontractors are not employees of Family Outreach, Inc.

Employment Agreements or contracts with service providers must be signed before services can be provided.

Employees of Family Outreach, Inc. or the child's guardian cannot be a sub-contractor unless the Resource/Service is not available and the Board of Directors approves.

Existing Resources/Services in the community will be utilized when appropriate.

All professional service subcontractors (i.e., Occupational Therapists, Physical Therapists, Speech Therapists) must have appropriate qualific-ations and license.

When the Resource/Service is not available, the Resource/Service subcontractor or Direct Service Provider will be recruited through the most appropriate means (e.g. advertisement). The most qualified Resource/Service provider will be recruited.

The consumer (as appropriate) will be the final decision maker on the selection of a specific subcontractor—or Direct Service Provider.

Orientation will be provided regarding Family Outreach Services, PSP procedures, specific Resource/Services and contracting or employment procedures.

The length of the contract cannot exceed the PSP cycle in which the Resource/Service is specified.

ii) Procedure

a) Individual Support Coordinator are responsible for recruiting and orientation for Resource/ Service needed by the consumer nd identified in the PSP. This may begin during the development of the PSP and Cost Plan.

ii) Family Support Staff will research existing community Resource/Services and utilize those if appropriate.

iii) If Resource/Services are not available or appropriate, then the Family Support Staff will advertise locally. Program Managers, and Local Employment Coordinators will assist for recruiting service providers.

iv) Recruited subcontractors or Direct Service Providers must meet the appropriate qualifications and license (when applicable).

v) The most qualified individual (possesses the necessary skills, good references, etc.) will be recruited. However, the consumer, as appropriate, will select the service provider that best meets their needs.

vi) If the only available option for Resource/Service is through a regular staff of Family Outreach, Inc. (on their own time) or the consumer's guardian, the Family Support Staff should inform the Director, who will present the situation to the Board of Directors. (The Family Support Staff may present the situation if they desire). The Board of Directors will review the request. The Board Secretary will record the decision in the meeting minutes and the Director will inform the Family Support Staff.

vii) Family Support Staff will provide orientation, as needed, regarding Family Outreach services, PSP procedures, specific Resource/Services and contracting and employment procedures.

(2) Developing Subcontracts and Employment Agreements

(a) Policy
Each consumer will have a budget based on objectives in her/his PSP and relating to the Resource/ Services allowable under the Title XIX Medicaid Waiver requirements (see E.4.a. Support Fund Budgeting).

Employment Agreements or contracts with Resource/Service providers must be signed before services can be provided.

(b) Procedure

i) After approval of the budget and the completion of the IFSP, the Family Support Staff will assist the family in locating a service provider who best meets the needs of the family and child, and the requirements of the Title XIX Medicaid Waiver.

ii) The Family Support Staff will develop a contract or employment agreement with the service provider for the provision of the services specified in the PSP.

iii) The Family Support Staff will explain the contract or employment agreement to the service provider.

iv) The contract for services must be signed by the service provider, the family, and forwarded to the Program Manager for approval.

v) Employment agreement and contract copies should be provided to the service provider, Family Support Staff's file, and the original should be in the master file.

(b) Services Accountability

(a) Policy

Services performance accountability is based on the PSP objectives, Prescriptive Programs (Consumer Focused objectives), and the Service Detail in the contract or employment agreement, and Cost Plan and will be reviewed at least monthly.

Service cost accountability will be based on the Cost Plan and contract or employment agreement and will be reviewed at least monthly.

Expenditures will be recorded by the Family Support Staff monthly and at the end of the PSP yearly cycle.

Performance information will be recorded by the Family Support Staff monthly and at the completion of the PSP yearly.

Employment Agreements or contracts can be discontinued for performance that does not meet specifications and for false reporting.

Timesheets and invoices from Service Providers are due by the first working day following the service delivery period.

(b) Procedure

i) Family Support Staff are responsible for performance and cost accountability for Direct Service Providers and contractors serving consumers on their caseload.

ii) Family Support Staff will review direct services based on the policies and procedures for the areas referred to above. (See E. 4. c. (2) (b) Developing Subcontracts and Employment Agreements.) Performance information (i.e., program data, hours of service) will be compared to requirements. If the performance meets the provisions, the invoice will be reviewed for cost compliance. If performance does not meet the requirements, the Program Manager should be informed. The Program Manager and Family Support Staff will develop a plan of action. If the problem is with a Direct Service Provider the Local Employment Coordinator may also be consulted. If the performance problem is serious (e.g., falsification of information) the contract or employment agreement can be terminated. (See E. 4. c. (4) Service Provider Termination)

iii) Family Support Staff will review timesheets and invoices for compliance and check to determine if the timesheet or invoice has been completed correctly. The Program Manager will be informed if the timesheet or invoice is incorrect and there is a question regarding the delivery of service. The Program Manager and Family

Support Staff will develop a plan of action. If the problem is with a Direct Service Provider the Local Employment Coordinator may also be consulted. If the problem with the timesheet or invoice is serious (e.g., falsification of information) the agreement contract can be terminated. (See E. 4. c. (4) Service Provider Termination. If the invoice or timesheet appears in order, then the Family Support Staff or authorized staff will sign it, complete information on the funding source, retain a copy for the consumer's file and forward the original to the Fiscal Department.

(4) Services Provider Termination

(a) Policy

Employment Agreements and contracts may be canceled by either the Service Provider or Family Outreach, Inc. without cause.

Direct Service Providers may be terminated or contractor services may be canceled by Family Outreach, Inc. if the service provider:

- fails to provide services within the time specified,
- provides false information regarding services provided or amount of service provided,
- is not in compliance with any law or regulation, or applicable licensure and/or certification requirement for the service,
- abuses or neglects the child being served.

(b) Procedure

i) The Family Support Staff will notify the Program Manager if a Direct Service Provider fails to meet their agreement.

ii) The Program Manager and Family Support Staff will discuss the appropriate plan of action. If the problem involves a Direct Service Provider the Local Employment Coordinator should be consulted.

iii) The Program Manager will notify the Director regarding any alleged abuse or neglect.

iv) The Direct Service Provider will be notified in writing regarding termination.

v) Copies of the letters will be filed in the Direct Service Provider file if appropriate

d. Naturally Occurring Supports

(1) Policy

The ISC, with the individual, will research and identify persons in the individual's environment who express an interest in providing some support (supervision, care, companionship, etc).

The ISC will encourage development of unpaid relationships by providing opportunities for the individual to interact with other community members.

(2) Procedure

(a) During information gathering and throughout the PSP cycle the ISC will document persons in the community with whom the enrolled individual has contact.

(b) The individual or the ISC with the permission and assistance of the individual, as possible, should explore with community contacts the possibility and desire to provide the individual with some supports. Persons identified may be involved in the meeting to develop the PSP and as needed might be involved in caregiver training and support educational activities.

(c) As part of PSP development the ISC should assess the availability and participation of unpaid supports in an individual's life. Some balance should be encouraged between paid and unpaid supports and the balance between paid and unpaid relationships should be addressed as part of PSP development.

(d) If it appears that the individual has a need for more unpaid supports the ISC should suggest as part of the PSP, a plan to develop more community relationships. This could involve attendance at community functions of interest to the individual, volunteer work in the community, as well as possible individual training on skills to promote relationships.

(e) Contacts with other persons in the individual's environment will be documented in meeting minutes, client contacts, and as appropriate, in the completion of PSP objectives.

F. Program Exit

1. Policy

Exit criteria includes:

A provider cannot meet the individual's health and safety needs.

A provider may exit an individual from services for the individual's failure to follow through with PSP Service Actions and Outcomes or PSP goals for thirty (30) days).

An individual may be exited from Waiver Services and General Fund services by the State Developmental Disabilities Program.

When an individual exits Family Outreach's Supported Living program to move to another agency or region, the assigned resources accompany the individual.

A program exit summary will be completed within 30 working days after an individual leaves the program.

2. Procedure

a. As per policy of the Developmental Disabilities program, if an individual's health and safety needs cannot be met and the consensus of the PSP team is they can, then the appeal process (ARM 378.34.1114) must be followed.

The agency must give 90 days written notice to the individual and all PSP team members. A plan must be developed and executed no later than 5 calendar days.

b. If Family Outreach, Inc. proposes to exit an individual from services for failure to follow through with PSP Service Actions and Outcomes or PSP goals for thirty (30) days then:

A ninety (90) day exit notice will be given to the individual and planning team members.

A planning meeting will be held within 10 working days from the receipt of notice.

The individual will have the opportunity to rewrite their visions and outcomes or actions.

During the 90 day exit period the new actions/outcomes must be implemented. If they are being followed then the exit notice will be null and void and the individual will remain in services.

If it is determined that the exit will take place then the individual will be notified in writing why they are being exited from services. A written notice must detail their right to request a Fair Hearing as per ARM 37.5.115.

c. If an individual is being exited from Waiver Services and General Fund services by the State Developmental Disabilities Program then:

The individual will be notified in writing within five (5) working days for the following reasons*:*

The State cannot assure the health and welfare of the individual.

The individual exhausts all Waiver service providers in the geographic area they choose to stay in.

Non-utilization of services. A planning meeting must be held within ten (10) working days of the 30th day of non-utilization of services to determine why the individual is not using the service.

The PSP must focus on what services the individual desires and whether or not those services are available.

If the individual no longer wishes to participate in any Waiver services then this must be stated in writing and signed by the individual, guardian, or advocate and submitted to the State office within five (5) working days from the date of the planning meeting.

If the planning team determines that the individual is not interested in DD services due to failure to participate the individual may be exited from DD services.

The team must document and justify their decision and request approval of termination from the Regional Manager.

The Regional Manager must make a determination within five (5) working days and notify the individual and team members in writing within five (5) working days from the date of the decision.

As per ARM 37.5.115; Individual will have the opportunity to request a Fair Hearing when they are not provided a choice of services as an alternative to institutional care, are denied services of their choice or the provider of their choice or the services are denied, suspended, reduced or terminated.

d. As part of information gathering, the ISC will review the individual's needs and priorities. If the individual chooses services in another region or services from a different agency, the ISC should inform the PSP team and work to develop a transition plan to facilitate the move. Resources assigned to support the individual would be moved with the individual.

e. If the ISC determines that an individual's residential needs can be met through generic community services without the resources of Family Outreach's Supported Living program, the ISC should review that recommendation with the PSP team.

f. If the ISC determines that the individual's health and safety needs are greater than assigned resources, she/he should discuss the need for additional resources with the Case Manager. If adequate funds are not available, the ISC should review the situation with the PSP team. If no resolution can be found the ISC should ask the team to recommend exit.

g. The ISC should inform the individual and the PSP teams of the criteria for exit, so that adequate transition plans can be made when needed.

h. Whenever it appears that an individual might be exiting Supported Living, the Director should be immediately informed so that any administrative arrangements can be made. (resources transferred, etc.)

i. Prior to program exit for any reason the ISC will review the situation with the Program Manager. The ISC will advise the individual and the PSP team of the advantages and disadvantages of program exit. Reasons for exiting the program should be documented in meeting minutes and client contacts.

   Within 30 working days after an individual has exited from the program, the ISC will have completed a program exit summary including the following information:
   - a brief summary of the services provided, outcomes and overall progress,
   - specific recommendations for future services and program needs,
   - Family Outreach's evaluation of the appropriateness of the exit,
   - the completed outcome and objective page of the last PSP.

j. The summary will be sent to the individual and appropriate agencies (if consent for release of information has been obtained). A copy will be placed in the individual's client file.

k. The individual will be informed that Family Outreach must retain records for eight years. After five years the files will be sent to the individual or destroyed as requested.

l. The individual's client file will be sent to the Administrative Assistant for filing.

G. Documentation

1. Incident Reporting

The intent of incident reporting is to ensure the well being of individuals with disabilities by keeping persons with a need to know informed of significant events. An important function of the ISC is to provide and promote continuous information exchange between persons and systems providing services to individuals with disabilities.

Required incident reporting would be expected to comprise only a minimal portion of the total information exchanged.

a. Policy

The ISC will complete all incident reporting as required by the DDP. The ISC will review with the PSP team any additional reporting needs and complete that reporting as agreed upon.

b. Procedure

(1) In order to most effectively comply with the intent of incident reporting, the ISC should discuss the potential need for incident reporting with the individual.

(2) The ISC will inform enrolled individuals, all direct service providers and support persons of the requirements for incident reporting. The occurrence of an incident as defined in DDP Incident Management policy should be reported to the ISC by the persons involved. The ISC is responsible for completing or monitoring any incident reporting notification process within the required timelines as possible. For example, when an individual is living with family members, a family may

attend to an emergency hospitalization and not inform the ISC until a regularly scheduled contact at a later time.

(3) All incidents reported as required by DDP policy will be reported to Incident Management Coordinator and will ultimately be reviewed by the Incident Management Committee.

(4) Refer to DDP's Incident Management Policies for reporting requirements including types of incidents and definitions (see Appendix)

2. Reporting of Abuse, Neglect or Exploitation

a. Policy
All Family Outreach staff including ISCs and DSPs are mandatory reporters of suspected abuse, neglect, and exploitation.

b. Procedure

(1) Staff who suspect abuse, neglect, or exploitation are to take immediate steps to prevent further harm to the individual. If warranted the assistance of medical and/or law enforcement personnel should be obtained immediately.

(2) Staff are mandatory reporters of Suspected abuse, neglect, and exploitation of individuals with Developmental disabilities.
Staff who suspect abuse, neglect, or exploitation of an individual are to immediately report the incident to Adult Protective Services (APS). If no one is available at the Adult Protective Service phone number staff will leave their name, where they can be reached, and what the suspect on the message.

(3) After notification of Adult Protective Services, staff who suspect abuse, neglect, or exploitation will directly/ immediately report the incident to the supervisory staff.

If there is reason to believe that The supervisory staff person was involved in the incident it should be reported to the next person in the chain of command or directly to DDP.

(4) Staff who suspect abuse, neglect, or exploitation will complete an

incident report form and give that directly to the designated supervisor or directly to DDP if supervisory personnel were involved in the incident.

(5) The designated supervisor will immediately report the suspected incident to APS and DDP. Law enforcement should also be notified where appropriate. The supervisor will also let DDP and APS know what steps they have taken to ensure the safety of the individual.(Even though the staff who witnessed the suspected abuse, neglect, or exploitation should have already reported the incident, this will serve as a back-up system to ensure reporting takes place.)

(6) The agency supervisor will ensure that a copy of the incident report is sent to DDP and APS (if APS requests it) and the individual's case manager.

(7) The agency supervisor will ensure that the incident report is not filed with the consumer's record nor will the report be sent out through the general/normal route of incident reports. It will maintained in a file designated as "pending APS investigation results" and routed to the appropriate people at the close of the investigated.

(8) As applicable the supervisor (see G. 1. Incident Reporting) will also contact the individual's guardian/ family to let them know that an incident has occurred and that steps have been taken to assure the individual's safety if the family/ guardian is not directly involved in the allegations.

3. Monthly Reporting

a. Policy

Individual Support Coordinators will document contacts in the child's file by contact type.

Individual Support Coordinators will record the amount of time in 15 minute increments for all client work.

Contact~~s~~ types and time are summarized on A monthly basis and recorded on the Family Support Staff's Monthly Contact Report.

Services will be documented in the file.

b. Procedure

(1) Individual Support Coordinators will record service contacts in the child's file on the Contact Record according to the type of contact (direct or phone to family; or direct or phone to others).

(2) Individual Support Coordinators will Also record time for all client Related work in the child’s file on The Contact Record. Examples are home visits, meetings, writing plans and programs, summarizing assessment results, etc.

(4) At the end of the month, Individual Support Coordinators will summarize their service contacts and time on the Monthly Contact form. The Monthly Contact form is completed by reporting the total number of monthly contacts by contact type (direct, phone, etc) for each assigned consumer and total time.

(5) The Monthly Contact form should be sent to the Fiscal Department by the first working day of the following month.

(6) The Fiscal Department will record consumers served and eligibility status on the State Monthly Invoice Information form. The Fiscal Department will total all direct service contacts and time. (See III. Fiscal Affairs, E. Reporting).

(7) The Fiscal Department will complete monthly billing procedures by the established due date.

(8) The Administrative Assistant will summarize information from the Family Support Staff's Monthly Contact form, copy it, and disseminate the summary to the Program Managers.

(9) The Program Managers will review the Family Support Staff's Monthly Contact form information and use it for accountability monitoring and staff evaluation and feedback.

4. PSP Quarterly Progress Reports

a. Policy

The ISC will submit a quarterly progress report for each individual to the Case Manager accounting for each residential and community PSP action.

b. Procedure

(1) At the end of each PSP quarter, the ISC will prepare a progress report for each individual which provides an update on each residential and community ~~P~~ PSP action. This should be completed by updating the Status/Progress section of the PSP.

(2) Each quarter a copy should be forwarded to the Case Manager and the original retained for the individual's client file.

(3) ISC’s have the option of electronically sending this report as an email attachment to the respective Case Manager.

5. Quarterly Reporting (agency)

a. Policy

The PSP is the primary accountability tool for reporting to the Developmental Disabilities Program.

b. Procedure

(1) At the end of each fiscal year quarter the ISC will summarize the information for each PSP which was completed during the quarter.

(2) The ISC will compile a summary of the status of actions and outcomes for each service category on the Quarterly Report form.

(3) The Quarterly Report form will be forwarded to the Program Manager by the 10th working day of the month following the end of the quarter.

(4) The Program Manager will review each Quarterly Report form for accuracy and forward completed reports to the Director.

(5) The Director will summarize Quarterly Report information for the agency and forward the report to the DDP Regional Manager on a semi-annual basis.