Workforce and Talent Management

Training Curriculum Series

Medicaid Service Coordination

CORE { Centralized Overview of Roles and Expectations

Trainer's Manual

EDUCATION & TRAINING
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Table of Contents

Overview and Instructions

Preparing For and Delivering the MSC CORE Training Session
Monitoring Your Language
Curriculum Format
Certificate Information
Welcoming Participants
Group Activity (Ice Breaker)

Section One: Overview of OPWDD

OPWDD Mission
OPWDD Vision
OPWDD Relationship to Voluntary Agencies
Activity: OPWDD Q&A

Section Two: Overview of Developmental Disabilities and History of Supports and Services

Definition of Developmental Disabilities
Types of Developmental Disabilities
History of Services
Paradigm Shift
Activity: History Quiz

Section Three: Philosophies and Concepts

The Individualized Service Environment
The IIIP
Informed Choice
Responsibility and Risk Management
Person Centered Approach and Person Centered Planning
Strengths and Capacities
Community Inclusion
Activity: The Decision Tree

Section Four: Supports and Services

Types and Locations of Supports and Services
Residential Supports
Day Services and Supports
Family Support Services
Individual Support Services
The Home and Community Based Services (HCBS) Waiver
Background of Service Coordination
Activity: Community Resource Building

Section Five: Service Coordinator Responsibilities to the System and the Person

Important Aspects of Medicaid Service Coordination
Responsibilities of the Service Coordinator
Activity: Defining Boundaries of the Job
Activity: A Day in the Life of a Medicaid Service Coordinator

Section Six: Service Documentation

The Service Coordination Record
MSC Forms
The Individualized Service Plan (ISP)

Section Seven: Self Advocacy

Self Advocacy Presentation
Role Play Activities

MSC Forms

Coaching and Evaluation Assessment

MSC CORE Participant Sign-in Sheet

Overview and Instructions

This MSC CORE Instructor manual accompanies the MSC CORE Participant Manual (both are available online on OPWDD's website www.opwdd.ny.gov), and both are to be used to deliver MSC CORE training. The complete training can be delivered in one day. This instructor manual provides a framework to deliver the MSC CORE curriculum effectively in order to properly prepare new Medicaid Service Coordinators to begin their new role helping individuals with developmental disabilities live richer lives.

MSC CORE is mandated, introductory training with a focus on the major roles and responsibilities of service coordinators within the OPWDD system. Please refer participants to the MSC Vendor Manual for further information. Also refer participants to the OPWDD website (www.opwdd.ny.gov) for additional training opportunities. Annual training requirements can also be satisfied from outside sources with pre-approval by the service coordinator's supervisor.

Preparing for and Delivering the MSC CORE Training Session:

Once you have verified that you meet the OPWDD requirements for being a CORE trainer as defined on the OPWDD website, please carefully review the following information prior to the training to help ensure your MSC CORE Training goes smoothly. It is suggested that you prepare work-related examples and open-ended questions to encourage active participation from the participants. You should also thoroughly review the MSC CORE Participant Manual and anticipate questions from participants based upon their pre-reading assignment. **Remember, trainer effectiveness is directly proportionate to the preparation, energy and enthusiasm of the trainer.**

MSC CORE Training Suggestions:

- The location should be **accessible** for people with special needs
- The location should have **parking available** and be close to **public transportation**.
- The location should have a **comfortable** environment (good lighting, space, climate)
- The training room should be set up in a style suitable for participation and group interaction

- All requests for reasonable accommodation should be satisfied.
- Make sure your **equipment is in good working condition** (e.g., computer, DVD player, etc)

- It is recommended that name tags or name tents be used for trainers and participants

Monitoring Your Language:

You, as a trainer, are an important role model in the proper use of accurate and non-offending language during training. Keep the following suggestions in mind:

- **Avoid Acronyms.** The use of unexplained or confusing acronyms confuses people, and makes them feel uninformed. It is okay to use acronyms, after you have explained what they mean.

- **Use "person first" language.** A disability label should not define a person. Say "child with autism" or "person with cerebral palsy," rather than "autistic child" or "cerebral palsied adult." Be careful to use preferred descriptions of disabilities, like "hearing impaired," rather than "hard of hearing," or "neurologically impaired," rather than "brain injured.

- **Emphasize ability over disability.** The trend in developmental disabilities services is to develop support plans based on a person's capacities and abilities, rather than a plan that attempts only to remediate disabilities and defects. As you describe people and situations, use terms that define what people can do, their abilities and capacities rather than what they cannot do.

Curriculum Format:

- Participant Materials are available on the OPWDD website and participants should bring copies with them to the training. The Participant Material contains pre-reading material and copies of the exercises that will be used throughout the day and additional information on many of the topics covered in this training. **Please ensure that participants are aware of the pre-reading requirement at the time of course registration.** Having their manuals available will eliminate the need for trainees to take extensive notes during the training. The Core Participant Manual should be kept for future reference.

- This training curriculum is organized into seven sections. Each section begins with a title page that includes:

    1. Section Overview
    2. Objectives
    3. Key Learning Points
    4. Activity
    5. Time
    6. Materials and Training Method

- Section Seven: Self Advocacy, **should be delivered by a self-advocate**. You should make proper arrangements to have a self-advocate be present for this section.

Welcoming Participants:

- Introduce yourself and give a synopsis of your educational background and experience in the areas of developmental disabilities, service coordination, and training. The trainer may use a personal anecdote to illustrate a special connection to the field and the audience.

- Trainers should briefly review the course outline and schedule with the participants as well as the MSC CORE Certificate Information.
  (Be sure to inform participants of session duration, scheduled breaks and lunch time)

Certificate Information:

CORE Certificate Information for Participants:

- Inform the participants that they must stay for the full training to receive a certificate of attendance.

- Ensure participants complete the enclosed MSC CORE Participant Sign-in Sheet, as it will be used by OPWDD to generate certificates. Information on the sign-in sheets should be clearly written and readable so OPWDD can produce an accurate certificate.

- Inform participants that their certificates will be emailed to them at the email address they provide on the sign-in sheet. If the participant does not have an email address, please ensure a mailing address is provided in order for OPWDD to mail them a certificate.

- Inform participants it is their responsibility to provide a copy of the certificate to their own respective agency. If they lose their certificate, please instruct them to contact OPWDD Talent Development and Training at the address and phone number provided below.

CORE Certificate Information for Instructors:

- Course Instructors are also required to sign the OPWDD sign-in sheet(s) to verify all the participants stayed for the duration of the course, and to verify that the most up-to-date OPWDD curriculum was used.

- Course Instructors must mail the **original** sign-in sheet to OPWDD within one week of the course's delivery. Please mail all original sign-in sheets to the following address:

NYS OPWDD
Talent Development and Training
44 Holland Avenue
Albany, NY 12229
(518) 473-1190

- Instructors, or the instructor's agency, shall keep copies of the sign-in sheets for a period of six years.

Group Activity:

Prior to beginning Section 1, you should allow the participants to introduce themselves and participate in a group activity to be used as an ice-breaker. You may use the ideas provided below, or create your own activity.

Ice Breaker Exercise:

- Have each person create a place card with their full name and agency

- Go around the room and have each person say the following (you should go first to help break the ice):

1. Name
2. Agency
3. What led them to becoming a Medicaid Service Coordinator

If time permits, you can use additional ice breakers:

- Something interesting that happened to you this morning in 15 words or less
- Describe yourself using the first letter of your first name
- State a strength and a weakness about yourself

Section One: Overview of OPWDD

The purpose of this section is to give an overview of the NYS Office For People With Developmental Disabilities (OPWDD) and its relationship with the Voluntary Agencies in serving individuals with developmental disabilities.

Objectives:

At the end of this section participants will have:

- An understanding of OPWDD's Mission
- An understanding of the vision of OPWDD
- An understanding of the structure of OPWDD
- An understanding of the role of voluntary agencies in the delivery of services and supports.

Key Learning Points:

- The Mission of OPWDD
- The Vision of OPWDD
- The Role and Structure of OPWDD
- Voluntary Agencies: Relationships with OPWDD

Activity: OPWDD Questions and Answers

Time: 20 minutes

Materials: Pre-reading packet

Suggested Training Method(s): Lecture, discussion, and review of pre-reading

Introduce this section by going over the importance of the information provided in Section 1 of the pre-reading: OPWDD and the voluntary agencies affiliated with it, help people with developmental disabilities live richer lives.

Inform Participants:

- OPWDD stands for the New York State Office For People With Developmental Disabilities. Until July 2010, OPWDD was known as OMRDD (Office of Mental Retardation and Developmental Disabilities). The new name eliminates the stigmatizing language which was part of the Agency's name and reflects "Putting People First."

- The OPWDD Vision and Mission Statements were developed as a response to the changing views of people with developmental disabilities.

- The Mission Statement and Vision reflect a philosophy of thinking about the individual first and recognizing people's strengths rather than their weaknesses.

Review:

The Mission of OPWDD:

We help people with developmental disabilities live richer lives.

The Vision of OPWDD:

People with developmental disabilities enjoy meaningful relationships with friends, family and others in their lives, experience personal health and growth and live in the home of their choice and fully participate in their communities.

OPWDDs Role and Structure:

Refer participants to their pre-reading material. Briefly discuss OPWDD's role and structure highlighting the relationship of their agency to OPWDD and their local Developmental Disabilities Regional Offices. Give a brief summary of the material provided.

Voluntary Agencies:

Explain to Participants:

- The majority of all services and supports in New York State are provided by non-profit private agencies, also known as voluntary agencies.
- Throughout the state there are approximately 800 voluntary agencies providing various services to people with developmental disabilities.
- Voluntary (non-profit) agencies are independent entities which receive the majority of their funding for services from federal and state sources and are subject to OPWDD regulations and policies. This funding is administered and allocated for various services by OPWDD.
- The primary source of this funding is Medicaid, which is a combination of federal, state, and in some instances local county money. Voluntary agencies must comply with the federal and state regulations which guide the use of these funds.

MILESTONES IN OPWDD HISTORY:

Refer participants to the **Milestones in OPWDD History** timeline in the participant pre-reading. Emphasize the following:

- The importance of this timeline is to note how the system has changed from an institutional model to a community-based model.
- Over the years, the number of people served in the community has drastically increased.

Activity #1 Review:

Briefly review Activity #1: Q&A from the pre-reading assignment. You can use this activity to review and summarize the topics covered in this section.

1. What is the mission of OPWDD?
   - Instructor Note: What does that mean?

2. What is the vision of OPWDD?
   - Have you had a chance to implement the vision of OPWDD with the people you serve?

3. How can you put OPWDD's Mission and Vision to life? How can you apply them?

   Suggested examples of implementing the vision of OPWDD:

   - Attending church, synagogue, etc.
   - Visiting the local diner and shops
   - Shopping at the mall
   - Helping at the soup kitchen
   - Reuniting with family
   - Living in a regular apartment

4. How is OPWDD Structured?

   - OPWDD has a Central Office in Albany, NY and Regional Offices located across the State. Central Office provides oversight and financial resources.

5. What is the relationship between OPWDD and voluntary agencies?

   - Examples:

     - Provides services to most of the population served
     - Regulated by OPWDD
     - Receives funding through OPWDD

6. Name 3 important milestones in the history of OPWDD. Why are they important?

Transition to Section Two: Overview of Developmental Disabilities and History of Supports and Services

Section Two: Overview of Developmental Disabilities and History of Supports and Services

Overview: The purpose of this section is to give an overview of developmental disabilities and a brief history of services and supports.

Objectives:

At the end of this section participants will have:

- An increased awareness of the characteristics of people with developmental disabilities.
- An increased understanding of society's methods of care, treatment, services and supports through recent history.

Key Learning Points:

- System changes from an intuitional model to a community based model.

Activity: Review of History Quiz

Time: Approximately 20 minutes

Materials: Participant pre-reading materials, Willowbrook Video*

Suggested Training Method(s): Lecture, discussion and review of pre-reading

*The Willowbrook Video is optional for this training. If you need a copy of the DVD, please contact OPWDD at:

NYS OPWDD
Talent Development and Training
44 Holland Avenue
Albany, N.Y. 12229
(518) 473-1190

Overview of Developmental Disabilities:

Summarize the following information from the pre-reading materials and ask the participants if they have any questions from the pre-reading material:

- In your pre-reading you reviewed the Mental Hygiene Law's definition of developmental disabilities and learned about different types of developmental disabilities.

- Developmental disabilities are a variety of conditions that become apparent during childhood and cause mental and physical limitations.

- These conditions include autism, cerebral palsy, epilepsy, mental retardation and neurological impairments. Developmental disabilities have a variety of causes, which can occur before, during, or after birth.

- The person(s) you serve probably came to you after he/she was determined to be eligible for services under the definition of developmental disabilities. This is a condition that occurred or manifested itself prior to the person attaining age 22.

History of Services:

Review the History of Services from the Pre-reading materials. Emphasize the following information as part of your summation:

Your pre-reading materials discussed the history of serving people with developmental disabilities. There were essentially five periods that we focus on as part of providing services:

1. **A period of complete neglect** (prior to 1800, people with disabilities were ignored, imprisoned, or shunned from being part of society.)

2. **Educational Residential Institutions** (during the 19th century, some pioneering members of society in Europe and America began recognizing and assisting the plight of the developmentally disabled.)

3. **Expansion of Institutions** (from the 1920s to the 1970s, the population in residential institutions grew to nearly a quarter million people.)

    - By the early 1970s, New York operated 20 of these residential institutions, called State Schools

4. **Willowbrook and the beginning of deinstitutionalization** (Briefly discuss the 1971 news story done by Geraldo Rivera in which he exposed the horrific conditions at the Willowbrook State School, the Willowbrook Permanent Injunction and Willowbrook class members. Also discuss the outcome of the Willowbrook case and the movement by New York State to begin the deinstitutionalization of individuals with developmental disabilities. **You may choose to show the Willowbrook video at this time.)**

- In 1975, the lawsuit brought by parents and other advocates for the 5000 individuals residing at the Willowbrook State School was resolved through a consent agreement.
    - This agreement specified the procedures that the state was to undertake to improve institutional services and develop community based residences and services.
    - People who resided at Willowbrook at the time of the lawsuit were guaranteed certain protections under what is called the Willowbrook Permanent Injunction.
    - Those covered by this injunction are known, within OPWDD, as *Willowbrook class members*. Some of you may have Willowbrook class members on your MSC caseload; if you do, you should speak with your supervisor about the Willowbrook requirements and make sure that you are following them.
    - Chapter 978 of the Laws of 1977 was signed into law creating a separate Office of Mental Retardation and Developmental Disabilities (OMRDD, now OPWDD)

(Optional) Video Discussion:

Possible Questions:

- What do you think?
- What did you observe?
- How do you feel about seeing what you saw?
- How does the institutional setting compare to how services are provided today?

5. **1990's to Present: Self Advocacy and Self Determination** (The concept of individual empowerment, civil rights activism, and the Americans with Disabilities Act led to a movement know as Self Determination:

    - Freedom to develop a personal life plan
    - Authority to control a targeted amount of resources
    - Support needed to attain one's personal goal(s)
    - Responsibility for contributing to one's community and using public dollars wisely

The Paradigm Shift:

Explain that serving individuals with developmental disabilities has experienced a paradigm shift:

- A paradigm shift is what happens when a previously accepted view is invalidated by the discovery of a new way of seeing the world. Paradigm shifts occur in all areas of life. (Example: When Columbus did not fall off the end of the world, he set in motion a paradigm shift: the world was not flat, it was round)

- When individuals with developmental disabilities moved out of institutions and into communities, this set in motion a paradigm shift: the way people with developmental disabilities were viewed changed and continues to change as individuals with developmental disabilities become a greater presence in the community!

- Previously, it was believed that individuals with developmental disabilities needed to be cared for by others and could not make important life choices. It was believed that they required 24-hour supervision and staff and family members to make decisions for them.

- When OPWDD started placing individuals with developmental disabilities back into the community, clinicians and other staff involved in the service system had to be willing to consider a whole different way of viewing the capabilities of individuals with developmental disabilities.

- The system continued to make drastic changes in its philosophies about providing supports and services to individual. So, today individuals are encouraged to become actively involved in their community, and if capable, own their own home and seek competitive employment.

- Eventually, the new way becomes the accepted way. Sometimes the cycle of change takes years to fully develop. **But once the cycle is completed, there is a paradigm shift**. Medicaid Service Coordinators and other staff who work with individuals with developmental disabilities must now have a new mind set, be creative and work as partners with individuals and their families/advocates to assist them in having a better life.

Emphasize:

In recent years, the field has undergone major shifts:

- From a system-centered approach where everyone received the same services no matter what their abilities, needs or interests to a person-centered approach where services are individualized.

- From primarily serving people in large institutions to serving people in small residential settings.

- From providing uniform day services in large day training and day treatment facilities to providing individualized day service options in the community.

- From a restrictive/protective model where decisions were made by professionals to a self-determination model where decisions are made by the person.

Briefly Review the History Quiz on Developmental Disabilities in the pre-reading.

Answers to History Quiz on the History of Developmental Disabilities: (True/False)

1. The Asylum for Idiots, New York's first institution for the "feebleminded" or retarded, was established in Albany in the early 1850's. It was devoted to a newly conceived program of special training and education.

   True. Relocated to Syracuse in 1854, the asylum demonstrated that it was possible to provide individuals with disabilities with living skills. Many were "mainstreamed" and returned to their home communities as functioning members of society. Pupils in these schools received physical training to improve their motor and sensory skills, basic academic training, and instruction in social and self-help skills.

2. By 1875, in many states, custody in prison-like settings had replaced the goal of integration in the community.

   True. By 1875, a number of states began building custodial institutions. Education as a goal was sacrificed for the greater concern of housing a quickly growing number of persons of all ages with all levels of disability. The goal of educating pupils for life in the community was changed to training inmates to work inside the institution. The more capable inmates were taught functional skills and used as laborers to reduce costs.

3. In the late 19th century and early 20th century, tens of thousands of people with disabilities were forcibly sterilized in the United States.

   True. Individuals with disabilities were forcibly sterilized because it was thought that they were moral menaces, who could potentially ruin the human species.

4. The Office of Mental Retardation and Developmental Disabilities was established in 1923 to oversee institutional care.

   False. OMRDD was established as a separate agency in 1977 after deplorable conditions were found in New York State institutions. Formerly, it was part of the Department of Mental Hygiene. In 2010, OMRDD was renamed the Office for People with Developmental Disabilities (OPWDD).

5. In the mid 1960's, the Director of the Danish National Service for the Mentally Retarded after visiting a state institution in California said, "It was worse than any institution I had seen on visits to a dozen foreign countries. In our country, we would not be allowed to treat cattle like that."

   True. This was part of the impetus for California to provide better care to people with developmental disabilities. In Geraldo's Willowbrook expose in 1972, he showed a segment which illustrated how much better care was in California.

6. In 1965, after visiting the Willowbrook State School in Staten Island, Robert Kennedy declared that the wards were less comfortable and cheerful than the cage in which we put animals in the zoo.

   True. In 1964, the per diem rate for a person living in an institution was $5.57, about one-half the amount devoted to tending animals in a zoo.

7. At Willowbrook State School, between 1963 and 1966, healthy children were intentionally injected with the virus that causes hepatitis and then monitored to gauge the effects of gamma globulin in combating it.

   True. This showed how little people with developmental disabilities were valued. In Massachusetts, children at the Walter E. Fernald School for the Feebleminded were fed radioactive oatmeal as part of a radiation experiment in the early 1950's. A law suit in the 1990's against M.I.T., Quaker Oats and the Commonwealth of Massachusetts earned each of the human subjects $50,000-$65,000.

8. In 1972, Geraldo Rivera's televised expose on Willowbrook State School showed a ward crowded with children, mostly naked. Some were smeared with their own feces. Essentially unattended, they were everywhere, under sinks, knocking their heads against walls, one even lapping water from a toilet bowl.

   True. As a result of this expose, the public was outraged. New York State was forced to change the way it provided services to individuals with developmental disabilities.

9. In 2005, there were approximately 1,600 individuals living in institutions in New York and more than 35,000 living in community residential settings.

   True. In 2005, more than 35,000 individuals with developmental disabilities lived in the community as opposed to the 27,000 who lived in institutions in 1967. The service system has shifted dramatically, from one that sent individuals away to large institutions to one that helps individuals live successful lives in the community.

Transition to Section 3: Philosophies and Concepts

Section 3: Philosophies and Concepts

Overview:

The purpose of this section is to give an overview of the Individualized Service Environment, the 3 I's and a P, Informed Choice, Person Centered Planning, Community Inclusion, Self Advocacy/Self Determination, and Employment First

Objectives:

At the end of this section participants will have:

An understanding of the Individualized Service Environment and the basic services and supports available in New York State for people with developmental disabilities.

Key Learning Points:

- An understanding of the concept of informed choice
- An understanding of the basics of responsibility and risk management
- An understanding of the basic elements and core values critical to quality of life.
- An understanding of person centered planning.
- An understanding of the features of person centered planning.
- An understanding of the importance of the belonging aspect of community.

Activity: Decision Tree, System vs. Person Centered Approach

Time: Approximately one hour

Training Method: Lecture, discussion, review of pre-reading

Philosophies and Concepts:

Explain to participants that the following philosophies and concepts are integral to their work as Service Coordinators and provide a framework for them to follow in their role of helping people live richer lives.

Discuss: The Individualized Service Environment

- The Individualized Service Environment (ISE) is OPWDD's "People First" strategy for assisting people with developmental disabilities.
- The ISE moves the focus of service planning and delivery to the person. It requires that services and supports be built around the person, not a program model and that planning activities be responsive to each person's goals, needs, and desires.
- An ISE can only be developed through a person-centered planning process. We will be focusing on the ISE throughout the day and the Service Coordinator's role in helping a person to develop and implement his or her ISE.

Review:

The 3 I's and a P:

Inclusion: Making certain that people have real relationships with fellow members of the community.

Individualization: Making certain that each person's life is unique: no two should ever be exactly alike.

Independence: Making certain that we are supporting self-reliance, not fostering dependency.

Productivity: Making certain that people's lives are meaningful and worthwhile to them.

Informed Choice:

A basic value that OPWDD supports is the right of individuals with developmental disabilities to make choices and be in control of their lives. Choices should be *informed* choices. An informed choice is a choice made based on experience and understanding. It involves:

- Understanding all the options available to choose from.
- Having had an opportunity to experience a number of options before making a decision
- Understanding the consequences of choosing each option
- Making a decision without fear of repercussion or coercion from others.

Choice-making is not just for individuals who are more capable, but for all people. And the choices we are talking about include major life choices, not just whether a person wants peas or carrots.

Explain:

One of the most important services you can provide as a service coordinator is helping someone to make informed choices.

In Class Activity:

Use any or all of the following three in-class activities to reinforce the benefits of informed choice, and the challenges of assisting individuals with severe disabilities in choice making. Use judgment in how many of the exercises you use, depending on time available. Use a flip chart to record participant responses, or just solicit them orally.

Ask:

1. Can any of you identify ways that you have used to assist individuals with developmental disabilities make choices?

This is a very important topic, so spend some time discussing it. Possible answers:

- Spending time to get to know the individual
- Spending time with those who know the person best (relatives, staff)
- Learning how the person reacts to particular people, situations, and places they like or don't like (i.e., body language, sounds, facial expressions)

- Assisting people to have lots of new experiences as often as possible, to broaden their experiential base
- Reviewing and discussing the person's service coordination record

2. What benefits do individuals gain when we support them in making their own choices?

Possible answers:

- Chance for success in the relationship, environment or activity is greater because the individual is doing what he or she likes and chose.
- Increased self-esteem and confidence.
- Increased ability to take care of themselves.
- Increase in new experiences and ability to make new choices.
- Increased communication skills.

3. What are the challenges in supporting individuals to make their own choices?

Possible answers:

- It might mean more work
- It might take longer
- There might be fear of making a "mistake"
- Liability concerns of staff and agencies
- Person may not have sufficient experiences to make a good choice
- Person might make an unsafe choice

Responsibility and Risk Management:

Explain and review steps to minimize risk:

There are many reasons to assist individuals in becoming more active members of their communities. However, the more a person becomes involved in a community, the more likely he/she will encounter risks. These risks could affect the individual's health and safety.

The following are recommended steps to follow when preparing someone for increased presence in the community.

1. **First, talk with the individual about the implications of community activity.**

    - Recognizing some people have limited expressive or receptive communication skills, a good faith effort should be made to communicate with the person in the most appropriate fashion to help him or her understand the benefits versus the dangers of certain activities. For example, if the person would like to cross the street to buy a drink at the corner grocery store, we should ask him or her if he/she knows about cars and street lights and what may happen if he/she steps in front of a moving vehicle.

2. **Second, start with incremental steps.**

    - Using the example of the person crossing the street, we would never expect someone to cross a busy street on the first try. We may begin by finding a small street that has very little traffic. Or, we may be more conservative and teach the person to cross a driveway before he or she attempts a street. Start with small steps and gradually introduce the person to risks based on a plan that has been discussed and approved by all the important stakeholders.

3. **Next, practice.**

    - Make a plan that explains when practice will be attempted and where, how closely staff will supervise the trial and the steps the person must follow. The plan should also show how many times the person must be successful before he or she may have the next level of staff supervision gradually withdrawn.

4. **Finally, and perhaps most importantly, document all your efforts.**

    - Document your discussions with the individual about the inherent dangers. Document the incremental steps that were taken and the success, or lack of success.

Person-Centered Planning:

Review materials in participant manual and highlight the following information:

Person Centered Planning (also known as Personal Futures Planning or Lifestyle Planning) is a formal way of planning for people with developmental disabilities, even those with very severe disabilities.

Basic features of the Person-Centered Planning Process:

- PCP is a discovery process which reveals the gifts, talents and capacities that an individual possesses. It also identifies how the individual can use these gifts and capacities to enrich his or her life. Many individuals with developmental disabilities have not had a rich experiential basis for determining their skills, capacities, likes and dislikes. Consequently, the discovery process gives individual's direction to further explore their wants and needs for the future.

- PCP does **not** focus on the disabilities and problems that the individual may have. It capitalizes on the **gifts and capacities** the person has to try to build the life the individual desires. Further, PCP focuses on the dreams and hopes of an individual over a long range of time.

- A **circle of support** is a group of people who care about the individual and know him or her best. These people make a commitment to meet regularly to create a support plan and to ensure that this support plan represents what the individual really wants and needs, as well as the actions to be taken to put the supports in place. This group is also responsible for risk assessment and decision making consequences.

- At every step, the person who is the focus of the plan has the opportunity to **make informed choices and express preferences** for a home, relationships, community activities and leisure. The individual is at the center of the planning process. His or her needs and desires drive decision-making. The needs, desires, and choices of the person result in **ISP valued outcomes**.

- Supports for the person come first from **natural and community resources;** only when those types of resources are not available or insufficient does the individual or circle look toward formal paid service providers for supports.

- PCP involves more than the development of a written plan. It is an on-going problem solving process.

Basic Steps to a Person-Centered Planning Process:

Highlight the basic steps in a person centered planning process:

Step 1: Get to know the individual and other people in that person's life:

Develop a circle of support that is committed to realizing the person's dreams and hopes for their life.

Step 2: Look for clues and discovering patterns from life experience:

Identify preferred activities that express the person's unique interests, capacities, and needs.

Step 3: Develop a focus for where the person wants to go:

Translate the individual's dream into a vision of the person's future and valued outcomes for the ISP.

Step 4: Take action by trying things and working together:

Formalize actions steps needed to realize the vision.

Step 5: Exploring community:

Build and strengthen personal relationships and ties to the community by using generic community and natural support systems.

Step 6: Develop constructive system supports:

Overcome barriers through organizational change, continuous learning and strategizing, and creative problem-solving.

Characteristics of Person-Centered Meetings:

These are meetings that use a person-centered process which differ in some ways from traditional interdisciplinary treatment team meetings. More traditional treatment team meetings typically are attended mostly by professional staff who focus on clinical assessments, progress toward specific treatment goals, and making the next set of treatment decisions and goals.

- At PCP meetings, the focus is driven by the individual and his or her skills and capacities. They should focus on exploring the community as a place for the person to grow and develop.

- Short Term and Long Term Action steps are drawn up that identify who will do what and when. Members of this group agree to meet regularly. They meet to discuss the progress made by the individual and any barriers that stand in the person's way. They work to address any problems identified and formulate new directions as needed so the person can live a life he or she is satisfied with.

- A facilitator can be very beneficial in leading this group. The facilitator makes sure that the group stays on task, that each person's contribution is solicited and respected, and that the focal person remains the center of the discussion and the plan. The service coordinator may act as facilitator, but this is not necessarily a role the service coordinator must assume.

Suggested In-Class Activity:

Purpose: To explore the difference between a person-centered approach and a system-centered approach.

1. **Direct:** participants break into small groups (minimum of 4 or 5 per group)

2. **Direct:** participants to consider the following scenario:

"Alan has a history of property destruction, assaultive behaviors and cutting his arms and hands by punching windows when under extraordinary stress. The institution is closing and he has to move. He says he's sick and tired of living with other people. He wants to live alone in his own apartment and have a kitten."

3. **Assign:** Have one person in each group role-play Alan, (or make it "Alice" if a woman doesn't want to role-play a man). Have the rest of the people in the small group role play meeting Alan/Alice for the first time and talk about moving.

4. **Explain:** there are two different scenarios:

Half of the small groups will interact with Alan/Alice from a system-centered perspective, so think about how you would be required to act from a system-centered approach.

The other half of the small groups will interact with Alan/Alice from a person-centered perspective, as if your primary focus is Alan/Alice. His interests and concerns should be foremost in your mind, ahead of anything else.

5. **Assign** each small group to be either system-centered or person-centered.

6. **Explain:** as this is a role play, try to stay in your role. Have a meeting with Alan/Alice. If you have any additional questions about his/her situation, ask Alan/Alice.

7. **Observe:** the role play for a couple of minutes.

8. **Direct:** participants to remain in their small groups during the discussion of the exercise. Alternate between the person-centered and system-centered tables.

9. Ask the following questions:

How did "Alan/Alice" feel during their meeting?

How did the professionals feel during the meeting?

10. **Read:** the rest of the story about Alan (below).

When it was finally his turn to move out of the institution, Alan was placed with three other men with very severe reputations: it made sense for the system as all three were considered to need the same kind of staff: big, brawny males. After a year, Alan was at the brink of incarceration because the house staff called the police whenever Alan became upset, which was more and more often. Succumbing at last to Alan's stated wishes, the administrators agreed to let him have his own place: an apartment by himself, with drop-in staff. Alan has been living on his own for over four years without one incident of breaking glass or self-abuse, and "Tom", the starving kitten Alan took home and nursed back to health is now a very fat, happy cat.

Explain: For many people like Alan, system-centered environments can be the wrong approach for an individual's needs. Rather than needing more intensive system-centered interventions, the person needs a unique solution to address their needs and preferences.

Trainer note – As you talk with each group, highlight certain patterns that may become apparent, such as:

In the system-centered groups:

- Alan reports feelings of anger and frustration when others try to "control" him.
- Professionals report that the dynamics are very familiar and uncomfortable.

In the person-centered groups:

- Alan reports feeling surprised that people listened or Alan might report feeling completely overwhelmed if he's given too many options at once.
- Professionals report feeling either very positive (usually those experienced in person-centered service coordination) or nervous about Alan making bad choices.

Summarize:

- Person-Centered Planning is a formal way of planning for people with developmental disabilities, even those with very severe disabilities.

- Person-Centered Planning is an involved process that is based on the premise that everyone, whether disabled or not, is a unique and whole person, and deserves to "live a typical life." It involves people close to the person and requires a considerable amount of time and resources.

- Person-Centered Planning leads to the identification of valued outcomes for the ISP.

- Person-Centered Planning is based on a core set of values that include individualized supports and services, activities and community inclusion based on interests, preferences and strengths and building community connections over time.

- A Person-Centered Approach uses the basic principles of PCP (i.e., the focus is on the person and the supports and services are based on the person's interests, needs and preferences) but does not require all the time consuming elements of the formal planning process.

Explain:

People should not have to be fixed first, or have all their problems corrected before they can live in the community and have typical and ordinary lives and experiences. PCP attempts to build a meaningful and enjoyable lifestyle by organizing community activities and memberships that are based upon capacities and preferences--**things the person likes to do, places he or she likes to be, and people he or she likes to spend time with.**

These preferences and choices should be reflected in the outcomes selected by the person or discovered through the person centered planning process. The service coordinator should incorporate these **outcomes into the ISP** and work to accomplish them.

Hallmarks of a Person-Centered Approach

- The individual's activities, services and supports are based upon his or her dreams, interests, preferences, strengths, and capacities.
- The person and people important to the person are included in lifestyle planning, and have the opportunity to exercise control and make informed decisions.
- The individual has meaningful choices and makes decisions based on his or her preferences.
- The person uses, whenever possible, natural and community supports.
- Activities, supports, and services foster skills to achieve personal relationships, community inclusion, dignity and respect
- The individual's opportunities and experiences are maximized, and flexibility is enhanced within existing regulatory and funding constraints
- Planning is collaborative, recurring, and involves an ongoing commitment to the individual.
- The individual is satisfied with his or her activities, supports and services.

Strengths and Capacities:

Explain:

It is very important to take the time to discover the individual strengths and capacities of each individual:

- **Strengths/Capacities** are things a person can do, the skills and abilities that he or she possesses. A "capacity search" is a listing of the strengths, capabilities, skills and interests of the individual. Doing this can lead to development of relationships, community building, personal contribution and meaningful work
- **Preferences** are all the activities, objects, and interactions an individual prefers or chooses; what he or she likes to do, where he or she likes to go, with whom he or she likes to spend time. A list of preferences should encompass preferred people, activities, music, food, transportation, learning, body position, furniture, clothing, environmental conditions, colors, smells, and staff supports. Every person has preferences, no matter how capable or how limited he or she may be.

- The less capable the individual appears, the more important this list of strengths and capacities becomes. The lists of strengths and capacities, along with the list of preferred people, places, and activities become the building blocks for daily routines, activities and functional learning.

- Building on these strengths and capacities should help to enhance the self-esteem and independence of the person. As for all of us, this is best done by emphasizing what a person can do right now and what that person may be able to learn to do in the future.

Emphasize:

- In the past, planning was done for the person rather than with the person.

- The emphasis was on the deficits of the person, and it was believed that these deficits had to be fixed or treated before a person could live in the community or participate in community activities.

- While it may be necessary to focus in part on diagnoses, problems, and weaknesses in order to determine the types of learning strategies and treatments which may be helpful, it is most helpful when these are integrated with the preferences, strengths, and capacities of the person.

- Remember, Service Coordinators should not simply try to "fix" a person, but instead try to optimize each person's opportunity to achieve the life he or she wants by enhancing those skills that are important to the achievement or maintenance of the life he or she wants.

- Person Centered Planning is initially time consuming, but then becomes routine. It is a very valuable tool for service coordinators and helps to keep our own values in check and promotes bridge building.

In Class Discussion:

Ask:

"What do you do when the person/family you are supporting wants something you're fairly certain is not possible?"

For instance, a family insists that their son will walk when all the medical experts say it will never happen.

Note:

It is likely that participants will focus on being realistic and firm with the family. Others may think it is their job to help move the family/individual out of denial.

Explain:

- No matter how "out-of-this-world" a person's dreams or desires are, there is a way we can maintain a stance of respect.
- Remember, we are partners with the individuals/family. It is not your job to "move" someone out of denial.

Stress:

- Service coordinators must be able to see situations from the family/individual's perspective. That requires you to take the necessary time to get to know the individual or family in order to understand what it is that they want.

Instructor Note:

This is a nice place to have a discussion about paying attention to what sparks an interest in the person, i.e., identifying that activity or subject that really turns the person on, and then working together to build from there.

For example, if a person wants to be a fire fighter, but you know that they will never be able to actually go into burning buildings to help save lives, nothing says that you a can't have conversations with the person about what that experience must be like.

There may be many ways that the person could be involved in supporting local fire fighters to do their jobs, i.e., volunteer for fund-raisers or perhaps to be employed to help keep equipment clean, etc.

Emphasize:

- While we may not be able to support the person in making his/her whole dream come true, it may be possible to make some part of that dream, the part that is most important a reality.

Values:

Explain:

Service coordinators help individuals to attain the life they want. For most people there are certain things that are most important, things we would not want to live without. These are called values. Let's try to identify some of the things we value.

Ask:

What do you value? What in life is most important to you?

Suggestion:

Write responses on a flip chart. Continue until about 20 items have been recorded.

Ask the participants to look at the list and can identify some common themes or concepts

Write the identified common themes on a second page of the flip chart. Title this page "Core Values."

Instructor Note:

The identified core values will most probably include ***home, family, friends, love, health, independence and dignity and respect.*** Other values that may be included are work, faith and/or spirituality, culture, children, recreation, material resources and helping others.

The discussion should center on the commonality of certain values among all people, including individuals with disabilities. These are universal values, shared by most people.

Emphasize:

- When working with people with disabilities it is important to remember that they will almost always value the same things as do people without disabilities. These values will drive their desires and dreams. When assisting a person to develop a plan it is important to remember what these common values are and try to explore (with the individual) ways to achieve these values.

- Be aware of how you are thinking: just because someone has a developmental disability, does not mean they need someone else to do and think and choose for them. Their values (i.e. their hopes and preferences) should be honored to the extent that is reasonable when making choices about their lives.

VALUES CLASH:

Sometimes situations do arise in which the individual wants to do one thing and you or someone else in authority thinks it's a bad idea. To help avoid these situations or to work through them, here are a few strategies:

- Develop a partnership with the individual and/or family
- Find common goals or agree to disagree to make a point
- Assist the individual and his/her family to find a support group with similar issues/needs
- Help the individual seek/find/join a self-advocacy group
- Introduce the individual to others who have been in their shoes
- Focus on strengths (both formally/informally)
- Do whatever it takes to make certain that the person/family understands what is at stake
- Give person/family some time to adjust, reflect and revaluate
- Be responsible to get all the facts
- LISTEN!
- Work on building trust, then decisions are not as stressful

Community:

Ask:

What is Community?

Explain:

- Community can be defined in at least two different ways, the first focuses on location, and the second focuses on feelings of belonging. As Service Coordinators you need to become more sensitive to the belonging aspect, which is, being **included** in the community. This will be a very important aspect of your work with individuals assigned to you.

- For most people, becoming part of the community in which they live is a valued outcome.

- For most, if not all of us here today, we are part of not one but several communities.

Ask:

What are some of the ways each of you get a sense of "community belonging"?

(List responses on Flipchart)

Here are some examples you could use to get the conversation started:

- Attending school events
- Attending community events
- Regularly attending church, synagogue, a mosque or other places of worship
- Being invited to dinner or a movie

Transition:

Let's look more closely at what community inclusion means and how we can foster inclusion for the individuals we serve.

Community Inclusion:

Ask:

What is Community Inclusion?

Definition of Community Inclusion:

Community Inclusion means the individual is an accepted member of his or her community and rightfully belongs in the community just as we all do. Community inclusion is a series of events that builds a connection over time to the people and places where the individual lives.

Key Points of Community Inclusion:

- It is important to remember that true inclusion builds upon activities that are meaningful and of interest to the individual.
- Community inclusion is a process that supports a wide variety of life experiences for people with developmental disabilities. It should provide people with opportunities to belong in relationships, places, and in the larger community.
- In order to help someone become an integral part of his/her community, one must know the person's interests, preferences and capabilities.
- As members of their communities, individuals with developmental disabilities should have an expanded community presence. This expanded community presence can provide opportunities for full participation in and lead to greater contributions to community life. This in turn will allow them to develop their capacities to the fullest and to be valued by others.
- Community Inclusion means the individual is more than just an observer.

Community Integration versus Community Inclusion:

Explain:

There are subtle differences between inclusion and integration.

Community Integration:

- Integration stresses that individuals should come out from behind the walls of their residences and participate in the same activities that other community members enjoy.

- However, in actual practice, integration usually meant the individuals entered the community, but were merely *visitors.* They did the same things you and I do, but they generally did not form any connections to other, non-disabled people. This was not inclusion.

- Some attempts at community integration and community inclusion resulted in **community intrusion.** For example, large groups of individuals living in a group home or coming from a day program were transported in large vans or school buses to one location. It was unlikely that everybody in the van or bus wanted to be there. Not everyone liked to shop at the mall for hours, wanted to see the same movie, watch a basketball game or go bowling.

Emphasize:

An individualized approach is necessary for true community inclusion. Match the interests of the people to the places they go and to the activities in which they participate.

Transition to Pre-Reading Activity: The Decision Tree

Pre-Reading Activity: The Decision Tree

Explain:

- We would like individuals with developmental disabilities to enjoy the rewards of community life. But it is very important that we take the appropriate steps to ensure their health and safety.

- It is sometimes very difficult for a service coordinator to know when to step back and quietly respect a person's choice and when to step in and question or challenge a person's reason for making a particular choice.

Your pre-reading provided you with a guide to use when providing support to individuals with developmental disabilities. It is called the *Decision Tree.*

Instructor Note: Briefly explain the Decision Tree and how it relates to the accompanying situations.

1. Is this a matter of likely harm or danger?

No
↓
Go to #2
↓

Yes
↓
Must Intervene

2. Is this a matter of certain disappointment or embarrassment?

No
↓
Go to # 3
↓

Yes
↓
Teaching Opportunity
The person makes a decision
with guidance

3. Is this a matter of personal taste or opinion?

No
↓
Other considerations may be necessary

Yes
↓
Respect the Choice

Review:

Ask the participants to quickly review "Sally and Bob's Story" from their pre-reading:

Sally and Bob's Story

Sally and Bob have just moved into an apartment together. A few weeks after their move, the service coordinator comes to visit and is appalled at the damage to the walls and furnishings. Broken glassware has been swept into a pile in the corner of the kitchen. Sally has bruises on her face and neck and Bob appears to have a broken finger. When the service coordinator asks about what happened, Sally and Bob begrudgingly admit that they have been fighting.

Ask:

Question #1, "Is this a matter of likely harm or danger to the person or someone else?"

In this case, it would be appropriate for the service coordinator to consider some form of intervention since both Sally and Bob have been physically injured and may in fact continue to hurt each other.

Review:

Ask the participants to quickly review "Nelson's Story" from their pre-reading:

Nelson's Story:

Nelson has a long-standing crush on Debbie, a coworker. Nelson tells his service coordinator that he has saved up his money to buy Debbie a great birthday gift: the beautiful black negligee he saw at the mall. The service coordinator is concerned about the appropriateness of this gift. She is fairly certain that Debbie's parents, who have been very worried about Debbie being taken advantage of by men, would be very upset by a gift of this intimate nature. She also knows how badly Nelson wants to make a good impression with both Debbie and her parents.

Ask:

Question #1 and Question #2:

- Is this a matter of likely harm or danger to the person or someone else?
- Is this a matter of certain disappointment or embarrassment?

This is not a likely a situation of which would harm or danger Nelson.

The service coordinator considers this choice of gifts a matter of almost certain disappointment and/or embarrassment and uses it as a ***teaching opportunity***.

Explain:

- The Service Coordinator helps Nelson to understand all the possible ramifications of such a gift and when it is clear that Nelson understands, she steps back and respects whatever choice Nelson makes. This does *not* mean she pulls her support away from him. On the contrary: The service coordinator is available to support Nelson in the event that his choice does result in disappointment and/or embarrassment.

- Some of our most important lessons in life come from disappointments. Nelson deserves the dignity of risk to learn and grow in his life just like anyone else.

Ask the participants to reflect on a personal disappointment and to identify any life lessons learned from the experience.

Review:

Ask the participants to quickly review "Jack and His Pink Lamps" from their pre-reading:

Jack and His Pink Lamps:

Jack was a man in his seventies who spent the last fifty years in a large institution. While living in the institution, he always wanted to have brightly colored decorations in his room, but was told he could not. When he finally had the chance to live in his own apartment, staff took him furniture shopping. When it came to lamps for his bedroom, Jack found exactly the ones: Powder pink with a shade with ruffles. The staff person, who cared for Jack very much, frowned and suggested the brown ones instead because they were more appropriate for a man's bedroom. Jack was determined in his choice, however, saying "I have wanted pink lamps all my life. Now that I have my own place, I am going to have pink lamps."

Ask:

Question #1, Question #2, and Question #3:

- Is this a matter of likely harm or danger to the person or someone else?

- Is this a matter of certain disappointment or embarrassment?
- Is this a matter of personal taste or opinion?

Jack's choice of lamps was clearly a matter of personal taste or opinion. Unless Jack was trying to impress someone with his interior decorating, it is unlikely that pink lamps would cause him embarrassment or disappointment. The appropriate action for the service coordinator is simply to support Jack in making his own choice.

Suggested Discussion (if time permits):

Try to illicit feedback from the new service coordinators' own experiences they have had with individuals with developmental disabilities. Ask if they have been unsure about whether or not to intervene in various situations.

Summarize:

The Decision Tree will be strongly influenced by the judgment of the user. One person's definition of embarrassment might be another's definition of danger. Remember to think about the philosophies and concepts we have just reviewed to help you make these important decisions.

Transition to Section #4: Supports and Services

Section 4: Supports and Services

Overview:

The purpose of this section is to give an overview OPWDD supports and services, including Medicaid Service Coordination

Objectives:

At the end of this section participants will have:

- Information about supports and services available within OPWDD, including the HCBS Waiver
- Information about the background of service coordination, now known as Medicaid Service Coordination (MSC)

Key Learning Points:

- Introduction to supports and services available within OPWDD
- Introduction to the HCBS Waiver Services
- An understanding of the background of service coordination.

Time: Approximately one hour

Training Method: Lecture, Discussion, review of pre-reading, exercises

Types and Locations of Supports and Services:

Explain:

There are four broad categories of services provided in NYS for people with developmental disabilities:

- Residential Services
- Day Services
- Family Support Services
- Individual Support Services

Residential Services:

As you read in the pre-reading, there are different types of community-based certified housing including:

- Intermediate Care Facilities (ICFs)
- Individualized Residential Alternatives (IRAs)
- Community Residences (CRs)
- Family Care Homes

In addition to community-based housing, people with developmental disabilities may also live in housing provided on campuses around the state. These settings are viewed as less desirable since they are considered segregated from typical communities. Nearly all non-community based housing is operated by OPWDD. Non-community based housing includes the following:

- Developmental Centers
- Small Residential Unit (SRU)
- Multiple Disabilities Unit (MDU)
- Regional Intensive Treatment (RIT)
- Center for Intensive Treatment (CIT)

Residential supports may also be provided in the person's home and in the community using the Residential Habilitation Service component of the HCBS Waiver.

Refer:

Definitions and explanations of the services and supports can be found in the participant pre-reading material.

Day Services and Supports:

Explain:

Day services and supports are provided through several different program models and individualized options. The most common day service is day habilitation, which is an HCBS waiver service.

Other program models, many of which are traditional models are:

- Day Treatment
- Day Training
- Senior Day Training
- Prevocational
- Supported Employment (SEMP)

Refer:

Descriptions of these can be found in your participant pre-reading materials

Family Support Services (FSS):

- Family Support Services (FSS) are services specifically designed to help families care for a family member with a developmental disability in their home.

- Family Support Services include respite, parent counseling and training, information and referral and service coordination. The types of Family Support Services available may vary by DDSO. These services are provided by both DDSO and voluntary agencies.

Individual Support Services (ISS):

- ISS is a flexible source of funding designed to allow a person to live independently in the community by allowing the person to purchase certain things he/she needs via an ISS contract.

- Typically, ISS contracts pay for things like rent and transportation, which are supports that are often not paid for by other program sources.

Home and Community Based Waiver:

Explain:

- Today, most (but not all) services provided by OPWDD and voluntary agencies are funded through the Home and Community Based Services (HCBS) waiver.

- The HCBS waiver has been in operation in New York State since September 1991. It is a federal program that allows the States to use Medicaid money for community-based services. Formerly, this money had been available only for institutional services.

- Types of HCBS waiver services include residential habilitation, day habilitation, respite, and environmental modifications. Some of these services can be provided in the community and some in the home. More information is included in the participant pre-reading materials.

- Some services are still funded through other federal, state, and county sources such as:
    - Intermediate Care Facilities (ICFs)
    - Day Treatment
    - Family Support Services (FSS)

Background of Service Coordination:

Review:

- Service Coordination is a widely used term that generally means assistance to arrange, coordinate, monitor, and evaluate a package of multiple services to meet a person's individual needs. The term "service coordination" has replaced the previous term "case management."

- Service Coordination has always been an integral part of the development of community based services and has become increasingly important as more and more individuals live in the community.

- In the 1980s, New York State provided service coordination under the federally funded Comprehensive Medicaid Case Management program (CMCM). For those

individuals being served under the HCBS Waiver, service coordination was provided as part of the waiver package.

- In March 2000, the Medicaid Service Coordination program (MSC) replaced both the CMCM and HCBS waiver service coordination program.

- OPWDD has a long history of providing service coordination/case management. In particular, service coordinators/case managers responded to the needs of individuals as they moved from institutions to community settings. They worked as team members to determine the type of residential setting and services that best suited each person; helped to locate and access supports and services; monitored the person's progress; and provided numerous services and supports to help individuals to overcome obstacles and maintain stability.

- OPWDD operates the MSC Program under the federal Targeted Case Management (TCM) program. Within the TCM framework, Medicaid Service Coordination helps a person access necessary supports and services including medical, social, educational, psychosocial, employment, habilitation, rehabilitation, financial, residential, and legal services available in accordance with the person's needs and valued outcomes as expressed in the Individualized Service Plan (ISP).

- Part 635.10.4 of Title 14 of New York State Mental Hygiene Law states that case management is an allowable service under the provisions of the HCBS Waiver funded or certified by OPWDD. Every person approved for participation in the HCBS waiver shall be assisted by a specific case manager.

Review pre-reading Activity:

ACTIVITY #4: COMMUNITY RESOURCE BUILDING:

Please provide three examples of community resources available to individuals with developmental disabilities (and to the general public) that do not require disability specific funding or support. Identify the specific resources by name and address and identify the type of activity or community opportunity available.

The resources should be places or activities where representation from the full community is present. Do not list disability specific activities or events attended mostly by individuals with disabilities (e.g., Special Olympics and agency sponsored dance on Friday night).

This information should be shared in class in order to help participants broaden their network of community resources. If possible, make copies during a break or lunch and distribute to the participants for their future use.

Community Resource: _____
Address: _____
Activities/Services Provided: _____
Phone #: _____
Contact Name: _____

Community Resource: _____
Address: _____
Activities/Services Provided: _____
Phone #: _____
Contact Name: _____

Community Resource: _____
Address: _____
Activities/Services Provided: _____
Phone #: _____
Contact Name: _____

Transition to Section 5: Service Coordinator Responsibilities to the System and to The Individual

Section Five: Service Coordinator Responsibilities to the System and the Person

Overview:

The purpose of this section is to define service coordination under targeted case management, and to give participants an introduction to the service coordinator's responsibilities to the system and to the person.

Objectives:

At the end of this section participants will have:

- An understanding of service coordinator responsibilities under laws, regulations, and funding sources

- An understanding of responsibilities of the service coordinator to the person in regards to the service plan, health & safety, advocacy and record keeping.

Key Learning Points:

- Aspects of service coordination and major responsibilities
- Assessment
- Service Plan Development and Implementation
- Linkage and Referral to Services
- Monitoring and Follow-up
- Service Documentation

Activities: Defining Boundaries, A Day in the Life

Time: **Approximately an hour**

Materials: Participant manual

Training Method(s): Lecture, Discussion, Group Activity

Important Aspects of Medicaid Service Coordination:

Explain:

- As we have been discussing, service coordinators focus on helping people with developmental disabilities live successful lives in the community according to their own dreams, desires and plans.

- OPWDD has **eight** fundamental expectations of service coordination that significantly impact how the service is administered and delivered. These expectations are critical to the effectiveness of service coordination both from the perspective of the person as well as from agency administration.

Review:

1. **Service Coordination is a separate and distinct service from all other services.**

- A service coordinator is not on staff of a certified residence (for example, an Individualized Residential Alternative), a day habilitation site, or any type of program or other service.

- To avoid a potential conflict of interest and to promote the independence of the service coordinator, staff providing direct services to a person cannot also serve as that person's service coordinator. This includes residence managers, clinicians (e.g., psychologists, nurses, habilitation specialists, Family Care home liaisons and direct support staff).

- Since service coordination is as an "unbundled" service, a service coordinator can independently advocate for people with disabilities. Agency policies or requirements must not compromise the service coordinator's ability to pursue the person's desired outcomes in his or her personal plan.

2. **The service coordinator works in partnership with the person and is not "in charge" or "in control."**

- Good service coordinators strive to achieve a working partnership with the people they serve. They share common goals and agree on what will be done and by whom. Each person feels respected by the other. There is trust.

- The service coordinator works for the person with developmental disabilities. The service coordinator is not the boss!

3. The service coordinator helps the individual achieve a balanced and integrated perspective of his or her life.

- This ensures that some areas of life are not overemphasized, under-emphasized, or omitted altogether. As an example, a service coordinator should advocate that the individual's personal plan address all the major areas of their life (family, community, interests and hobbies, spiritual and cultural concerns, etc.).

4. The service coordinator is chosen by the person and advocate.

- Personal choice is an important value not only to the individual but to OPWDD as well. Medicaid Service Coordination requires that a person choose his or her service coordinator from all available providers in the region.

- People should never be assigned or transferred to a service coordinator without having a choice.

5. The service coordinator is always assessing and attempting to maximize the individual's satisfaction.

- If the individual is not satisfied with supports and services, or if his or her outcomes are not being pursued, the effectiveness of the ISP may be jeopardized.

- The service coordinator determines satisfaction in many ways including meeting with and/or observing the person and by talking to people who know the person best, such as; direct support staff, friends, family members, other caregivers, and service providers.

6. The service coordinator always promotes and monitors the individual's health and safety.

- Safeguards and protections are an important part of planning and the ISP. Some examples are: a person who bangs his head must wear a helmet, a person needs a follow-up medical evaluation at a specialty clinic, or a person in a wheelchair needs a special fire evacuation plan.

- It is the responsibility of the service coordinator to ensure that a current Individual Plan of Protective Oversight (IPOP) for an individual living in IRA is attached to the ISP.

7. The service coordinator always fosters inclusion (community membership) and self-determination. These are basic values of our service delivery system.

- Community inclusion is one of the most important outcomes of an ISP and the supports it identifies.

- It is important that individuals have meaningful, regular community participation and membership. (This may be accomplished in many ways by having someone: work, volunteer, become a regular at a neighborhood coffee shop, become a member of a civic or recreational organization, or belong to a religious congregation.)

8. The service coordinator is an advocate for the individual.

- The service coordinator helps promote the person's cause and defends the person's rights when the person cannot do so alone.

- The service coordinator is in a position to do this from within the service delivery system and can ensure safeguards are in place to keep the person well and safe. The service coordinator always promotes self-advocacy and self-determination.

Summarize:

These fundamental aspects of service coordination significantly impact the way in which services are delivered and how people benefit from these services

Responsibilities of a Service Coordinator:

In order to help a person access necessary and available supports and services, a service coordinator's responsibilities include:

- Assessment
- Service plan development and implementation
- Linkages and referrals to services
- Monitoring and follow-up
- Service documentation

Define:

Assessment:

- Actions taken to determine a person's functional status, service needs, personal goals and preferences.

Service plan development and implementation:

- Actions taken to develop the individualized service plan (based on the assessment process) and to coordinate service provision

Linkage and referrals to services:

- Actions taken to assist the individual and his/her advocate to identify and access specific service providers.

Monitoring and follow-up:

- Actions taken to oversee the individual's participation in the needed/desired HCBS waiver services, supports and activities, according to the individualized service plan (ISP).

Service Documentation:

- The service coordinator must track relevant information about the individual's life in order to allow the service coordinator to maintain a written record of major events, changes, issues and progress, and thereby provide person-centered services.

Service Coordinator Responsibilities; Laws, Regulations, and Funding Sources:

Explain and Emphasize:

OPWDD requires service coordinators to follow the rules established under state and federal policies and regulations. These responsibilities are stated in the following materials. You should obtain copies of the following documents from your agency, or OPWDD's website. Put these in your service coordinator "tool box," as you will refer to them regularly in your role as a service coordinator:

- **The Medicaid Service Coordination Vendor Manual** (MSC recipients)
- **The Key to Individualized Services** (HCBS Waiver recipients)
- **OPWDD Regulations: Part 624: Reportable Incidents, Serious Reportable Incidents and Abuse in Facilities Operated or Certified by OPWDD**
- **Part 633: Protection of Individuals Receiving Services in Facilities Operated and/or Certified by OPWDD**
- **Part 635: General Quality Control and Administrative Requirements Applicable to Programs, Services or Facilities funded or Certified by OPWDD**

Additional responsibilities for service coordinators can be found in the following:

- **The Willowbrook Permanent Injunction** (Willowbrook Class Members)
- **Community Placement Procedures** (OPWDD operated or certified residential locations)
- **The Family Care Manual** (Family Care recipients)

The Home and Community-Based Services Waiver:

In relation to the HCBS Waiver (The Key to Individualized Services), service coordinators are required to do the following:

- Ensure the completion of an annual level of care determination for ICF/MR enrollment.
- Secure or continue searching for an advocate for each enrolled person who requires one.
- Notify DDSOs of HCBS terminations, and inform the terminated individual about connecting with follow-along services.
- Ensure that the person's fire safety needs are addressed as stated in the ISP. If a person lives in an IRA, the service coordinator ensures the assessment of that person's fire safety needs occur at least annually. The fire safety needs of individuals

living in their own homes should be reviewed and discussed, but an assessment is not required.

- Develop, implement and maintain the ISP.

The Willowbrook Permanent Injunction:

- A full time service coordinator with even one Willowbrook class member on his or her caseload can serve no more than 20 work units. A caseload must be pro-rated for service coordinators who work less than full time in this capacity.

- The service coordinator for a Willowbrook class member must be a qualified mental retardation professional (QMRP) who is either a state employee, or an employee of a voluntary agency that does not provide residential or day service to the individual. However, a class member or the class member's correspondent may choose a functionally independent service coordinator employed by the same agency that provides residential or day services, if such a person is available.

- Service coordinators and supervisors are to perform the functions detailed in Appendix I of the Injunction on behalf of Willowbrook class members. Case managers/service coordinators and supervisors should ensure that class members on their caseloads receive the legally mandated services as stipulated in the permanent injunction.

- Appendix I includes a definition of case management/service coordination, functions, and responsibilities for assessment, program plan development, record keeping, coordination, linking, support, monitoring/follow-up, discharge, and reporting.

Community Placement Procedures:

These policies describe the process of helping a person relocate from an OPWDD operated or certified residential location to another residential setting. In most situations, it is the responsibility of the service coordinator to implement these procedures.

- This includes scheduling meetings, sending notifications, updating the ISP, receiving approvals for the change in residence, and handling any objections by the person or his or her advocate.

Regulation Part 624: Reportable Incidents, Serious Reportable Incidents and Abuse in Facilities Operated or Certified by OPWDD:

- The regulation applies to the "...reporting, investigation, reviewing, correcting and/or monitoring of certain events or situations to enhance the quality of care provided to persons with developmental disabilities and to protect them (to the extent possible) from harm, and to ensure that such persons are free from mental and physical abuse." (Source: *Basic Provider Training Resource Manual* presented by the Division of Quality Assurance, 1998. Service coordinators must comply with these regulations).

Regulation Part 633: Protection of Individuals Receiving Services in Facilities Operated and/or Certified by OPWDD:

- This regulation specifies the "minimum requirements and standards for ensuring and/or promoting the protection of persons with developmental disabilities."

- Service coordinators must comply with portions of this regulation. This includes notification to the person and others of his or her rights; notification to parents, guardians, correspondents if a health problem required ER treatment or admission to a hospital; notification to the person and others of his or her right to object or appeal to care and treatment and the procedures for doing so; ensure the confidentiality of HIV related information; and, if the person is sexually active, he/she is offered the opportunity to be trained in HIV awareness and methods of protection.

- To monitor the health and safety of the person, the service coordinator should also know the regulations for personal allowance, medication and storage of medication.

Regulation Part 635: General Quality Control and Administrative Requirements Applicable to Programs, Services or Facilities Funded or Certified by OPWDD:

- This regulation specifies general quality control and administrative requirements with which a program, service or facility funded or certified by OPWDD must comply.

- To monitor the person's ISP and his or her health and safety, the service coordinator must know portions of this regulation, which includes general health and safety requirements, supplies and services requirements, and the Home and Community Based Services Waiver requirements.

Responsibilities in Working with School Age Children:

Explain:

Service coordinators responsibilities in the special education process include:

- Be knowledgeable of the rights of parents of children with disabilities age 3-21
- Be knowledgeable of the IEP process and the role of the Committee on Special Education (CSE)
- Understand the Transition Planning Timeline – it begins at age 12!
- Medicaid Service Coordinators could be included at IEP meetings. Parents and school personnel have discretion to include other individuals who have knowledge or special expertise regarding the student.
- Once a child is approved and getting services through Early Intervention, they will not be eligible for MSC for the period of time the child is in Early Intervention.

Additional Responsibilities: Direct participants to review the Additional Resources in their pre-reading packets

- The Family Care Policy Manual
- **Regulation Part 671** (HCBS Waiver Community Residential Habilitation Services for Persons with Developmental Disabilities)
- Understanding Cultural Competence

Responsibilities of a Service Coordinator:

Instruct:

1. Developing, Implementing and Maintaining the ISP

- All people enrolled in MSC must have an Individualized Service Plan (ISP). The ISP must be completed within 60 days of the person's enrollment in MSC.

- All ISPs must be developed using a person centered approach to planning. This means that the needs, capacities and preferences of the individual are the focus of the planning. The planning must identify the person's desired outcomes and those supports and services the person wants and needs to attain the desired outcomes.

2. Insuring the Individual is Healthy and Safe

- Service coordinators must document in the ISP that safeguards are in place to protect the individual's health and safety. This should include fire safety issues.

- Service coordinators ensure that for residents of IRAs and Family Care, the person has an **Individual Plan of Protective Oversight.**

For individuals who live in OPWDD certified residences, the service coordinator must:

- Report suspected unmet health or safety needs in any OPWDD certified residential setting. Either following the elements contained in the Service Coordination Observation Report (MSC7-SCOR) or completing the SCOR where required for Willowbrook class members, is one of the ways service coordinators can report unmet health and safety needs. (See Chapter Five and Appendix One.)

- Ensure that for residents of IRAs, the person has an Individual Plan of Protective Oversight.

- For people living in a CR or Family Care, document in the safeguard section of the ISP the supports needed to keep the person safe from harm and actions to be taken when the health or welfare of the person is at risk. Fire safety issues must be addressed in the safeguards section.

- Report, in consultation with the service coordination supervisor, suspected child abuse to the State Central Register of Child Abuse and Maltreatment at 1-800-342-3720.

- Comply with Part 624 (Reportable Incidents, Serious Reportable Incidents and Abuse in Facilities Operated or Certified by OPWDD) and take reasonable steps to prevent violation of Part 633 (Protection of Individuals Receiving Services in Facilities Operated and/or Certified by OPWDD), and subpart 635-9 (Provision of Required Services) (Appendix One).

For individuals who live independently, with others or at home with family, the service coordinator must:

- Document in the safeguards section of the ISP that there are safeguards in place to protect the person's health and safety. This must include a summary of fire safety needs.

- Report, in consultation with the service coordination supervisor, suspected child abuse to the State Central Register of Child Abuse and Maltreatment at 1-800-342-3720.

- Address suspected abuse, neglect, and financial exploitation of adults, including situations where an individual cannot care for him or herself. This may require a call to the local adult protective system. In New York City, suspected abuse or neglect of adults is reported to Protective Services for Adults. Outside New York City, the local county department of social services should be contacted to determine which office has responsibility for this function in the county where the individual lives.

- Comply with Part 624 (Reportable Incidents, Serious Reportable Incidents and Abuse in Facilities Operated or Certified by OPWDD) and take reasonable steps to prevent violation of Part 633 (Protection of Individuals Receiving Services in Facilities Operated and/or Certified by OPWDD), and Part 635 Subpart 635-9 (Provision of Required Services) (Appendix One).

- **Explain: Be aware that your own agency may have additional policies on dealing with these issues**.

For further information regarding the actions to be taken when it is suspected that an individual is in a dangerous situation, service coordinators should refer to the **Handbook for All OPWDD Providers - Part 624**. Section seven of the handbook addresses the application of this regulation to non-certified programs and services.

Advocating for the Individual

- A service coordinator advocates on behalf of individuals by working with others to protect and uphold a person's rights including intervening when a person feels his or her rights are being denied.

- A service coordinator advocates by observing if an individual appears healthy during face-to-face visits and verifying the health of the individual with other persons and service providers when the service coordinator does not see the person face-to-face.

- When conducting visits in the home, a service coordinator assesses whether the quality of the living environment appears safe and takes appropriate action if any safety concerns are identified.

4. Record Keeping

- The service coordinator is responsible for maintaining a separate record for each person receiving MSC.

- The Service Coordination Record provides an ongoing written account of the service coordination activities needed by and provided to the person.

- The Service Coordination Record also contains the documents that verify the person's eligibility for various programs.

Activity: Defining Boundaries of the Job

Explain:

The purpose of this exercise is to facilitate a discussion about the boundaries of a service coordinator's job responsibilities. This activity will bring up areas of controversy and disagreement. The important points to make are that:

- Most of what a service coordinator does should relate to the primary tasks of developing, implementing, and maintaining the ISP, advocating, and record keeping.
- Service coordinators should be somewhat flexible in their job definition.
- There will be times when service coordinators must decide for themselves where they should draw the line. Note: It is recommended that they seek out their supervisor's opinion to make sure that the choice made was the best decision.

Ask:

Which of the following would you consider to be a legitimate part of being a person's service coordinator?

- Finding the name of a doctor for a person on your caseload?
- Taking the individual bowling after work hours?
- Providing a little therapy to the individual when they're down?
- Driving a person to and from his job?
- Calling the individual's parents to help resolve a disagreement?
- Giving legal advice?
- Being the individual's friend?
- Lending an individual money?
- Taking the person to church and introducing them to congregants?

Facilitate a discussion around those activities considered to be "borderline."

Ask:

Is there any decision you have made that you are unsure about?

Emphasize:

Remind participants they must be sensitive to boundaries of their jobs, while being as flexible as possible--ultimately, they must decide for themselves.

Activity: A Day in the Life of a Service Coordinator

Trainer Note:

There are three versions of this activity, a Suburban/Rural version, a City version, and an Alternate version. Please choose the appropriate version for your location and participants.

Instruct:

Using the "A Day in the Life of a Medicaid Service Coordinator" activity, we are going to examine a service coordinator's responsibilities. Ask participants to read the scenario, "A Day in the Life of a Medicaid Service Coordinator" (note which version they should read). Give the participants about five minutes to read the scenario silently.

On the flip chart, list the following areas:

- Assessment
- Service plan development and implementation
- Linkage and referrals to services
- Monitoring and follow-up
- Service documentation

The purpose of this activity is to identify the above five areas within the scenario. For example, in the suburban/Rural scenario the service coordinator is checking on a medical assessment. Ask the participants to identify where this would fall under from this list. Checking on a medical assessment could fall under several categories. Assessment would be one of them. The assessment could be something necessary in order to link or refer to a service. Noting that the assessment was completed/received falls under service documentation.

Also look for areas that may be outside of the responsibilities of the service coordinator.

A Day in the life of a Medicaid Service Coordinator (Suburban/Rural)

As I sit here at a red light at a busy intersection, I glance at my appointment book. It's going to be a busy week and every day holds adventure because I am a Medicaid Service Coordinator. I fill my gas tank before heading to the office because once I get going there will be little time to stop.

First stop, the office. I need to check my messages on my voice mail. On really busy days like today, I usually call in for my voice mail. However, I need to check the post mail for a medical assessment for a new person applying for waiver services. I get a cup of coffee and head to my desk only to find that the medical assessment has not yet arrived. I call the doctor's office and the receptionist tells me that she finally received the release of information form from the advocate and that the assessment will be mailed out today. I enter this information in my MSC notes for this person.

I leave the office for XYZ Day Habilitation program where I plan to meet two individuals I serve. Mary has been having some concerns that we need to discuss. Sara is new to the program and I am glad she is adjusting well. She had been unhappy in her last day program and had been reluctant to try another. I had arranged visits for her to four different day programs before she finally settled on this one. Still, I had worried. But Sara tells me she is happy and that she has made friends. This news makes me feel great. Before I leave, I check in with the Day Habilitation coordinator.

Next, I'm off to visit Robert at his home. I have with me a copy of the updated ISP for review and signature. Upon review of the ISP, Robert, his mother, and I agree that some changes still need to be made. Since Robert aged out of school last June, he has been home during the day. Robert is non-verbal and conveys his likes and dislikes through his behavior. Robert's Mom tells me he has been acting out a lot lately. Robert misses the structure of his school day and we all agree that Robert should try a day program. Robert also loves being in the water and so I will look for a recreational swim program for him. We agree on the ISP changes and I tell Robert and his Mom that I will mail the revised ISP to them for their review and signature. I tell them that they should let me know as soon as they can if the updated ISP meets their approval. I want to make sure that I get all the necessary signatures within the 60 day window.

Before I leave, we decide to create an Activity Plan to help keep track of what needs to be done to find Robert a day program and a recreational swim program. In the activity plan, I write out the activities Robert and his Mom would like completed. I agree to make referrals to different day programs and Robert and his Mom agree to keep appointments to visit these programs. I also agree to look for a recreational swim program for Robert.
I grab a quick bite and head back to the office to check my e-mail and messages. I write my notes for the face-to-face visits I completed in the morning. I also add the day program referrals and ISP changes to my to-do list.

Next I call to confirm my appointment at ABC IRA. I want to make sure that both Linda and Carmen will be home. Last time I visited, I found some damage in Linda's bedroom. After the water from a burst pipe had been cleaned up, a hasty patch job had been done and plaster kept falling from her wall. Linda had been very unhappy because she thought her room looked ugly. I had documented the falling plaster and shared my findings with the residence manager. The residence manager had promised me that he would submit a work order right away and that the repairs would be done shortly. Now, I want to make sure that the repairs have been done.

As I am about to leave, Paul, a person on my caseload, calls me. He is very upset because his ride didn't show and he wants me to give him a ride. I tell him I am running late but he insists that he can't be late for his appointment. Since he is only a few blocks from the office, I agree to take him.

I pick up Paul and, luckily, I am able to make terrific time. But after I drop him off, I get caught behind a garbage truck. Now, I am really running late. I call ABC IRA to say I will be there as soon I can. When I finally arrive, I meet with both Linda and Carmen. They fill me in on what's been going on in their lives. They don't have any problems to report. In fact, Linda is particularly excited. She grabs my hand and takes me to her room. It has been completely repainted in the color she has chosen, a sky blue and it looks great. She is so proud of her room that it is hard to get her to leave it. I take a tour of the rest of the house and everything looks good. I say goodbye and get ready to head home.

In my car, I make myself a note to write my notes for the face-to-face visits at the residence. It's been a long day and I am tired. But it's a good tired. I feel that I am making a difference in people's lives. Every day holds new challenges and small victories. As I drive home I reflect over this day, a day in the life of a Medicaid Service Coordinator.

A Day in the Life of a Medicaid Service Coordinator (City)

As I hold on to the subway pole, I glance at my appointment book. It's going to be a busy week and every day holds adventure because I am a Medicaid Service Coordinator.
First stop, the office. I need to check my voice mail messages. On really busy days like today, I usually call in for my voice mail. However, I need to check the post mail for a medical assessment for a new person applying for waiver services. I get a cup of coffee and head to my desk only to find that the medical assessment has not yet arrived. I call the doctor's office and the receptionist tells me that she finally received the release of information form from the advocate and that the assessment will be mailed out today.

I leave the office for XYZ Day Habilitation program, which is located a couple of blocks from the office. I plan to meet with two individuals I serve for a face-to-face meeting. Mary is home ill, so I'll have to make arrangements to see her later in the month. Sara is new to the program and I am glad she is adjusting well. She had been unhappy in her last day program and had been reluctant to try another. I had arranged visits for her to four different day programs before she finally settled on this one. Still, I had worried. But Sara tells me she is happy and that she has made friends. This news makes me feel great. Before I leave, I check in with the Day Habilitation coordinator.

Next, I'm off to visit Robert, who lives a few blocks from the XYZ Day Habilitation program for my required quarterly visit to the home. I have with me a copy of the updated ISP for review and signature. Upon review of the ISP, Robert, his mother, and I agree that some changes still need to be made. Since Robert aged out of school last June, he has been home during the day. Robert is non-verbal, and conveys his likes and dislikes through his behavior. Robert's Mom tells me he has been acting out a lot lately. Robert misses the structure of his school day and we all agree that Robert should try a day program. Robert also loves being in the water and so I will look for a recreational swim program for him. We agree on the ISP changes and I tell Robert and his Mom that I will mail the revised ISP to them for their review and signature. I tell them that they should let me know as soon as they can if the updated ISP meets their approval. I want to make sure I get all the necessary signatures within the 60 day window.

Before I leave, we decide to create an Activity Plan to help keep track of what needs to be done to find Robert a day program and a recreational swim program. In the activity plan, I write out the activities Robert and his Mom would like completed. I agree to make referrals to different day programs and Robert and his Mom agree to keep appointments to visit these programs. I also agree to look for a recreational swim program for Robert.
I grab a quick bite and head back to the office to check my mail and messages. I write my contemporaneous progress notes for the face-to-face visits I completed in the morning. Then I note these visits on my monthly billing sheet. I also add the day program referrals and ISP changes to my to-do list, as well as a reminder to reschedule my meeting with Mary.

Next I call to confirm my appointment at ABC IRA. I want to make sure that both Linda and Carmen will be home. Last time I visited, I found some damage in Linda's bedroom. After the water from a burst pipe had been cleaned up, a hasty patch job had been done and plaster kept falling from her wall. Linda had been very unhappy because she thought her room looked ugly. I had documented the falling plaster and shared my findings with the residence manager. The residence manager had promised me that he would submit a work order right away and that the repairs would be done shortly. Now, I want to make sure that the repairs have been done.

As I am about to leave, Paul, a person on my caseload, calls me. He is very upset because his ride didn't show and he wants to know if I can take him to his appointment. I tell him I am running late but he insists that he can't be late. Since he lives close to the office and is only going two subway stops from Linda and Carmen's home, I agree to take him.
I pick up Paul and take him where he needs to go. After I drop him off, I am able to catch a bus right away and am feeling pretty lucky. But then the bus gets caught behind a garbage truck. I glance at my watch and see that I am now really late. I call ABC IRA to say I will be there as soon as I can.

When I finally arrive, I meet with both Linda and Carmen. They fill me in on what's been going on in their lives. They don't have any problems to report. In fact, Linda is particularly excited. She grabs my hand and takes me to her room. It has been completely repainted in the color she has chosen, a sky blue and it looks great. She is so proud of her room that it is hard to get her to leave it. I take a tour of the rest of the house and everything looks good. I say goodbye and get ready to head home.
On my subway ride home, I make myself a note to write my contemporaneous notes for the face-to-face visits at the residence. It's been a long day and I am tired. But it's a good tired. I feel that I am making a difference in people's lives. Every day holds new challenges and small victories. As I tightly clutch the subway pole, I reflect over this day, a day in the life of a Medicaid Service Coordinator.

A Day in the Life of a Medicaid Service Coordinator (Alternate Version)

As Diana Prince settles herself at her cubicle, she finds herself reviewing the day's schedule. Today is the 15th day of the month. She has one community based home visit with Sarah and hopes Sarah's mother is home to review the respite applications, one ISP meeting that was rescheduled from the 2nd, and at the end of the day, she'll catch two of her individuals as they arrive home at Main Street IRA, where a late afternoon clinical meeting is scheduled. Hopefully there will be time to run into the ARTS day program, to check on Ivy, a new participant who was having a little difficulty settling in. But right now, Diana has to return a few phone calls, check her email, send out an ISP that her supervisor hopefully approved, fill out her mileage sheet and submit her weekly time sheet. She also had to pack up her brief case with all the necessary forms, so that she could complete her paperwork contemporaneously. There's always filing, but since Diana takes her supervisor's advice and completes any visits and ISP meetings within the month's first 3 weeks, the last week is always available to reschedule last minute cancellations, complete community placement packets for future moves and research new recreation programs.

Diana's first three messages are from staff at various IRAs. John was involved in a seriously reportable incident. He's okay, but there is follow up that Diana needs to complete as soon as possible. Leslie had an emergency room visit that resulted in a new prescription that needs informed consent. The staff tried to reach Lisa's sister all night, but she is apparently out of town and Diana will need to track her down, and coffee was accidentally spilled on the fax that Diana sent outlining Fred's vacation itinerary so she needs to send another so Fred can get his shopping done as planned today. The next message is from a transportation company she called a few days ago to request an application and eligibility criteria. So far, there is nothing out of the ordinary. The fourth message was from Ivy's father, Mr. Smith. Ivy refused to get on the bus this morning and he has to go to work. He sounded more concerned than frustrated but clearly was at a loss. The last message was from Ivy's day program asking what Diana was going to do about Ivy's refusal to come in today. "Well I guess I'll get a chance to see Ivy today after all, so much for emails, and filing this morning. I hope my supervisors won't be too upset that my time sheet will be late, and that ISP will just have to go in this afternoon's mail" she thought.

Using her hands free cell phone, Diana called Sarah's mother, Mrs. Jones and apologized, but would be late for this morning's face to face visit. She explained that the respite applications were finished and that the day program tours were set up for next month. Thankful that she decided to continue using the activity plans, Diana knows all the activities she has to complete for everyone on her caseload are tracked and easy to look up. Diana then placed a call to her supervisor and left a voicemail message explaining why her time sheet would be late.

When Diana arrived at Ivy's house, Mr. Smith was clearly relieved, but Ivy was crying. Ivy explained that she hates day program because she misses her favorite television shows and

she has to eat lunch an hour later than she likes. After a few minutes, Diana thought she had a good understanding of the problem. Diana asked Ivy's father if he had a DVR or VCR. Unfortunately, he did not. "Well, just another obstacle" Diana thought. "If I could get a VCR, would it be okay if we taught Ivy how to tape her shows and she could watch them when she gets home?" Mr. Smith agreed and although Ivy didn't quite understand the plan, she trusted Diana and agreed to go to program if she could eat at her normal lunchtime. Diana then called the ARTS program manager and discussed the problem. After using all her negotiation skills, Ivy's lunch period was changed. Only a half hour late for her meeting with Mrs. Jones, Diana said goodbye, promised to work on getting a VCR in the next few days and waved as Mr. Jones and Ivy pulled out of the driveway.

Remembering she left the office without looking up the directions to her ISP meeting at the middle school of a neighboring community, Diana once again used her hands free cell phone and called one of her peers at the office. Diana knew she was interrupting Peter's busy day, but all of her office mates would lend a hand. Without it, their jobs would be 10 times harder. A little behind schedule, Diana completed her day at the Main Street IRA. Following two face to face visits and a productive clinical meeting, Diana asked the manager if she could use the house phone to call the office. She didn't want to break the agency guideline of returning calls within 24 hours, so she wanted to gather the numbers and make a few calls from here. There were only three new messages. One from Ivy saying that she still didn't like lunch, but she would go to ARTS tomorrow and one from Lisa's sister saying that she got the message and was giving consent for the new medication. The final call was from Diana's supervisor saying she found the ISP and sent it out. The supervisor ended the message by thanking Diana for a job well done. "Gee" Diana thought, "I was only doing my job, but it sure feels great to know someone is noticing!"

Trainer Note: When summarizing the role play, try to make the following points:

- Time management is critical for service coordinators. You must use time **efficiently** and be organized. It is important that service coordinators keep careful notes and keep track of their time.

- Service Coordinators must also regularly communicate with the individuals they serve and involve their supervisors and others as needed.

- Routine activities are integrated into each day, like service meetings, phone calls, application packets, and notes. Making notes in the field saves time.

- Some days can be challenging and sometimes progress can be slower than you may anticipate. Remember to:

    - Prioritize
    - Organize
    - Network with peers
    - Connect with your supervisor
    - Go to training

Refer participant to materials in pre-reading material for further information:

- Communicating with People with Developmental Disabilities
- Strategies for Effective Collaboration with Families

Transition to Section Six: Service Documentation

Section 6: Service Documentation

Purpose :

This section's purpose is to provide an overview of the service coordination record and the forms used by service coordinators.

Objectives:

Participants will:

- Understand how to maintain the service coordination record
- Understand how to complete MSC forms
- Understand how to write and maintain service coordination notes
- Understand how to complete the ISP

Key learning points:

- The importance of the service coordination record
- Monthly notes and their importance to billing
- The importance of the ISP

Time: ½ hour

Materials: Participant Materials

Training Method: Lecture

Please Note:

MSC Vendor Manual:

The MSC Vendor Manual is written for service coordinators and administrative staff of vendors that provide Medicaid Service Coordination (MSC) under contract with the Office for People with Developmental Disabilities (OPWDD). The manual includes copies of the MSC forms, regulatory language related to MSC and other relevant information. The MSC Vendor Manual can be found on the OPWDD Website (www.opwdd.ny.gov)

The Service Coordination Record:

Review:

Let's discuss the individual's service coordination record. Each service coordination record has four main sections:

- **Section 1** - Eligibility/Enrollment Documentation (includes application for participation, documentation of a diagnosis, documentation of Medicaid eligibility, Notice of Rights, Service Coordination Basic Agreement, etc.)

- **Section 2** - Written Evaluations (includes clinical assessments and recommendations, service provider reports, medical information, ICF/MR final summary, service plans for non-HCBS Waiver services, etc.)

- **Section 3** - The Individualized Service Plan (ISP) with Attachments (includes Waiver habilitation plans, Individual Plan of Protective Oversight for individuals in IRAs, Service Coordination Activity Plan, etc.)

- **Section 4** - Service Coordination Notes

Now we will review the MSC forms in the MSC Vendor Manual:

- Indicate the purpose of the form and where it is filed in the record.

MSC 1-APPL: Application for Participation in Medicaid Service Coordination – for people enrolled in MSC after March 1, 2000:

- The individual, or a person authorized to give consent on behalf of the individual, documents the choice to receive MSC by signing the MSC 1.

MSC 2- CHNG: Individual Request for Change of Medicaid Service Coordinator Vendor

- All requests for a change in vendor must be referred to the DDSO. The DDSO must process the person's request to change vendor within 30 days of receiving the MSC 2. A person may initiate a change in MSC vendor by notifying his or her current MSC vendor or the DDSO directly.

- The effective date of the change of vendor must always be the first of the month.

MSC 3-WITH: Withdrawal from Medicaid Service Coordination

- The request for a withdrawal must originate with the person, person's family, or advocate.

MSC 4-VER: MSC – Individual Withdrawal Verification Form

This form is used by the DDSO to verify that all individuals requesting to be withdrawn from MSC:

- Made the decision on their own without any pressure from another person or an MSC vendor

- Understand what it means to be no longer receiving MSC

- Are not interested in pursuing other vendor/provider options

- Understand that if they are in the HCBS Waiver, they will be receiving Plan of Care Support Services (PCSS) in order to keep their IPS and level of care current

- Understand that they can re-enroll in MSC if needed in the future, by contacting their PCSS staff person (HCBS Waiver participants only) or the DDSO MSC Coordinator (non-HCBS Waiver participants)

MSC 5- SCA-Medicaid Service Coordination Agreement

- This form clearly outlines the rights and responsibilities associated with Medicaid Service Coordination.
- This agreement must be reviewed annually at the time of the face-to-face ISP review meeting.
- This review should be documented on the MSC Service Coordination Notes form (MSC -10 or MSC-10b).

MSC 6-TRN: MSC Service Coordinator's Training Record

- This form verifies the training that the service coordinator has received within their training year.

MSC 7- SCOR: Service Coordination Observation Report

- A major responsibility of the service coordinator is to ensure that each individual is healthy and safe.
- The SCOR is required for all Willowbrook class members.
- As of October 1, 2010, the SCOR is not required for non-Willowbrook class members, although a service coordinator should be observant of the living environment and if there is a problem, should discuss this with the staff person and/or family or advocate. The service coordinator should report any problems to his/her supervisor and take appropriate action if advised by the supervisor, or as necessary.

Review:

Briefly review the three "questions" listed on the SCOR:

1. Based on my discussion with the individual(s) and my own observations, the following physical care, heath or hygiene problems have been identified.
2. Based on my discussion with the individual(s) and my own observations, the following hazardous conditions have been identified.

3. Based on my discussion with the individual(s) and my own observations, the following related to the cleanliness and maintenance of the home have been identified.

MSC 9-SCAP: Medicaid Service Coordination Activity Plan

The Service Coordination Activity Plan (SCAP) describes the specific service coordination activities that will be carried out by the individual, service coordinator, or other people. These activities relate to the personal goals (valued outcomes) identified in the ISP.

- MSCs need to show a start date when an activity begins and check off when a task is completed.
- A SCAP needs to be reviewed every six months but activities can be added at any time.
- A SCAP must be completed for Willowbrook class members and for non-Willowbrook class members if they choose to have one.

MSC-10 & MSC-10b: Medicaid Service Coordination Notes

The Medicaid Service Coordination Note is the required contemporaneous note necessary to substantiate billing for MSC. Either of these note formats are used to document the required elements necessary to substantiate MSC billing.

Note:

Briefly discuss the HCBS Waiver Services Forms and reference: The Key

- Waiver Application
- LCED (Level of Care Eligibility Determination
- Documentation of Choice

Introduction to the Individualized Service Plan (ISP):

Instructor Note:

Reference Chapter Seven in **The Key** and Chapter Four in the **MSC Vendor Manual** have information on the ISP. Please note that any local or agency-specific rules and expectations are not included. **Be prepared to differentiate between the two!**

Ask:

What is the ISP?

Explain:

- This is a basic introduction to the ISP
- The material we will be covering in this unit applies to all individuals enrolled in MSC and/or the HCBS Waiver, regardless of where they live or what services or supports they receive.

Discuss:

- The ISP is assembled by the service coordinator after person-centered planning has begun. A person-centered plan is a means and not an end.
- The ISP is an overall plan that drives services and supports for a person. It should be developed with the person, family/advocates and no one should be shocked by what is written in the ISP. Everyone is involved.
- An ISP is an ever-changing personal life plan.
- An ISP describes the individual's current needs and choices and is proactive by incorporating the person's outcomes for the future. It is ongoing, not stagnant, and is modified as priorities change and as temporary setbacks and accomplishments occur. It should not get in the way of a person's life but be a tool to help the person live his or her life.
- Though it may give some clinical information, it is not a clinical assessment nor does it merely summarize clinical assessments. While an ISP is not a system-centered report, it must be completed to meet certain system-centered needs.

- It is a document that records the end result of person centered planning
- It is the "Parent Plan" from which all specific service plans flow.
- Each support and service helps the person pursue the outcomes identified in the ISP. Personal Valued Outcomes are those things that the person with disabilities wants to achieve or strive for. They are destinations or goals that the person wants to accomplish or pursue. Valued Outcomes can be long-term desires or simple day-to-day choices. Valued Outcomes must be listed in the person's ISP. Valued Outcomes are:
    - Individualized
    - Chosen as part of collaborative planning and discovery making. The individual chooses his/her valued outcomes. Assistance is provided through a collaborate effort of friends, family, the MSC service coordinator and other service providers. This collaborative endeavor occurs when everyone meets at the ISP review meeting. These meetings are part of an on-going process to make discoveries and to understand the life of the individual with disabilities.
    - Chosen based on informed choice and empowerment
    - Built on capacities and interests
    - Clearly stated and as specific as possible at the time. Vague outcomes can leave the person's life up to chance.
    - Responsive to change. Outcomes can change at any time.
    - Not limited to skill development, but can include specific skill development goals.
    - Shared between service providers. Different service providers can help the person pursue the same outcome, but in different ways by emphasizing complimentary skills and experiences.
    - Not limited by unnecessary prerequisites.
    - Always chosen with recognition for the individual's health and safety.
    - The MSC service coordinator must ensure that there is at least one valued outcome listed in the Valued Outcome section of the ISP for each Waiver Habilitation Service (residential habilitation, day habilitation, pre-vocational

services and SEMP) listed in the HCBS Waiver Service Summary section of the ISP. There must be a "match" or correlation between at least one valued outcome for a waiver habilitation service in the ISP and the same valued outcome in the habilitation plan. Habilitation service providers may include goals and supports in the habilitation plan that do not directly correlate to the ISP valued outcome.

- The ISP is an agreement between the individual and the provider of supports and services (paid and unpaid)
- The ISP is the document that describes the services an individual receives through the HCBS Waiver. **For this reason, the accuracy, completeness, and timeliness of the ISP are critical.**
- **Safeguards** are important to discuss in any planning process. They are a critical component of every ISP. Safeguards are those activities, supports or services that must be in place to keep the person reasonably safe from harm.
- Most of us have plans for what we want our life to be like in the future but only a few of us have written plans.
- The ISP is much more than just a record-keeping system. It is a tool to make things happen!
- The ISP is integral to billing!

Emphasize:

- Without a current ISP, billing by the MSC Service Coordinator is invalid.
- A provider of Waiver services should not bill for Waiver services without a current ISP. (A provider agency may not be paid or may be asked to return Medicaid payments if it is determined that the agency did not have a current ISP for a particular person.) It is therefore absolutely essential that the service coordinator make sure the ISP is current and distributed to all parties within the required timeframes.

Explain:

- The ISP is written within 60 days of the waiver enrollment date (which can be found on the HCBS Waiver Notice of Decision) or of the MSC enrollment date (found on the MSC Application Form), whichever occurs first.
- The ISP is reviewed by the service coordinator, in collaboration with the person and all other planning parties, twice within every 365 days and at least one of these reviews must be a face-to-face meeting with the individual, advocate, and all major service providers.
- The ISP must always be kept current. Otherwise, the plan would not be reliable or trustworthy and its effectiveness as a working tool would be jeopardized.
- The basic format of the ISP must be adhered to. **The sections and the sequencing of information or categories cannot be changed!**
- Service coordinators may expand the information in the header, transfer the form to word processing, or add additional sections or categories.
- The ISP contains **attachments** (as appropriate for the person):
    - Service Coordination Activity Plan (SCAP) – if the individual chooses to have one (optional; required for an individual who is a Willowbrook class member)
    - Waiver Habilitation Plans: residential, day, pre-vocational, supported employment, SD/CSS
    - Plan of Protective Oversight if the person lives in an Individual Residential Alternative (IRA).
    - Clinic Treatment plan or written recommendations from an Article 16, 28 or 31 Clinic. Note: This could be hard to get, so note the attempt.

Note to Participants:

To learn more, take the ISP Training Course (required), and Valued Outcomes. Talk to your supervisor for more information.

Transition to Section Seven: Self Advocacy (if not already presented) or skip to the course summary

Section Seven: Self Advocacy

Overview:

The purpose of this section is to give service coordinators a better understanding of their role in relation to the individuals they serve.

Objectives:

At the end of this section participants will have:

- A better understanding of the life experiences and role of self-advocates
- Information about the relationships that self-advocates prefer with service coordinators.

Key Learning Points:

- There are similarities between our dreams and the dreams of self-advocates.
- The most important things service coordinators should and should not do in supporting individuals with disabilities.

Activity: Presentation by self-advocates

Time: Approximately an hour

Materials: Participant manual (role plays)

Training Method: Presentation by self-advocates

What is Self-Advocacy?

Explain:

Self-advocacy means:

- The person decides what he or she wants
- The person finds out how to go about getting what he or she wants
- The person seeks assistance from others to help achieve goals and desires
- The person learns new skills necessary to successfully advocate for him or herself

A major goal of self-advocacy is to empower people to speak for themselves and participate in decisions affecting their lives.

Introduce:

Today, we have (Self Advocate's Name) to speak to you about self-advocacy.

- Ask the self advocate to discuss Self-Advocacy in New York State (SANYS) and the role of the self-advocates.
- Then, have the self-advocate briefly describe his or her background, present living situation, work/daytime activities, supports and services that they now receive.

Activity: Sharing Dreams

Self-advocate's Note:

- "I am here today to share my dreams and goals with you."
- Self-advocate will begin stating their dreams and goals for his or her life.

Instructor Notes:

1. Make two columns on a flipchart and write the self-advocate's dreams/goals on the left side of the flipchart.
2. Then the self-advocate will ask the participants to share their personal dreams and goals.
3. Write the Core participants dreams/goals down on the right side of the flipchart.
4. Compare the dreams of the self-advocates to the dreams of the participants.

Note:

Most likely the dreams of each group will be similar. The self-advocate should emphasize this.

Self-Advocates Experience with Service Coordination:

The self-advocate will now present his/her experience with service coordinators. If necessary, a CORE Instructor can facilitate this section by asking the following questions:

1. How many service coordinators have you had in the last 5 years?
2. What have you liked about your service coordinators?
3. What have you not liked about your service coordinators?
4. How often do you meet with your current service coordinator?
5. How often do you speak with your service coordinator? Who initiates the contact?
6. Does your service coordinator meet with you at home? If not, where do you usually meet?
7. Do you meet every 6 months with your service coordinator to review and discuss your ISP and other service plans?
8. If you could change one thing about your current experience with your service coordinator, what would that be?
9. What are the most important things a service coordinator should do for you?

Ask the participants if they have any questions for the self-advocate

Transition to the first role-play activity.

Role Plays – Conversations with Service Coordinators

MSC Core Training **Role Play 1: Two individuals speaking on a phone: Sonny Nocare, MSC for ABC Agency and Henry Wright, a person on his caseload.**	
Sonny	Hi, is this Henry?
Henry	Yeah, who's this?
Sonny	You don't recognize my voice? It's your Medicaid Service Coordinator, Sonny Nocare.
Henry	Who? I don't remember anyone by that name…
Sonny	You forgot so soon?!! We met about two months ago, you remember, you came to the Center and we talked in the lobby.
Henry	Oh, you! I haven't heard from you for so long! Where have you been? Aren't you supposed to be in regular contact with me?
Sonny	Hey, I'm a busy guy! I do my best! You know what kind of caseload I have? It's crazy!
Henry	But aren't you supposed to help me get stuff like services, a job, and housing? I never talk with you!
Sonny	Yeah, you're right, that's what I do, but there's just too much paperwork to keep up with! I know I'll do better! You'll see! Right now, you've got to help me!
Henry	Help? What do you want?
Sonny	Are you near a fax machine?
Henry	Well, there's one in the staff room, but why do you want to know?
Sonny	Well, I've got to send you the signature page of your ISP! I need you to sign it and fax it back to me!
Henry	ISP? You mean my Individualized Service Plan? How can I sign that page if I haven't seen my ISP?
Sonny	Listen, don't worry! It's a great plan! It's got everything in it that you need! Just trust me. I've got to get your signature before the auditors get here!

Henry	This doesn't sound right to me! I thought you had to meet with me and my mother to go over my ISP? It doesn't really seem like you are doing anything for me.
Sonny	How can you say that? I've done so much for you – I – I – wrote this ISP for you and I must say it is darn good!!

Henry	How can you write something about me without talking with me first?
Sonny	Hey, what's there to know? You're disabled and from an old ISP, I know you're in a workshop, you like living in a group home and you like football. In fact, in your valued outcome section, I put that we are going to explore volunteer options with the local football team. What else do I need to know!
Henry	You don't know anything!! I want my own apartment, I just started a job at the mall and my game is baseball, not football!
Sonny	Hey, now you're being difficult and I don't have time to change anything. So let's leave it alone and just give me the fax number there.
Henry	Okay, the fax is (518) 78…hey, I don't think this is right. I don't think I should sign something that is really not about me. I don't want you as my MSC anymore. I am going to ask for a new MSC!
Sonny	Hey, that's the gratitude I get for all the work I've done for you! I guess I will have to get through the audit without your signature on the ISP.
Henry	Okay, goodbye – and – good luck with your audit!

Ask:

What did this service coordinator do wrong?

I noted at least 10 things. How many can you identify? Let's list these on the flipchart.

Suggested Ten:

1. The service coordinator and Henry are not meeting regularly.
2. The last face-to-face meeting was in the lobby – not a place to have a serious, confidential meeting.
3. The tone of the conversation is too casual.
4. The ISP should never be signed without giving the person the time to review it.
5. The ISP should never be written without consultation with the individual.
6. The service coordinator is working on his timeframe and need to produce the ISP for the audit – not according to the needs of the person.
7. The service coordinator is not familiar with the person.

8. While it is okay for the service coordinator to refer to an old ISP, the MSC should not make judgments based only on the ISP information.

9. The ISP should not set up any service without consulting with the person

10. The service coordinator sees Henry as "disabled," not as an individual with a disability with his own specific needs.

MSC Core Training

Role Play 2: Two individuals speaking on a phone: Sonny Cares, MSC for ABC Agency and Henry Wright, a person on his caseload.

Sonny	Hello, am I speaking with Henry Wright?
Henry	Yeah, who's this?
Sonny	This is Sonny Cares, your Medicaid Service Coordinator.
Henry	Who? I don't remember anyone by that name…
Sonny	I'm really sorry. We met almost two months ago but only spoke for a few minutes in the Center lobby. Then I was on vacation and when I came back I called you but was told you were on vacation.
Henry	Oh, you! I haven't heard from you for so long! Aren't you supposed to be in regular contact with me?
Sonny	Yes. This summer has not been good with our vacation schedules.
Henry	But aren't you supposed to help me get stuff like services, a job, and housing? I never talk with you!
Sonny	You're right! It's important that we meet as soon as possible so that I can start helping you get the services you need and want!
Henry	My last service coordinator, Harry sure was fun. He came to my house a few times and he told a lot of jokes. He was so funny. I miss him. I thought he could be a good friend.
Sonny	But did he help you with your services?
Henry	No, not really. But you should have seen him at the Christmas party. I couldn't stop laughing!
Sonny	Henry, your service coordinator is supposed to get things done for you. I'm sure Harry was a nice guy and it's good to have friends, but your service coordinator is supposed to work for you. It's okay if you like each other, but you service coordinator's main job is to find out what you want and need and help you get those things.
Henry	I definitely have wants and needs. Today is laundry day and I have to wash my pants! You see I only have one pair of pants so I have to remember to wash them on time or I won't have anything to wear when I go out.
Sonny	You only have one pair of pants? What happened to the rest of your clothes?!

Henry	People borrow my clothes and never remember to bring them back. That's what I need! A new pair of pants! I only have one pair of pants and they're pink!
Sonny	Pink?

Henry	Well, they started out red but I've washed them so many times that they've faded into a pinky kinda color. It's embarrassing!
Sonny	Henry, this shouldn't be! We need to talk with your staff and get you some decent clothes!
Henry	But I don't want to get anybody in trouble because then I'll be in trouble with them!
Sonny	You don't have to worry! You have rights and there's nothing wrong with speaking up for yourself! Henry, I would like to meet with you as soon as possible and I promise that I will keep in contact with you regularly. Also, I see that your ISP needs to be updated. So, you will have to let me know what you think about the services you are getting now and let me know if there are changes that you want to make. I read in your ISP that you like football. I may be able to get you a very cool volunteer opportunity with the local football team.
Henry	I do want changes. I want my own apartment! I don't like living in a group home. Do I have to do that volunteer job? I really don't like football. Baseball's my game!
Sonny	Of course, you don't have to take the football volunteer job. This is why we need to meet. I have to get to know you. When would it be a good time for me to meet with you?
Henry	Well, I can't go out right now because supper is almost ready. It's macaroni and cheese. We've had macaroni and cheese every night this week! It's a good thing I like it. So, you see, I can't leave to see you because then I'd miss my supper.
Sonny	You don't have to come here! I'll come to see you. How about tomorrow at 4:00?
Henry	That's a good time for me.
Sonny	I look forward to seeing you. When I come, we can talk about your meal plan and your clothes and well, everything! I'll see you tomorrow at 4. Bye.-
Henry	Okay. I'll see you tomorrow. Bye.

Ask:

What did this service coordinator do right?

I noted at least 10 things. How many can you name? Let's list these on the flipchart.

Suggested Ten:

1. The service coordinator was honest and sincere – explained delays in meeting caused by mutual vacations.

2. The service coordinator confirmed his role as someone who assists the individual in a professional way, not as the person's friend.

3. The service coordinator listened to the person and had him evaluate the performance of his prior service coordinator. While that service coordinator appeared to be a friend to Henry, he didn't do his job and did not help Henry get the things that he wants.

4. The service coordinator not only listened, but asked the person questions and tried to learn more about the person, e.g., information on his clothing and meal situation.

5. The service coordinator offered to help the person get more clothing and a better meal plan.

6. The service coordinator educated the person about his rights to advocate for himself.

7. The service coordinator found out that a "valued outcome" in the ISP was incorrect and needed to be changed.

8. The service coordinator assured the person that his plan was designed around him, not based on some incorrect assumptions.

9. The service coordinator explained the importance of scheduling regular meetings with the person to discuss satisfaction with present services and with items he would like to change.

10. The service coordinator advised the person that meetings should be at a time and place that is convenient not just to the MSC, but to both of them.

The following should be presented by the self-advocate(s):

Top Ten things you should <u>not</u> do when you support us:

1. Do not think we don't think!

2. Do not change your *tone of voice* when you see us or we come into a room (give example).

3. Don't *touch our property* or move our equipment without asking us!

4. *Never* ask someone else what we want ("Does he take cream in his coffee?) *Ask us!*

5. Do not make decisions for us!

6. Do not have meetings about us without us!
7. Do not talk to us in an authoritative way or with a "*sing-song*" tone of voice!
8. Do not discount our abilities!
9. Do not think that those of us with disabilities are all the same. *We are all different*, including you!
10. Do not *patronize* us!

Top ten things you <u>should</u> do when you support us:

1. Forget the records--Get to know us as People!
2. Listen and hear our voice--We've got a lot to say!
3. Treat us like you want to be treated--with Respect and Dignity!
4. Ask us how we feel about stuff.
5. Make your goal to help us accomplish ours.
6. Take time to explain things if we don't understand something.
7. Put yourself in our shoes--walk our walk!
8. Tell us the truth.
9. Believe in us and our dreams.
10. Be good to yourself--We need you to be healthy and energized!

Questions from the participants

Summarize:

- Service coordinators need to listen, be flexible, be available, act when needed, and push to get things done.

Self-Advocates should emphasize:

- Listen -- we need you to hear what we're saying
- Remember -- Nothing about us, without us.
- You may be the professionals but we are the "professionals" about ourselves -- ask us first!
- It is your job to help us realize our dreams and goals.

Transition to Course Summary

Course Summary:

This concludes the MSC CORE course. You should have a better working knowledge of:

- OPWDD's Mission, Vision, Values and structure. As well as OPWDD's relationship with its voluntary agencies
- The history of serving individuals with developmental disabilities, including important milestones
- The philosophies and concepts that support Medicaid Service Coordination, such as Informed Choice and Person-Centered Planning
- The various services and supports provided by OPWDD and the voluntary agencies
- Responsibilities of a Service Coordinator in regard to the system and the individual
- A general knowledge and understanding of service documentation
- A better understanding for serving persons with developmental disabilities based on the presentation by the self-advocate(s)

Remember to refer to your MSC CORE Participant Manual for more information. In it you will find an "Additional Resources" Section which will provide you with further reading to help you in your role as a service coordinator.

STATE OF NEW YORK
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MSC1-APPL

Individual Application for Participation in Medicaid Service Coordination

Section I. Individual Information

Name: Last First MI	TABS ID# (if known)	Social Security Number:
Address: (Street)	Date of Birth:	Medicaid Number:
City: State: ZIP Code:	Phone:	DDSO:

Section II. MSC Vendor/DDSO Information

Vendor/DDSO Name:		
Vendor address:		
City:	State:	ZIP Code:
TABS Program Code:		

Section III. Individual Signature

I am requesting participation in MSC effective (date)		
I have chosen the MSC Vendor/DDSO identified above to provide the MSC services I want and need.		
Individual's Signature	Phone:	Date:
Family Member or Advocate's Signature (if appropriate)		
Phone:	Date:	
Family Member of Advocate's Address (if different from individual):		

Section IV. Vendor Signatures

The individual identified above has indicated a need for an MSC service coordinator. To the best of my knowledge, this individual meets all of the eligibility criteria necessary for participation in MSC.	
MSC Vendor/DDSO Contact's Name (print)	
MSC Vendor/DDSO Contact's Signature	
Phone Number:	Date:

Section V. To be completed by the DDSO MSC Coordinator

Date Application Received:

- ☐ Request for MSC **APPROVED** for TABS processing
- ☐ Request for MSC **WITHDRAWN** by individual
- ☐ Request for MSC **DENIED**

Reason for Denial:

- ☐ Individual is not enrolled in Medicaid.
- ☐ Individual does not have a diagnosis of a developmental disability.
- ☐ Individual is permanently enrolled in another comprehensive Medicaid long term care service coordination program.
- ☐ Individual currently resides in an ICF/MR, ICF/DD or in another Medicaid facility that provides service coordination.
- ☐ Individual did not respond to request for information.
- ☐ Individual does not meet the need for ongoing and comprehensive service coordination.

Signature of DDSO MSC Coordinator:	Date:
Data Entry Person's Initials:	Date:

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

MSC1-APPL

Instructions for Completion of the
Individual Application for Participation in Medicaid Service Coordination (MSC1-APPL)

Please clearly print (or type) all information

Section I *Individual Information*: This section should be completed by the MSC vendor, or DDSO for state delivered MSC, selected by the individual.

Section II *MSC Vendor/DDSO Information*: This section should be completed by MSC vendor, or DDSO for state delivered MSC, selected by the Individual.

Section III The individual and MSC vendor, or DDSO for state delivered MSC, must agree upon an effective date. The effective date should be the date on which the individual needs MSC to begin, if all eligibility factors are met.

This section must be signed by the individual, or individual's family or advocate, if appropriate. The signatures verify that the individual has chosen the agency identified above to provide him or her with MSC.

The family member or advocate's address must be included if different from the individual's address.

Section IV This section is signed by a staff person representing the MSC vendor, or the DDSO for state delivered MSC. The signature verifies that the individual has indicated a need for MSC and, in the best judgment of the vendor or DDSO, the individual meets all of the eligibility criteria required to receive MSC.

Once Sections I, II, III, and IV have been completed, this form should be sent to the DDSO's MSC Coordinator.

Section V This section is to be completed by the DDSO's MSC Coordinator. Please refer to MSC Manual section, *Individual Enrollment in MSC,* for additional information.

Date Application Request Received: DDSO date stamps application upon receipt.

Request APPROVED for TABS Processing: If application form is complete and DD diagnosis verified: DDSO checks this item, signs and dates this section, and then forwards application to data entry person for TABS processing and eligibility determination.

Request for MSC WITHDRAWN by Individual: At any point in the process, the individual may voluntarily withdraw his or her application. This decision should be documented, If application is withdrawn: DDSO checks this item, signs and dates this section, and forwards application to data entry person so individual can be removed from the pended file.

Reason for MSC DENIED: When it has been determined that the individual will not meet the MSC eligibility criteria, or the individual hasn't send in the required documents within the allotted time frames: DDSO checks this item, checks the specific reason for denial, signs and dates this section, and forwards a copy to the data entry person so the individual can be removed from pended file.

Data entry person initials and dates the form after completing the data entry.
The form is then returned to the DDSO's MSC coordinator.

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

MSC2 -CHNG

Individual Request For Change of Medicaid Service Coordination Vendor

Section I. Individual Information

Name: Last First MI	TABS ID# (if known)	Social Security Number:
Address: (Street)	Date of Birth:	Medicaid Number:
City: State: ZIP Code:	Phone:	DDSO:

Section II. Current MSC Vendor/DDSO Information

Vendor/DDSO Name:		
Vendor address:		
City:	State:	ZIP Code:
TABS Program Code:		

Section III. New MSC Vendor: *To be completed by new MSC vendor or DDSO (for state delivered MSC)*

Vendor/DDSO Name:		
Vendor address:		
City:	State:	Zip Code:
TABS Program Code:		
Requested Effective Date of Change: *(Must be the first day of a month following the month in which the request is made.)*		
MSC Vendor or DDSO Staff Person:	Phone:	Date:
Individual's Signature		Date
Family Member or Advocate's Signature (if appropriate):	Phone:	Date

Section IV. To be completed by the DDSO MSC Coordinator

Change of MSC Vendor Approved? ☐ Yes ☐ No Effective Date:	
TABS Program Code for New MSC Vendor: Program Code:	
Signature of DDSO MSC Coordinator	Date:
Data Entry Person's Initials:	Date:

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

MSC2 -CHNG

Instructions for Completion of the
Individual Request for Change of Medicaid Service Coordination Vendor (MSC2 - CHNG)

Please clearly print (or type) all information

All request to change MSC vendors must be referred to the DDSO MSC Coordinator. The DDSO will work with the individual to complete Sections I and II of this form. The DDSO will also provide the individual with information about MSC vendors in the district. Section III is completed by the new MSC vendor or the DDSO, if the Individual chooses to receive state delivered MSC.

Section I *Individual Information*: This section is completed by the DDSO and the Individual when the Individual indicates his or her desire to change MSC vendors.

Section II *MSC Vendor/DDSO Information*: This section identifies the current MSC vendor/DDSO. This section is completed by the DDSO responsible for processing the Individual's request to change MSC vendors.

Section III *New MSC Vendor:* This section is completed by the Individual's new MSC vendor/DDSO. The effective date must be the first day of a month following the month in which the requested change is being made. Both the staff person completing Section III and the Individual sign and date the form. If the Individual is unable to sign and date the form, the Individual's family member or advocate can sign and date it.

Section IV The DDSO's MSC Coordinator reviews the form for completeness and verifies an available opportunity with the new vendor. If approved, the MSC Coordinator signs and dates the form and forwards it to the DDSO data entry person.

Data entry person initials and dates the form after completing the data entry.
The form is then returned to the DDSO's MSC coordinator.

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

MSC3 -WITH

Individual Withdrawal From Medicaid Service Coordination

Section I. Individual Information

Name: Last First MI	TABS ID# (if known)	Social Security Number:
Address: (Street)	Date of Birth:	Medicaid Number:
City: State: ZIP Code:	Phone:	DDSO:

Section II. Current MSC Vendor/DDSO Information

Vendor/DDSO Name:		
Vendor address:		
City:	State:	ZIP Code:
TABS Program Code:		

Section III. Individual is Being Withdrawn from MSC Due to Loss of Eligibility

Reason for Withdrawal (check one from list below):

☐ Individual is no longer enrolled in Medicaid;

☐ Individual is now permanently residing in an ICR/MR or ICF/DD, or another Medicaid facility that provides service coordination (*Nursing Facility, Psychiatric Hospital, Specialty Hospital, Developmental Center*):

☐ Individual is enrolled in another Medicaid funded service coordination program (e.g., *Care-at-Home, Office of Mental Health*);

☐ Individual is deceased (date of death);

☐ Individual does not meet the need for ongoing and comprehensive service coordination.

☐ Other reason (specify):

Effective Date of Withdrawal (Must be the date on which individual became ineligible):

Individual's Signature	Phone:	Date:

Section IV. Individual Requests to Withdraw from MSC

Reason why the individual wishes to be withdrawn from MSC:

Individual's signature verifies that he/she agrees to the following:

- I understand that by signing this form I will no longer receive Medicaid Service Coordination.
- It is my decision to withdraw, and no person or agency has talked me into withdrawing against my wishes.
- I have been informed that I can re-enroll in MSC if I require this service in the future.
- (*For HCBS Waiver Participants only*) – I select the following agency to be responsible for keeping my ISP and level of care up to date (*Plan of Care Support Services*):
- The DDSO has provided other MSC vendor options, but I am not interested in continuing the service.

Individual's Signature	Date
Family Member or Advocate's Signature (if appropriate):	Date

Section V. To be completed by the DDSO

Check all appropriate boxes

Process remove from Program:

☐ Individual has withdrawn from MSC due to no longer meeting eligibility criteria; effective date

☐ Loss of Medicaid ☐ Duplicate Service coordination

☐ Ineligible living arrangement ☐ Death

Process add to Program:

☐ Add Individual to Plan of Care Support Services: TABS Program Code: Effective date:

DDSO Coordinator	Date:
Data Entry Person's Initials:	Date:

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

MSC3 -WITH

Instructions for Completion of the Individual Withdrawal from Medicaid Service Coordination (MSC3 - WITH)

Please clearly print (or type) all information

Section I *Individual Information*: This section should be completed by the MSC vendor.

Section II *Current MSC Vendor/DDSO Information*: This section should be completed the Individual's current MSC vendor/DDSO.

Section III *Individual is being Withdrawn from MSC Due to Loss of Eligibility:* The Individual's current MSC vendor checks the reason why the Individual is no longer eligible to receive MSC and is being withdrawn from the program. Indicate the effective date of withdrawal.

Note: The effective date must be the day on which the Individual lost his or her MSC eligibility.

The MSC vendor/DDSO staff person signs and dates this section.
The MSC vendor/DDSO staff person sends the completed form to the DDSO's MSC Coordinator.

Section IV *Individual Requests to Withdraw from MSC*: The Individual's MSC vendor/DDSO indicates the reason the Individual wishes to withdraw from MSC.

The Individual's MSC vendor/DDSO makes sure the Individual, Individual's family, or advocate understands what it means to withdraw from MSC and understands who to contact if they want to re-enroll in MSC.

<u>If the Individual is participating in the HSBS Waiver,</u> the Individual, the Individual's family or advocate identifies an agency that will be responsible for keeping the person's ISP and Level of Care up to date (Plan of Care Support Services.)

The Individual signs and dates the form. If the Individual is unable to sign and date the form, the Individual's family or advocate can sign and date the form for him or her.

The Individual's MSC vendor/DDSO sends the completed form, along with a copy of the Individual's most current ISP and Service Coordination Agreement, to the DDSO's MSC Coordinator.

Section V *To be completed by the DDSO*:
<u>Individual has withdrawn from MSC due to no longer meeting eligibility criteria</u>: The DDSO reviews the information in Sections I, II, and III for accuracy. If these sections are complete, checks this box, checks the reason for the loss of eligibility, and identifies the effective date of withdrawal (Must be the date on which eligibility was no longer met). The DDSO staff signs and dates the form and forwards the form to the data entry person.

<u>Individual Voluntarily Withdraws from MSC:</u> The DDSO reviews the information in Sections I, II and IV for accuracy. This includes the identification of a Plan of Care support Services agency for individuals who are participating in the HCBS Waiver. If the information in these sections is complete, the DDSO completes an MSC4-Withdrawal Verification Form. If the individual's request to withdraw from MSC is approved on the MSC4, the DDSO checks the voluntary withdrawal approval box on the MSC3, and inserts the effective date of withdrawal. The MSC3 is forwarded to data entry. **For individuals voluntarily requesting to withdraw from MSC, the MSC3 form should not be sent to data entry until the MSC Verification (MSC4-VER) form has been completed by the DDSO.**

<u>Add Individual to Plan of Care Support Services</u>: If the Individual voluntarily withdraws from MSC and is participating in the HCBS Waiver, the individual must be enrolled in Plan of Care Support Services. The MSC Coordinator reviews and dates the form, checks this box, indicates the PCSS TABS Program Code and effective date of entry into Plan of Care Support Services, and sends the form to data entry person for an *add to program* transaction in TABS.

Data entry person initials and dates the form after completing the data entry.
The form is then returned to the DDSO's MSC coordinator.

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

MSC4 - VER

MSC – Individual Withdrawal Verification Form

Section I. Individual Information

Name: Last	First	MI

This form is to be used by the DDSO to verify that all individuals requesting to be withdrawn from MSC:

- Made this decision on their own without any pressure from another person or an MSC vendor;
- Understand what it means to be no longer receiving MSC;
- Are not interested in pursuing other vendor/provider options;
- Understand that if they are in the HCBS Waiver, they will be receiving Plan of Care Support Services (PCSS) in order to keep their ISP and level of care current;
- Understand that they can re-enroll in MSC if needed in the future, by contacting their PCSS staff person *(HCBS Waiver participants only)* or the DDSO MSC Coordinator *(non-HCBS Waiver participants)*.

Section II. Individual Requests to Withdraw from MSC

An individual's request to withdraw from MSC can only be approved by the DDSO if the DDSO answers Yes or N.A. to **all** of the following questions. The DDSO will obtain this information by talking with the Individual, Individual's family or advocate, and by reviewing the Individual's ISP and Service Coordination Agreement.

☐ Yes ☐ No — Does the individual truly want to withdraw from MSC, (i.e., has not made this request merely because of dissatisfaction with his/her current MSC Service Coordinator or vendor)?

☐ Yes ☐ No — Has the individual, individual's family or advocate freely and voluntarily chosen to withdraw from MSC, and has not been unduly influenced by another person or MSC vendor?

☐ Yes ☐ No ☐ N.A. — For an Individual participating in the HCBS Waiver, has the individual requesting to withdraw from MSC identified an agency responsible for the provision of PCSS?

☐ Yes ☐ No — Has the Individual, Individual's family or advocate been fully informed about his/her right to be re-enrolled in MSC at any time if the need exists?

☐ Yes ☐ No ☐ N.A. — For an Individual participating in the HCBS Waiver, has the Individual, Individual's family or advocate been informed to contact his or her PCSS staff person if he/she wishes to re-enroll in MSC?

☐ Yes ☐ No ☐ N.A. — **For an Individual not participating in the HCBS Waiver**, has the Individual, Individual's family or advocate been informed they should contact the DDSO's MSC Coordinator if he/she wishes to re-enroll in MSC?

☐ Yes ☐ No — After speaking with the Individual, Individual's family or advocate, and after reviewing the Individual's ISP (especially the safeguard section) and Service Coordination Agreement, has the DDSO determined the Individual's health and safety needs are reasonably addressed, and the Individual can manage his/her current living arrangement and daily activities without a Medicaid Service Coordinator?

Request for Withdrawal is ☐ Approved ☐ Denied*

*** Note**: An Individual's request for withdrawal from MSC can be denied by the DDSO if there are health and safety concerns on the part of the DDSO. If the Individual's request is denied, the DDSO must: (a) specify the basis for their denial on the back of this form; (b) provide the individual with a written explanation for the denial; and (c) inform the Individual of his or her right to file a 633.12 appeal.

Effective Date of Withdrawal: (The last day of the month in which withdrawal has been approved)

DDSO Staff Signature:	Date:

Specify basis for DDSO denial:

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

MSC5 – MSCA
October 1, 2012

Medicaid Service Coordination Agreement
Statement of Rights and Responsibilities

Name of the Person:

Medicaid Number (CIN#):

The purpose of this document is to outline your rights and responsibilities under the Medicaid Service Coordination (MSC) program and what your service coordinator will do for you. This document must be reviewed with you at the time of enrollment in MSC and signed. It only needs to be signed once but must be reviewed once a year with your service coordinator. This document should be forwarded to the chosen provider whenever you change MSC vendors.

Rights and Responsibilities

Informed Choice

You and your service coordinator will talk about Informed Choice. Your service coordinator will help you make informed choices.

Informed Choice

The service coordinator assists individuals on his/her caseload to understand and make informed choices.

A person has made an informed choice when he or she has made a decision based on a good understanding of the options available and a good understanding of how that choice may affect his or her life.

A person can make an informed choice on his/her own or may ask family members, friends, or others for assistance if the individual needs help making a good decision. Informed choices can be about everyday things, like what to wear, or big life changing things like where to live, what kind of work to do, or who to be friends with. These decisions can also be about what kinds of services or supports someone wants or needs, and where and how to get them.

When making an informed choice a person should understand the possible risks involved and what can be done to reduce the risks. A person should also realize that his/her ability or desire to make choices may change over time, or may be different for different kinds of decisions.

Personal choices should be respected and supported by others involved in the person's life.

Free choice of MSC vendor and service coordinator:

You have the right to make an informed choice about your service coordination vendor and service coordinator.

If you think you can be better served by another service coordination vendor, you can request information from your service coordinator or the OPWDD Regional Office about other service coordination vendors that may be available.

If you think you can be better served by another service coordinator, you can request information from your current service coordinator about other service coordinators within the agency or be referred to the OPWDD Regional Office for information about the availability of other service coordinators.

Free choice of HCB Waiver Service providers:

You have the right to select any available qualified provider for HCB Waiver Services. You may request a change in service providers if you think you can be better served by another available qualified Waiver provider.

Comprehensive Assessment

You and your service coordinator will use a person-centered planning process to identify your personal valued outcomes and necessary supports and services.

Development of a Specific Care Plan and Periodic Review

You and your service coordinator will develop an Individualized Service Plan (ISP) and periodically reassess your ISP to make sure that it is correct and addresses your valued outcomes and supports and services as identified.

The ISP must be reviewed at least semi-annually (twice per year) by the service coordinator with you and others as necessary or as agreed upon. At least once a year, the ISP review must be a face-to-face meeting with the service coordinator and you, your advocate (as appropriate), and all major service providers and others as necessary or agreed upon.

Advocacy, Linkage, Referral and Related Activities

You and your service coordinator will work together along with others to determine the services and natural supports that you need and desire to achieve your valued outcomes.

Your service coordinator will assist you to complete all necessary forms to make referrals to services identified.

You and your service coordinator will develop an Activity Plan if you choose to have an Activity Plan. An Activity Plan describes the short-term service coordination activities that are most important to you. An Activity Plan will help you meet specific valued outcomes as described in your ISP. An Activity Plan lists tasks you would like to complete and the person responsible for completing each task. It is your service coordinator's responsibility to help you get the services you want and need. Your service coordinator will work to get you these services whether or not you choose to have an Activity Plan. **Note: an Activity Plan is required for all Willowbrook Class Members.**

Your service coordinator will complete the MSC withdrawal form with you if you no longer want or need service coordination. If you are enrolled in the HCBS Waiver and choose to discontinue MSC, you will be immediately enrolled in Plan of Care Support Services (PCSS). You can continue to get PCSS from your current service coordinator if feasible.

Your service coordinator will provide you with information about other service coordinators or other service coordination agencies if you would like to make a change. Your service coordinator will refer you to the OPWDD Regional Office if you want to change your service coordination vendor.

You agree to notify the service coordinator of personal changes (such as changes in health, Medicaid status, address, telephone number), program or service changes (such as new service needs or a desire to switch programs or agencies) and when there is an emergency to report.

Monitoring and Follow-Up

- You and your service coordinator will stay in contact to talk about what is happening in your life.
- You and your service coordinator will meet in your home to identify and help with any health and safety problems or concerns.
- Your service coordinator will do his or her best to contact the right people, programs and providers to make sure that your service plan is followed.
- Your service coordinator will talk with you about the supports and services you are getting and make sure the people working with you are helping with what you need and want.
- Your service coordinator will ask if you are happy and satisfied with the supports and services listed in your ISP and with the supports and services you are getting from these providers.
- You and your service coordinator will work together to identify any new needs and make changes to your service plan as necessary.
- Your service coordinator will provide you with a 24-hour emergency telephone number and will inform you and your advocate(s) of any changes to the emergency number. This is a responsibility of your MSC agency.

Signatures - By signing this form you, your family member or advocate (as necessary), service coordinator and service coordination supervisor affirm that MSC rights and responsibilities were discussed, that you made informed choices and that all parties understand and agree to the conditions specified.

Person Received MSC _____ **Date** _____

Family Member/Advocate _____ **Date** _____

MSC Vendor_____ **Date** _____

Service Coordinator _____ **Date** _____

Service Coordinator Supervisor _____ **Date** _____

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

MSC6 - TRN

MSC Service Coordinator's Training Record

Section I. Service Coordinator Information

Training Year Begins:

Name: Last	First	MI	Date MM/DD/YYYY

Section II. Service Coordinator's Supervisor Information:

Name: Last	First	MI

Vendor or DDSO Name:

Date(s) of Training	Title of Training and Topic Area	Who Presented the Training	Length of Training (Hrs)	Supervisor's Initials

Total hours for training year:

Revised 1-20-2011

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

MSC6 - TRN

Instructions for Completion of
MSC Service Coordinator's Training Record (MSC6-TRN)

Please clearly print all information

Service Coordinator Information:	Enter your name.
Training Year Begins:	Indicate the date (MM/DD/YYYY) on which your training year begins. If you were providing HCBS Waiver service coordination or CMCM prior to 3/1/2000, your training year begins on 3/1/2000. If you began providing service coordination after 3/1/2000, your training year begins on the date you were hired, or assumed your service coordination responsibilities.
Service Coordinator's Supervisor Information:	Enter the name of your immediate supervisor.
Vendor/DDSO Name:	Enter the name of the MSC Vendor for whom you work. Service coordinators who are OPWDD employees should enter the DDSO name.
Date(s) of Training:	Enter the date(s) you attended the training (MM/DD/YYYY).
Title of Training and Topic Area:	Specify ***both*** the title of the training and topic area of the training (e.g., Title – Living in the Community: Topic Area – How to access housing in the community for people with DD).
Who Presented the Training:	Identify the person and agency/organization who presented the training (e.g., John Smith, ABC Agency).
Length of Training:	Enter the length of training in hours.
Supervisor's Initials:	Your supervisor must enter his or her initials verifying both your attendance at the training and that the training is relevant to your work as a service coordinator.

Please Note:

1. The Training Record is to be used to record your attendance at various training sessions.
2. All service coordinators are required to attend 15 hours of job related training each year. Service Coordinators and Supervisors with three (3) years of experience (who do not serve Willowbrook class members) will need to complete a minimum of 10 hours of professional development in the year.
3. Attendance at an OPWDD approved Core training cannot be counted towards the 15 hours.
4. A copy of the workshop offering or training announcement for each entry on the Training Record should be attached to the Training Record.
5. A new Training Record needs to be completed each year (12 month period).

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

MSC7-SCOR

Service Coordination Observation Report
(for Willowbrook Class Members Living in OPWDD Certified Residences)

Instructions on Page 2

Type of Residence (check one): ☐ Supervised CR ☐ Supervised IRA ☐ Family Care ☐ Supportive CR ☐ Supportive IRA ☐ ICF

Name of Service Coordinator: Date:

Agency/DDSO Operating Residence or Family Care Home:

Residence Address (include City, State, and Zip):

Name(s) of Individuals Visited:

Question 1: Based on my discussion with the individual(s) and my own observations, the following physical care, health, or hygiene problems have been identified → ☐ Check here if no problems are identified. **Guidelines:** • Is there anything about the way any of the individuals look or behave that may indicate a potential health or hygiene problem (e.g. person is unusually lethargic or agitated)? • Is there anything about the way any of the individuals are dressed that is of serious concern to you (e.g., clothes are torn or soiled)?	**Comments:**
Question 2: Based on my discussion with the individual(s) and my own observations, the following hazardous conditions have been identified → ☐ Check here if no problems are identified. **Guidelines:** • As you visit with the individual and observed the home, see if any obvious hazards are present. Hazards include, but are not limited to: Exposed wires, blocked exits, sharp edges, broken windows or doors, and broken equipment or safety devices. • Observe if the individual's bedroom door can be locked from the outside so the individual cannot exit his or her room.	**Comments:**
Question 3: Based on my discussion with the individual(s) and my own observations, the following problems related to the cleanliness and maintenance of the home have been identified → ☐ Check here if no problems are identified **Guidelines:** • Observe the home's appearance. The home should be reasonably clean and well maintained, and be free of offensive odors. • Ask the individual if the refrigerator, stove, washer, dryer, showers, faucets, and toilets work. If the individual is unable to respond, ask a staff person or Family Care Provider.	**Comments:**

Actions Taken: This section is to be completed by the service coordinator after completing the observation report. ***Please note:*** Questions A and B below refer to **all** individuals living in the residence, including those you visited.

A. During your visit, did you observe or become aware of any conditions that place any individual in imminent danger of being harmed?
☐ Yes ☐ No ***If Yes****, you must take whatever action is necessary to protect the individual(s) [e.g., call for emergency assistance] and remain on site until the situation is addressed. In addition, you must immediately inform the executive director of the residential agency, or his/her designee, and your supervisor.*

B. Did you observe or become aware of any event or situation which may be considered abuse according to the definition in Part 624?
☐ Yes ☐ No ***If Yes****, you must immediately inform the residence manager/charge person, or Family Care provider, and your supervisor. In addition, the service coordinator must ensure that an abuse allegation form is completed by the appropriate agency. Please refer to Part 624.5 (d) (2) for a more complete description of actions to be taken. If this situation is likely to result in imminent danger to individual(s), follow the actions in question A above.*

C. Did you review the findings of this observation report with the residence manager/staff or Family Care provider during or following your visit? ☐ Yes ☐ No ***If No****, you must follow-up by phone promptly. If problems were identified, follow-up must be within 48 hours.*

I, or my advocate had an opportunity to provide information about the observations and comments made on this report. Individual's or Advocate's Signature (if present) Date:

- For all Willowbrook Class Members, a home visit is required at least four times in a calendar year.

When visiting an Individual's home, service coordinators should be aware of the environment in which the person is living. Environmental problems can affect health and safety. The Individual may let the service coordinator know of problems in the house but the service coordinator may notice problems on his/her own.

**** INSTRUCTIONS:**

1. A SCOR must be completed by a service coordinator at least two times in a calendar year for all Willowbrook Class Members living in an OPWDD certified Supervised CR, Supervised IRA, Supportive CR, Supportive IRA, or Family Care home or an ICF. Even if no serious problem is found, the SCOR still must be completed at least twice a year, but not in consecutive calendar quarters. Service coordinators should establish either a 1st and 3rd, or 2nd and 4th quarter cycle for completing an Individual's mandatory SCOR. (Refer to the MSC Vendor Manual for further guidance.)
2. A SCOR should not be completed for an Individual living in his/her own family home or living in a non-OPWDD certified home.
3. For all certified sites, a SCOR must be completed whenever a serious problem is identified during a home visit.
4. When visiting more than one Individual living in the same certified residence or Family Care home, only one report needs to be completed, but the report must reflect the input of each of the Individuals.
5. Problems reported by the Individual and/or the service coordinator should be noted in the Comments box. This box should also note any response by residential staff or Family Care providers to the problems cited.
6. **If no problems are identified** – a copy of the SCOR must be kept in a separate file by the service coordinator and in a separate file in the Individual's residence, except for an Individual living in a Family Care home. For an Individual living in a Family Care home, the service coordinator must send a copy of the SCOR to the Family Care liaison responsible for the home. The liaison must file the report in the Family Care home's certification file. For Individuals living in Supervised CRs or Supervised IRAs, if no problems are identified, a SCOR is not required.
7. **If problems are observed and reported** – a copy of the SCOR must be kept in a separate file by the service coordinator and in a separate file in the Individual's residence, except for an Individual living in a Family Care home. The service coordinator must send a copy of the SCOR to his/her supervisor. The service coordinator's supervisor must send a copy to the executive director of the voluntary agency operating the residence or to the DDSO Director for state-operated residences. For an individual living in a Family Care home, the service coordinator's supervisor must also send a copy to the Family Care home's liaison and to the Agency/DDSO Family Care Coordinator.

Regardless of whether problems are identified, the **Service Coordination Observation Report (SCOR)** must be completed by the service coordinator, with input from the Individual and/or advocate. Documentation of these observations creates a written record that facilities communication between the Individual, the service coordinator, and the Family Care provider/residential staff.

Problems that are identified must be addressed by the residential service provider.

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

MSC9 - SCAP

Medicaid Service Coordination Activity Plan

Individual's Name: MSC's Name: Date of Initial Activity Plan Date of 6 Month Review

The Activity Plan describes the short-term service coordination activities that are most important to you and that will help you meet the individualized valued outcomes described in your ISP. Below write down the services you are requesting and/or the personal goals that you would like to achieve. Then write down the activities you would like completed. Also, show the person responsible for completing each activity and the date that work begins on an activity. In the final box, place a check when an activity is completed. This list must be reviewed at least every six months but you may add activities at any time.

Service Request or Personal Goal:

Activities to Complete	Who will complete Task				Start Date	Check if Task is Done
	MSC	Ind.	Fam.	Other		

Service Request or Personal Goal:

Activities to Complete	Who will complete Task				Start Date	Check if Task is Done
	MSC	Ind.	Fam.	Other		

Service Request or Personal Goal:

Activities to Complete	Who will complete Task				Start Date	Check if Task is Done
	MSC	Ind.	Fam.	Other		

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

MSC9 - SCAP

Service Request or Personal Goal:

Activities to Complete	Who will complete Task				Start Date	Check if Task is Done
	MSC	Ind.	Fam.	Other		

Service Request or Personal Goal:

Activities to Complete	Who will complete Task				Start Date	Check if Task is Done
	MSC	Ind.	Fam.	Other		

Service Request or Personal Goal:

Activities to Complete	Who will complete Task				Start Date	Check if Task is Done
	MSC	Ind.	Fam.	Other		

Service Request or Personal Goal:

Activities to Complete	Who will complete Task				Start Date	Check if Task is Done
	MSC	Ind.	Fam.	Other		

Medicaid Service Coordination Notes
Month and Year of Service: _____

Name of Individual:_____ Agency Name: _____

Initials Key

For each MSC Service Coordinator or other qualified staff who provided an MSC service or MSC activity this month, include their printed name, title, signature and their initials.

Name:	Title:	Signature:	Initials:
Name:	Title:	Signature:	Initials:

ISP Review

Was an ISP Review conducted this month? ☐yes ☐no	If Yes, Date of ISP Review:
Was the Service Coordination Agreement reviewed this month? ☐yes ☐no	If Yes, Date of SCA Review:
Was the Individual Present at Review? ☐yes ☐no	Initial & Date (mth/dy/yr):

ICF/MR Level of Care Eligibility Determination

Was the Level of Care Eligibility Determination (LCED) completed this month? ☐yes ☐no	
If Yes, Date LCED was completed:	Initial & Date (mth/dy/yr)::

Face-to-Face Contact(s) with the Individual

Date of Contact	Purpose and Outcome of Contact	Location of Service Meeting	Initial & Date (mth/dy/yr):

Referral / Linkage, Benefits Management, or Monitoring Activities (see instructions)
(Note: A minimum of two activities are needed to meet the billing standard if all activities fall under this section)

Date of Activity	Purpose and Outcome of Contact	Identify person contacted and relationship to individual	Initial & Date (mth/dy/yr):

Monthly Summary

Include the person's satisfaction with services along with any follow-up actions, any significant changes in the person's life, and any concerns regarding health and safety.

_____
_____
_____
_____
_____
_____
_____

Signature:	Printed Name:	Title:	Date (mth/dy/yr):

Attach additional sheets if necessary

Note: by entering initials, staff attests that the activity was provided on that day.

Medicaid Service Coordination Notes Instructions

Element	Instruction
Month and Year of Service:	Enter the month and year for which MSC is being provided.
Name of Individual:	Enter the individual's first and last names.
Agency Name:	Enter the name of the agency that is providing MSC.

The sections below must be completed by staff providing the MSC activities

Initials Key	
Name:	Print first and last name.
Title:	Print title.
Signature:	Sign first and last name.
Initials:	Enter initials used to sign the documentation.
ISP Review	
Was an ISP review conducted this month?	Check "yes" if the ISP was reviewed or check "no" if the ISP was not reviewed during the service month. The ISP should be reviewed at least twice annually. If "no" is indicated, the remaining fields in this section are left blank. An ISP review includes updates or addendums.
If Yes, Date of ISP Review:	If the ISP was reviewed within this service month, provide the date of the review.
Was the Service Coordination Agreement reviewed this month?	Check "yes" if the Medicaid Service Coordination Agreement was reviewed or check "no" if the MSC Agreement was not reviewed during the service month.
If Yes, Date of SCA Review:	If the Service Coordination Agreement was reviewed within this service month, provide the date of the review.
Was the Individual Present at ISP Review?	Check "yes" if the individual was present at the ISP review or check "no" if the individual was not present. The individual should be present at an ISP review at least once annually.
Initial & Date (mth/dy/yr):	After the ISP Review Section is completed, initial and enter the full date. The date initialed must include the month, day and year. Initials and date are not required if no activity occurred.
ICF/MR Level of Care Eligibility Determination	
Was the Level of Care Eligibility Determination (LCED) completed this month?	Check "yes" if the LCED was completed during the service month or "no" if the LCED was not completed during the service month. MSC staff must ensure that the LCED and subsequent redeterminations are completed and signed within 365 days from the prior review and authorized signature date, if the individual is enrolled in the HCBS waiver.
If Yes, Date LCED was completed:	Enter the date that the LCED was completed in that month. The date must include the month, day and year.
Initial & Date (mth/dy/yr):	After the section is completed, initial and enter the full date including the month, day and year. Initials and date are not required if no activity occurred.
Face-to-Face Contact(s) with the Individual	
Date of Contact	Enter the date on which a face-to-face service meeting was held with the individual.
Purpose and Outcome of Contact	Include a brief description of the service coordination activities provided and the outcome of the contact. The purpose of the contact must serve to develop, monitor and/or implement the valued outcomes of the person's ISP and should not be purely social in nature.
Location of Service Meeting	Describe the location of the face-to-face service meeting (e.g., in the person's home, day program, or community location)
Initial & Date (mth/dy/yr)	After the section is completed, initial and put the full date. The initials date must include the month, day and year.

Referral/Linkage, Benefits Management or Monitoring Activities	
Date of Activity	Enter the date on which the activity occurred. The date must include the month, day and year.
Purpose and Outcome of Contact	Include a brief description of the activities provided and outcome of the activities. The purpose of an activity must be related to referral, linkage, and/or monitoring to ensure that the ISP is implemented and addresses the needs of the person. Contacts may include a phone call, personal contact, meetings, email exchange, or letter/correspondence exchange.
Identify person contacted and relationship to individual	Enter the name of the individual and the relationship to the individual. The person should be a qualified contact. A qualified contact is defined as someone directly related to the identification of the individual's needs and care and who can help the service coordinator with the assessment, care plan development, linkage, referral, monitoring, and follow-up activities for the individual.
Initial & Date (mth/dy/yr)	After the section is completed, initial and put the full date (month/day/year).
Monthly Summary	
Monthly Summary	Complete this section to include: 1. Information about the individual's satisfaction/dissatisfaction with the supports and services in his or her ISP. Any follow-up activities taken by the service coordinator to address any concerns that the individual may have about his or her supports or services must also be noted. 2. Significant changes or events in the individual's life. This might include changes in valued outcomes, employment, home, personal relationships, health and other person-centered information. If no changes or events occurred during the month, then this should be noted. 3. Any concerns regarding the health and safety of the individual and individual's environment and actions taken by the service coordinator to correct the situation. If there were no concerns about the individual's health or safety during the month, then this should be noted. The monthly summary may also be used to document outcomes of an ISP review meeting and other relevant information.
Signature:	Sign first and last name
Printed Name:	Print first and last name
Title:	Enter title
Date (mth/dy/yr):	Enter the date signed. The date must include the month, day and year.

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

Medicaid Service Coordination Notes
Month and Year of Service: _____

Name of Individual:_____ Agency Name: _____

The MSC Service Coordinator or other qualified staff that provided an MSC service or MSC activity this month, must include their printed name, title and signature at the bottom of the form no later than the 15th of the month following the service month.

ISP Review

Was an ISP Review conducted this month? ☐yes ☐no	If Yes, Date of ISP Review:
Was the Service Coordination Agreement reviewed this month? ☐yes ☐no	If Yes, Date of SCA Review:
Was the Individual Present at Review? ☐yes ☐no	

ICF/MR Level of Care Eligibility Determination

Was the Level of Care Eligibility Determination (LCED) completed this month? ☐yes ☐no	
If Yes, Date LCED was completed:	

Face-to-Face Contact(s) with the Individual

Date of Contact	Purpose and Outcome of Contact	Location of Service Meeting

Referral / Linkage, Benefits Management, or Monitoring Activities (see instructions)
(Note: A minimum of two activities are needed to meet the billing standard if all activities fall under this section)

Date of Activity	Purpose and Outcome of Contact	Identify person contacted and relationship to individual

Monthly Summary

Include the person's satisfaction with services along with any follow-up actions, any significant changes in the person's life, and any concerns regarding health and safety.

_____
_____
_____
_____
_____
_____
_____

Signature:	Printed Name:	Title:	Date (mth/dy/yr):

Attach additional sheets if necessary

Note: by signing this form, staff attests that the activity described above was provided on the dates indicated.

STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

Medicaid Service Coordination Notes Instructions
Special Instructions for **MSC-10b**
Optional Format Requiring One Signature

Element	Instruction
Month and Year of Service:	Enter the month and year for which MSC is being provided.
Name of Individual:	Enter the individual's first and last names.
Agency Name:	Enter the name of the agency that is providing MSC.

The sections below must be completed by staff providing the MSC activities

ISP Review	
Was an ISP review conducted this month?	Check "yes" if the ISP was reviewed or check "no" if the ISP was not reviewed during the service month. The ISP should be reviewed at least twice annually. If "no" is indicated, the remaining fields in this section are left blank. An ISP review includes updates or addendums.
If Yes, Date of ISP Review:	If the ISP was reviewed within this service month, provide the date of the review.
Was the Service Coordination Agreement reviewed this month?	Check "yes" if the Medicaid Service Coordination Agreement was reviewed or check "no" if the MSC Agreement was not reviewed during the service month.
If Yes, Date of SCA Review:	If the Service Coordination Agreement was reviewed within this service month, provide the date of the review.
Was the Individual Present at ISP Review?	Check "yes" if the individual was present at the ISP review or check "no" if the individual was not present. The individual should be present at an ISP review at least once annually.
ICF/MR Level of Care Eligibility Determination	
Was the Level of Care Eligibility Determination (LCED) completed this month?	Check "yes" if the LCED was completed during the service month or "no" if the LCED was not completed during the service month. MSC staff must ensure that the LCED and subsequent redeterminations are completed and signed within 365 days from the prior review and authorized signature date, if the individual is enrolled in the HCBS waiver.
If Yes, Date LCED was completed:	Enter the date that the LCED was completed in that month. The date must include the month, day and year.
Face-to-Face Contact(s) with the Individual	
Date of Contact	Enter the date on which a face-to-face service meeting was held with the individual.
Purpose and Outcome of Contact	Include a brief description of the service coordination activities provided and the outcome of the contact. The purpose of the contact must serve to develop, monitor and/or implement the valued outcomes of the person's ISP and should not be purely social in nature.
Location of Service Meeting	Describe the location of the face-to-face service meeting (e.g., in the person's home, day program, or community location)

Referral/Linkage, Benefits Management or Monitoring Activities	
Date of Activity	Enter the date on which the activity occurred. The date must include the month, day and year.
Purpose and Outcome of Contact	Include a brief description of the activities provided and outcome of the activities. The purpose of an activity must be related to referral, linkage, and/or monitoring to ensure that the ISP is implemented and addresses the needs of the person. Contacts may include a phone call, personal contact, meetings, email exchange, or letter/correspondence exchange.
Identify person contacted and relationship to individual	Enter the name of the individual and the relationship to the individual. The person should be a qualified contact. A qualified contact is defined as someone directly related to the identification of the individual's needs and care and who can help the service coordinator with the assessment, care plan development, linkage, referral, monitoring, and follow-up activities for the individual.
Monthly Summary	
Monthly Summary	Complete this section to include: 1. Information about the individual's satisfaction/dissatisfaction with the supports and services in his or her ISP. Any follow-up activities taken by the service coordinator to address any concerns that the individual may have about his or her supports or services must also be noted. 2. Significant changes or events in the individual's life. This might include changes in valued outcomes, employment, home, personal relationships, health and other person-centered information. If no changes or events occurred during the month, then this should be noted. 3. Any concerns regarding the health and safety of the individual and individual's environment and actions taken by the service coordinator to correct the situation. If there were no concerns about the individual's health or safety during the month, then this should be noted. The monthly summary may also be used to document outcomes of an ISP review meeting and other relevant information.
Signature:	Sign first and last name.
Printed Name:	Print first and last name
Title:	Enter title
Date (mth/dy/yr):	Enter the date signed. The date must include the month, day and year. Note by signing the form, staff attests that the activity described on the MSC-10b form was provided on the dates indicated.

The ISP with any addendums or revisions and the services described remain in effect until a new ISP is written.

This is the required ISP format that must be followed. MSC Vendors may use this template or create their own. Additional information may be added to the header of the form and additional sections may be added throughout the ISP. However, all minimum required sections of the plan, the required content for each section, and the sequence of each section cannot change. The instructions under each header are provided for guidance and may be removed for the final presentation of the ISP.

Individualized Service Plan

Name of Person: _____ **ISP Date:** _____

Medicaid Number (CIN#): _____

Dates ISP Reviewed	Face to Face? YES	Face to Face? NO	MSC Initials	Dates ISP Reviewed	Face to Face? YES	Face to Face? NO	MSC Initials
_____	☐	☐	_____	_____	☐	☐	_____
_____	☐	☐	_____	_____	☐	☐	_____
_____	☐	☐	_____	_____	☐	☐	_____

Section 1: The Narrative

(Profile, the Person's Valued Outcomes and Safeguards)

Profile: Include selected person-centered information about the person discovered during the planning process. For example, abilities, skills, preferences, relationships, health, cultural traditions, community service and valued roles, spirituality, career, challenges, needs, pertinent clinical information, or other information that affects how supports and services will be provided.

Valued Outcomes: List the person's Valued Outcomes that derive from the profile. Outcomes are brief, clearly stated and as specific as possible. Please ensure that there is at least one outcome for each HCBS Waiver Service the person will receive.

Safeguards: List the individualized supports needed to keep the person safe from harm and the actions to be taken when the health or welfare of the person is at risk. Fire safety and evacuation ability is required. In addition, the following areas should be considered: chronic medical conditions, allergies, ability to self-administer medications, special dietary needs, ability to manage finances, ability to give consent, level of supervision required in home and community, ability to travel independently, and safety awareness.

Section 2: The Person's Individualized Service Environment

Natural Supports and Community Resources: List people, groups or organizations that are a resource to the person. For example family, friends, neighbors, associations, community centers, spiritual, school groups, volunteer services, self-help groups, clubs, etc. Include the name of the person, place or organization and a brief statement about what is being done to help the person. Assistance related to achieving a Valued Outcome should be noted.

Medicaid State Plan Services: Complete a section below for each Medicaid State Plan service including services provided by Article 16, 28, or 31 Clinics. Add more sections as needed. For each service state the **name** of the provider or agency (e.g., Dr. Smith, ARC Day Treatment Center, Southern DDSO Clinic) and the **type of service** (e.g., physician, day treatment, MSC, transportation, durable medical equipment, etc.). For **Clinic services**, for "Name of Provider" indicate the name of the provider and whether the clinic is an Article 16, 28, or 31 (e.g. UCP Article 28 Clinic) and for the "Type of Service" indicate the Clinic service type (e.g, Physical Therapy, Occupational Therapy, Speech Therapy, etc.).

Name of Provider:
Type of Service:

Name of Provider:
Type of Service:

Name of Provider:
Type of Service:

Federal, State or County Funded Resources: Complete a section below for each service. Add more sections as needed. For each service state the **name** of the provider or agency (e.g., VESID, HUD, NYS Office of the Aging, Education Department, BOCES, DOH, Department of Social Services); and the **type** of service (e.g., Senior Citizen Services, educational services, housing).This category does not include Medicaid Funded Services.

Name of Provider:
Type of Service:

Name of Provider:
Type of Service:

Name of Provider:
Type of Service:

HCBS Waiver Services: Complete a section below for each waiver service. Add more sections as needed. For each service state the **name** of the provider or agency (e.g., Sunshine Co. UCP, Southern DDSO), the **type** of service (e.g., residential habilitation, supported employment, environmental modification), the **frequency** of the service (billing unit of service), the **duration** (e.g., on-going), and **effective date** (e.g., 1/1/2010).

Name of Provider:
Type of Service:
Frequency:
Duration:
Effective Date:

Name of Provider:
Type of Service:
Frequency:
Duration:
Effective Date:

Name of Provider:
Type of Service:
Frequency:
Duration:
Effective Date:

Other Services or 100% OPWDD funded supports and Services: Complete a section below for each service. Add more sections as needed. For each service briefly state the **name** of the provider or agency (e.g., Sunshine Co. UCP, Southern DDSO); and the **type** of service.

Name of Provider:
Type of Service:

Name of Provider:
Type of Service:

Name of Provider:
Type of Service:

Signatures:

Service Coordinator: _____ Date: _____

Service Coordinator Supervisor: _____ Date: _____

Person: _____ Date: _____

Advocate: _____ Date: _____

Individualized Service Plan (ISP) Instructions

SECTION BY SECTION INSTRUCTIONS

The Header

Name of the person:
Name of the person for whom the ISP is written.

ISP Date:
This is the date of the face-to-face ISP review meeting or the non face-to-face ISP review which results in a written or rewritten ISP. This date does not change unless the ISP is rewritten by the service coordinator.

Medicaid Number or CIN Number:
The person's Medicaid number, also known as the person's Client Identification Number (CIN).

ISP Review Dates:
List each date the ISP was reviewed. ISP reviews must take place at least twice annually. One of these reviews must be a face-to-face review meeting with the individual and major service providers. Use the check boxes to indicate whether the review was a face-to-face meeting. The annual face-to-face review meeting must occur within 365 days of the prior face-to-face meeting or by the end of the calendar month in which the 365th day occurs. It is suggested that, at a minimum, an ISP review occur every six months.

*For **Willowbrook** class members, ISP reviews should occur every six months, be convened as face-to-face meetings and involve the individual, his/her active representative, service coordinator, service providers and persons relevant to the plan of services. Willowbrook advocates may request quarterly meetings on behalf of an individual class member.*

Section 1: The Narrative

The Profile, the Person's Valued Outcomes, and Safeguards

The Profile
The Profile is a narrative about the person. It includes selected person centered information about the person discovered during the planning process. The profile may address abilities, skills, preferences, accomplishments, relationships, health, cultural traditions, community service and valued roles, spirituality, career, recreational interests and enjoyment, challenges, needs, pertinent clinical information, or other information that impacts how supports and services will be provided.

The profile tells the reader about the person and his/her current needs and wants. It assists those helping the person provide supports and services with an understanding and sensitivity to what is important to the person. This information is necessary to successfully put the plan into action. The profile is not a static history of the person. It is updated regularly in order to accurately reflect the person's changing needs and goals. It is not necessary to indicate age, height, weight, etc. unless this information relates to the person's needs and services.

Use the following questions as a guide when writing the profile: Who is this person? What is important to this person? What are the individual's strengths and preferences? What is not working in the individual's life? What is unique about this individual? What does this individual want their life to be like? What are their goals? What will this plan accomplish? In what type of setting does the person live and in what type of setting would they prefer to live? Would this individual like to participate in paid, competitive employment? What type of work is this person interested in? Would this person be interested in an employment training program, such as an internship? Would this person like to be a volunteer? What type of volunteer work interests this person? What specialized supports would this person need in order to have a successful work or volunteer experience, such as transportation or travel training?

The Person's Valued Outcomes

Valued outcomes are the person's chosen life goals and are the driving force behind the services and supports the person receives. The valued outcomes should simply state what the person wants to achieve. List the person's valued outcomes that derive from the profile and planning process. There must be at least one valued outcome for each HCBS Waiver service the person will be receiving. The Waiver Service is "authorized' only where the service relates to at least one of the person's valued outcomes.

Safeguards

State the safeguards that must be in place to keep the person safe from harm. Safeguards are actions to be taken when the health or welfare of the person is at risk. The habilitation plans, or referenced documents, will provide greater detail about how safeguards are ensured within the context of the respective service environment. The "Individual Plan for Protective Oversight" can be referenced in the safeguards section for people who live in an Individualized Residential Alternative (IRA). However, the service coordinator should also include safeguards that pertain to other environments where the person spends time.

Fire safety must be discussed in the safeguard section of all ISPs unless it is discussed in the attached Individual Plan for Protective Oversight for people who live in IRAs. The service coordinator must ensure that there is a current and reasonable assessment of the person's specific needs relative to his/her capacity to evacuate the home in a timely manner in the event of a fire emergency. If the person lives in a non-certified site, the service coordinator must ensure that actions and recommendations relative to addressing a person's assessed fire safety needs are specified in the ISP.

In addition, the following areas should be considered: chronic medical conditions, allergies, ability to self-administer medications, special dietary needs, ability to manage finances, ability to give consent, level of supervision required in the home and community, ability to travel independently, and safety awareness.

*For **Willowbrook** class members, identify supports and coverage needed in the event the person is hospitalized, and list any circumstances that impact the individual's frequency of inclusion activities, i.e., clinical/health concerns, weather restrictions, preferences, etc. These areas must be discussed in the safeguard section of all ISPs for class members unless it is discussed in the attached Individual Plan for Protective Oversight for people who live in IRAs.*

Section 2: The Individualized Service Environment

Section 2 of the ISP lists all the supports and services necessary to help the person live a successful life in the community and pursue his or her valued outcomes. Supports and services are coordinated to keep the person healthy and safe from harm.

Natural Supports and Community Resources

Natural Supports and Community Resources exist in the community for everyone. They are routine and familiar supports that help the person be a valued member of his or her community and live successfully on a day-to-day basis at home, at work, at school, or in other community locations. Assistance related to achieving a valued outcome should be noted.

*For **Willowbrook** class members, reflect whether the person self-advocates or whether family member(s) or the Consumer Advisory Board (CAB) serve as sole advocate or co-representative on their behalf. If family is involved, include the frequency of visits and/or participation with team members. Guardianship arrangements should also be identified when applicable.*

List people, places, or organizational affiliations that are a resource to the person by providing supports or services, such as family, friends, neighbors, associations, community centers, spiritual groups, school groups, volunteer services, self-help groups, clubs, etc. Include the name of the person, place or organization and a brief statement about what is being done to help the person. List the activities that the person likes to participate in. Consider these questions when completing this section: What does the person like to do? What are the person's favorite places? Who are the most important people in the person's life**?**

Example entry: "John's neighbor, Harry Smith, helps John with his grocery shopping every Saturday," or "John is a member of the local fire department and attends most of the scheduled activities, especially the Tuesday night meetings."

*For **Willowbrook** class members, include individual strategies that promote community life based on capabilities and needs; variety that reflects a rhythm of life appropriate for the person; frequency as often as possible given the individual's needs, interests and capabilities; group size as appropriate for the person and the community experience; and documentation to confirm implementation.*

Funded Services

- **Medicaid State Plan Services** are those services that a person can access with his or her Medicaid card. These services include **Medicaid Service Coordination**, physician, pharmacy, laboratory, hospital, dental, physical therapy, audiology, durable medical equipment, day treatment, and psychology.

  Services provided in **Article 16, 28, or 31 Clinics** should also be described in this section. These services may include Physical, Occupational, Speech, Rehabilitation Counseling, Nutrition, Psychology, Social Work, Psychiatry, nursing, or dental. Indicate what **type of Clinic** (16, 28, or 31) and the **specific service** being provided.

- **Federal, State, or County Funded Resources** are government services funded by agencies other than OPWDD. These include Vocational and Educational Services for Individuals with Disabilities (VESID), State Office for the Aging (SOFA), Housing and Urban Development (HUD), Board of Cooperative Educational Services (BOCES), Department of Health (DOH), Department of Social Services (DSS), public schools, Medicare, etc.

- **HCBS Waiver Services** are those services funded by the Home and Community-Based Services Waiver. These include residential habilitation, day habilitation, community habilitation, prevocational services, supported employment, respite, adaptive devices, environmental modifications, family education and training, plan of care support services, consolidated supports and services, financial management services, support brokerage, community transition services, and intensive behavioral services.

- **Other Services or 100% OPWDD Funded Supports and Services** are services that do not fit in the other categories or are solely funded by OPWDD and have no Medicaid funding. These include Family Support Services, Individualized Support Services, and some Community Service Plan services such as Non-Waiver Enrolled Service Coordination.

Required Information for HCBS Waiver Services

- **Name of the waiver service provider or agency**

- **Type of waiver service** (e.g., residential habilitation, supported employment, consolidated supports and services, respite).

- **Frequency of the support or service.** The frequency of an HCBS Waiver Service must correspond to the billing unit of service (e.g., day, month, hour, or one time expenditure). See the Frequency of HCBS Waiver Services Appendix at the end of these instructions.

- **Duration of the support or service**. This means for how long the assistance is expected to last. If the service does not have an expected end date, write "ongoing."

- **Effective date of the support or service**. This is the date the current provider first provided the service. Waiver services must have the exact and correct effective date and this date must be on or before the date the provider began delivering the service. A waiver service provider's billing will be jeopardized if the date the provider billed for the service is prior to the effective date on the ISP. For a one time service or purchase, such as environmental modifications and adaptive devices, the anticipated purchase/completion date is used as the effective date.

Note: The above information (name and type of provider, frequency, duration, and effective date) must be accurate for HCBS Waiver Services since the ISP substantiates the payment of these services.

Required Information for all other funded services including Medicaid State Plan Services; Federal, State and County Funded Resources; and Other or 100% OPWDD Funded Services:

- **Name of the provider or agency** (e.g., Dr. Smith, Community General Hospital, VESID, Housing and Urban Development, or DDSO). For clinic services also indicate the type of clinic (Article 16, 28, or 31).

- **Type of provider or type of service** (e.g., physician, cardiologist, educational, housing, or Medicaid Service Coordination).

Signatures

The ISP must be signed by the following:

- service coordinator
- service coordinator's supervisor
- the person
- advocate (if the person is not self-advocating)

Signatures are required every time a new ISP is written. Once the service coordinator writes the ISP he/she should sign the ISP then distribute it for signatures. The date of the service coordinator's signature should be within 45 days of the review that resulted in the rewritten ISP. Signature lines must not be left blank. If the person is unable or unwilling to sign, this should be noted on the signature line. If the person is a self-advocate and the advocate is not signing, "self-advocate" should be written on the line. Signatures must be dated MM/DD/YYYY.

Attachments

The following are required attachments to the ISP if the person is receiving the service:

- Any Waiver Habilitation Service Plans including residential habilitation, day habilitation, prevocational services, supported employment plan, community habilitation, consolidated supports and services
- Individual Plan for Protective Oversight if the person lives in an IRA
- Medicaid Service Coordination Activity Plan (if the person has requested one or is a Willowbrook Class Member)
- Clinic treatment plan recommendations for long-term therapies provided by Article 16 Clinics.

REVIEWS, TIME FRAMES, and DISTRIBUTION

The Initial ISP is written and signed by the service coordinator within 60 days of the HCBS Waiver enrollment date (which can be found on the HCBS Waiver Notice of Decision form) or within 60 days of the MSC enrollment date (which can be found on the MSC Notice of Authorization), whichever comes first.

Updating the ISP

The service coordinator ensures that the ISP is kept current, adapted to the changing outcomes and priorities of the person as growth, temporary setbacks, and accomplishments occur.

Addendums

The ISP does not need to be rewritten and re-dated every time there is a change or need for revision. Changes may be made by using an addendum. The addendum must include the name of the person, the date of the ISP to which it applies, the date of the change, the new or changed information, and the signature of the service coordinator.

Addendums require only the signature of the service coordinator. A note must be written in the MSC record indicating the change was discussed with and agreed upon by the individual and/or advocate. Addendums are filed with the current ISP and distributed to all appropriate parties.

Changes to the ISP must be communicated to day treatment providers and HCBS Waiver habilitation service providers. If an addendum is used, copies are distributed.

Reviews of the ISP

The service coordinator is responsible for coordinating a review of the ISP and making any needed changes to the plan as a result of the review.

ISP reviews must take place at least twice annually. One of these reviews must be a face-to-face review meeting with the individual and major service providers. The annual face-to-face review meeting must occur within 365 days of the prior face-to-face meeting or by the end of the calendar month in which the 365th day occurs.

For example, a face-to-face ISP review meeting is held on March 15, 2010. The semi-annual review is held sometime in the month of September, 2010. The next face-to-face review meeting must be held no later than March 31, 2011.

It is recommended that, at a minimum, ISP reviews occur every six months. However, if it is in the best interests of the individual served to have the semi-annual review during a different month earlier or later than the six month point this is acceptable as long as the rationale is provided in the MSC monthly notes.

If there is some unforeseeable circumstance, such as a hospitalization, that causes an ISP review to exceed the allowable time frame, this should be noted in the service coordination record and all efforts should be made to reschedule and hold the review as soon as the individual's circumstances will allow.

*Again, for **Willowbrook** class members, ISP reviews should occur every six months, be convened as face-to-face meetings and involve the individual, his/her active representative, service coordinator, service providers and persons relevant to the plan of services. Willowbrook advocates may request quarterly meetings on behalf of an individual class member.*

The ISP with any addendums or revisions and the services described remain in effect until a new ISP is written. An individual may continue to receive the services described in the ISP regardless of whether the ISP review timeline described in these instructions is met.

If the service coordinator and individual determine that the semi-annual review does not require a face-to-face meeting the service coordinator contacts all habilitation providers to request any updates to the current habilitation plans. If there are changes to the ISP these may be communicated by the use of an addendum as described above or the ISP may be rewritten.

At the time of an ISP review, if there are no changes to the ISP the service coordinator may list the date of the review with his/her initials on the top of the ISP. The service coordinator must notify the individual and service providers verbally or in writing that there were no changes to the ISP. A record of this notification should be kept in the service coordination record and include the names of those contacted. Distribution of the ISP is not required when there are no changes.

As noted, at least annually the ISP review must be a face-to-face meeting. This meeting includes the individual, advocate, service coordinator and major service providers (including all HCBS waiver service, day treatment, or clinic service providers). Every major service provider invited should send a representative.

On an annual basis the service coordinator must review with the individual and/or advocate the contents of the Service Coordination Agreement and ensure that the individual has the current 24 hour contact information for the MSC provider in the event of an emergency. It is recommended that this be done at the time of the annual face-to-face ISP review meeting. Documentation that this review occurred should be made on the MSC monthly note.

Maintenance, Retention, and Distribution of the ISP

The signed ISP (with attachments) is maintained by the person's service coordinator and filed in the service coordination record.

Copies of the signed ISP (with attachments) are forwarded by the service coordinator to:

- the person,
- his/her advocate,
- all waiver service providers (for example, residential habilitation, day habilitation, consolidated supports and services, supported employment, respite)
- Article 16, 28, or 31 Clinics
- day treatment
- other providers and individuals with the consent of the person and/or advocate

HCBS Waiver habilitation providers have 30 days from the date of the ISP review to make any necessary revisions to the **habilitation plan** and send the completed and revised plan to the service coordinator.

The service coordinator has 60 days from the date of the ISP review to send the full ISP or addendum and any revised habilitation plans to the individual, advocate, and appropriate service providers. The service coordinator must document distribution of the ISP indicating the parties to whom the ISP was sent and the date of distribution. Evidence of distribution may include, but is not limited to, a sheet stating when the document was distributed, a monthly service note indicating that the document was distributed, a page attached to the ISP indicating when it was distributed, or a notation on the ISP or addendum indicating when it was distributed.

If the 60 day time frame cannot be met because of delays in obtaining the signature of the individual and/or advocate, the service coordinator should still sign and send copies of the ISP to all appropriate parties without the individual and/or advocate signatures. The ISP must be sent with a note indicating that the original document with the required signatures can be found in the individual's service coordination record.

If the habilitation service provider fails to send the habilitation plan to the service coordinator within the allowed time frame the service coordinator should still distribute the ISP without the habilitation plan so as to not exceed the required distribution time frame for the ISP. In this case the habilitation provider is then responsible for distributing the habilitation plan to the service coordinator and all other required parties.

Appendix *updated 10/1/12

Frequency for HCBS Waiver Services

Note: The frequency of HCBS Waiver Service corresponds to the billing unit of service. These frequencies also apply to any OPTS services listed in the Waiver section of the ISP.

Residential Habilitation	
IRA or Community Residence	Month
Family Care	Day
Day Habilitation	
Group	Day
Individual	Hour
Community Habilitation (Phase I)	Hour
Community Habilitation (Phase II)	Month
Supported Employment (SEMP)	Month
Pre-Vocational Services	Day
Respite	Hour
Adaptive Devices	One Time Expenditure
Environmental Modifications	One Time Expenditure
Plan of Care Support Services	Month
Family Education and Training	1 or 2 Units per Year
Consolidated Supports and Services	Month or Hour
Community Transition Services	One Time Expenditure
Agency with Choice/Financial Management Services	Month
Intensive Behavioral Services	Product/Hourly