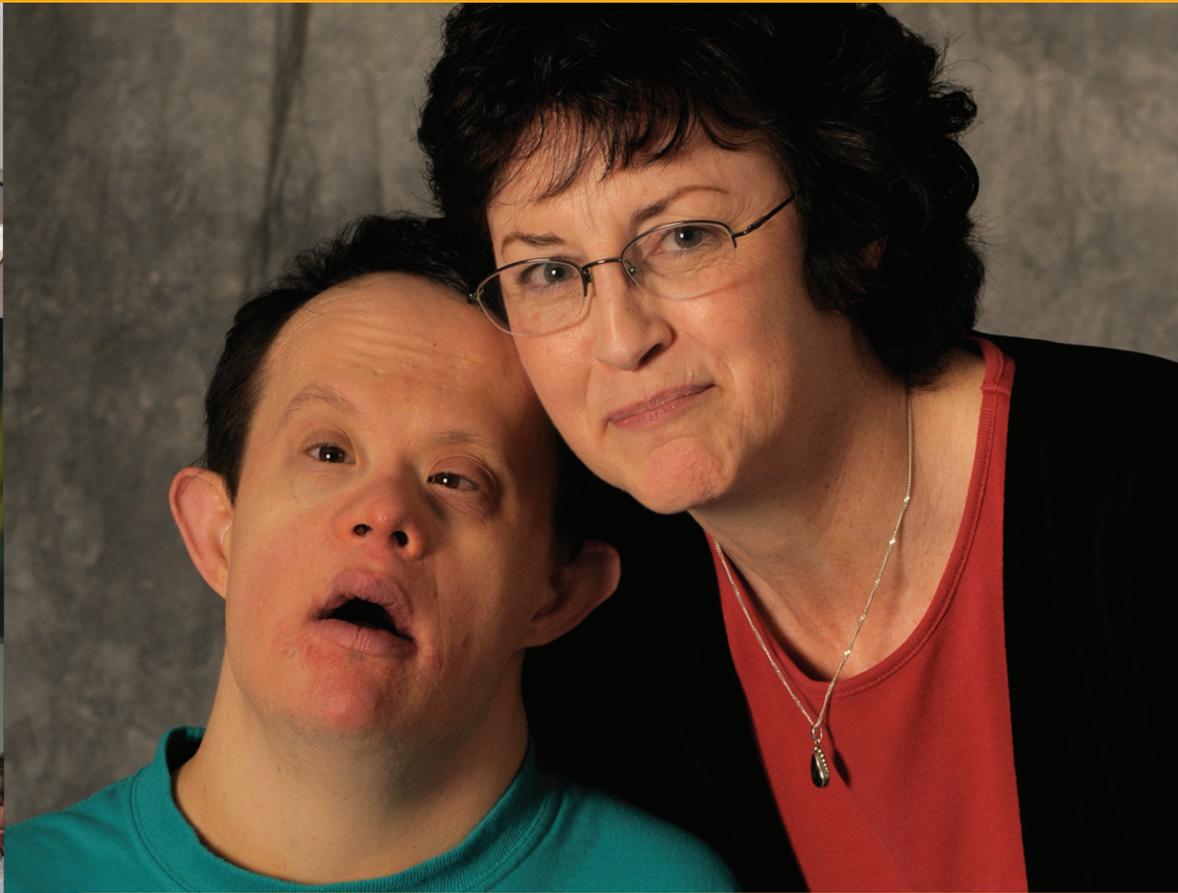




Office for People With Developmental Disabilities

Workforce and Talent Management

Training Curriculum Series



Medicaid Service Coordination

CORE

 { Centralized Overview of Roles and Expectations

Participant's Manual

Education and Training Online Resource Library



Welcome MSC Core Participant!

This participant manual contains pre-reading materials for the upcoming MSC CORE training that you will be attending. Please thoroughly read the designated information prior to attending your one-day MSC CORE training. You will also come across some activities in the pre-reading, please complete these activities and bring them with you to the class. If you have questions, please write them down and bring them to the attention of the course instructor. **Please remember to print and bring this manual with you on the day of your training.**

As you probably know, Medicaid Service Coordinators (MSCs), and staff who directly supervise MSC Service Coordinators, are required to attend a one-day OPWDD approved CORE training program within six months of assuming MSC responsibilities. The MSC CORE training offers an introduction to developmental disabilities and an overview of the services and supports available to people with developmental disabilities.

The objectives of the MSC CORE training are:

- Review the structure, role, and mission of OPWDD, as well as the Agency's history
- Learn about the current types of services and supports OPWDD and its network of voluntary agencies provide
- Understand person-centered philosophies and other concepts behind Medicaid Service Coordination
- Understand your role and responsibilities of being a Medicaid Service Coordinator
- Review and understand standard Medicaid Service Coordination documentation requirements

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Additional Resources

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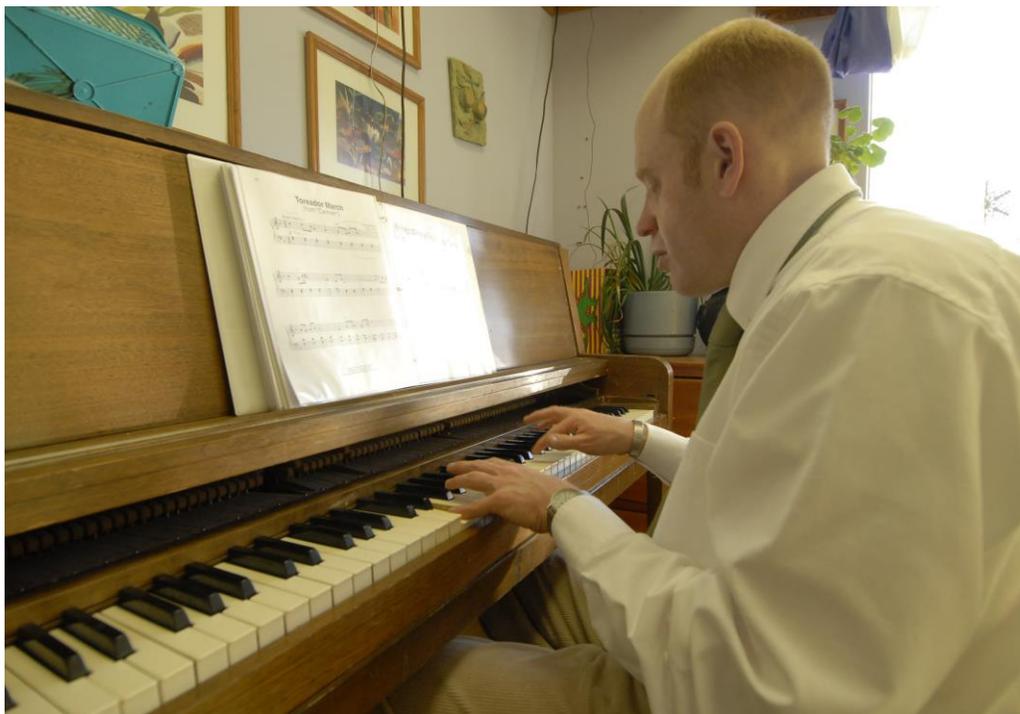
Five Accomplishments

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SECTION 1

THE NEW YORK STATE OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES (OPWDD)

To become better acquainted with OPWDD, you should begin by reviewing the Agency's mission, vision and values.

OPWDD'S MISSION:

We help people with developmental disabilities live richer lives.

OPWDD'S VISION:

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.



OPWDD ROLE AND STRUCTURE:

OPWDD sets policies and regulations for providers of services to the population served under its umbrella. It also ensures that these policies and regulations are complied with and that federal and state laws pertaining to the population served by OPWDD and the service providers are followed.

In addition to regulating voluntary agencies, OPWDD also provides direct services to people with developmental disabilities. OPWDD has its Central Office in Albany with a Regional Office in New York City. It operates district offices throughout the state called Developmental Disabilities Regional Offices (DDRO). In addition, it operates a research facility called the Institute for Basic Research (IBR).

Central Office functions are primarily administrative in nature. Central Office personnel do not directly provide individual services and supports. The Divisions of Central Office which impact voluntary agencies most directly are the Division of Quality Improvement and the Division of Fiscal and Administrative Solutions. The first is responsible for monitoring the quality of services provided by voluntary agencies, and the second is responsible for the administration and allocation of the funding for the services provided by voluntary agencies.

For a listing of Regional Offices and the counties they cover, go to:

www.opwdd.ny.gov

Regional offices provide some direct individual services and supports; they also provide technical assistance to the voluntary agencies within their catchment area.

For additional information on OPWDD, go to:

http://www.opwdd.ny.gov/news_and_publications/home

VOLUNTARY AGENCIES:



The greater portion of all services and supports is 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 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:

Please review the following timeline. Note how the system has changed from an institutional model to a community-based model and the increased numbers of people served in the local community.

1967 - 27,000 persons with developmental disabilities are living in institutions in New York State.

1972 - Television documentary - written and narrated by TV news journalist Geraldo Rivera revealed deplorable living conditions at New York's Willowbrook State School.

1972 - Parents of 5,000 persons living at Willowbrook State School filed suit in federal court over the inhumane living conditions at the facility.

1972 - First community residence for persons with developmental disabilities opened in New York State.

1974 - State Schools renamed "Developmental Centers".

May 5, 1975 - Willowbrook Consent Decree signed. New York State commits itself to a program of improving community placement for the "Willowbrook class" clients. Shortly thereafter, then Governor Hugh Carey extends similar benefits to all persons served by the OMRDD system.

1977 - Chapter 978 of the Laws of 1977 created a separate Office of Mental Retardation and Developmental Disabilities (OMRDD).



April 1978 - OMRDD begins operations. About 16,447 persons resided in developmental centers; 7,340 persons lived in community residences; 22,355 persons received day treatment services. More than 42,800 people receive services through OMRDD.

December 1983 - 11,728 persons lived in developmental centers; 12,100 persons lived in the community; 30,000 individuals received day services. More than 45,700 people received services through OMRDD.

1983 - Plans announced to close Willowbrook State School.

1984 - Family Support Services program established as a \$200,000 demonstration project.

1985 - OMRDD launches Supported Work Program.

March 1986 - Residential census at Staten Island Developmental Center (formerly the Willowbrook State School) reaches 250 people – the original goal of Willowbrook Consent Decree.

June 1986 – The Self-Advocacy Association of New York is founded to assist local groups and individuals with developmental disabilities as well as help familiarize legislators and public officials with issues related to independent living, personal choice and program flexibility.

December 1986 - Plans are announced to close Westchester Developmental Center.

January 1987 - Plans are announced to close five additional Developmental Centers; Craig, Bronx, Manhattan, Rome and Newark.

February 1987 - Federal Court approves Willowbrook "1987 Stipulation," setting forth guidelines for providing community placements for class members.

September 1987- A promise fulfilled; Willowbrook Developmental Center declared "officially and forever closed".

December 1988 - 16,000 persons live in community residences. About 15,000 families receive Family Support Services. Fewer than 9,240 persons live in developmental centers. About 38,000 receive day treatment. More than 66,200 people receive services through OMRDD.

December 1988 - Craig Developmental Center closes.



December 1988 - Westchester Developmental Center closes.

November 1989 - Rome Developmental Center becomes the fourth institutional facility to close. Open since May, 1894, it had been one of the first institutions in the United States to care for persons with developmental disabilities.

July 1990 - U.S. President George Bush signs the "Americans with Disabilities Act" into law - landmark federal legislation guaranteeing people with disabilities the same rights to employment and access to public facilities as other citizens.

July 1991 - Newark Developmental Center closes.

August 1991 - HCFA approves New York's application for HCB Waiver to allow persons to receive certain Medicaid-funded services while living in the community. The Waiver subsequently becomes a central component of the Individualized Service Plan, case management and other parts of person-centered planning.

September 1991 - HCBS Waiver program is introduced as a pilot program in J.N. Adam, Letchworth, Long Island and Wassaic DDSOs.

September 1991 - The Self-Advocacy Association holds its first statewide seminar; this represents the coming of age of a growing consumer empowerment movement in New York State.

December 1991 - Manhattan Developmental Center, one of the first facilities, opened to ease Willowbrook overcrowding - becomes the sixth facility to close its doors.

May, 1992 - The Care-at-Home Waiver Program, which is similar to the HCBS Waiver but applicable to children enrolls 200th child. There are 1,700 persons served overall through the HCBS Waiver.

August 1992 - Landmark legislation signed into law creating statutory definition, State reimbursement policy and plans to expand Family Support Services.

December 1992 - Bronx Developmental Center closes.

March 1993 - Willowbrook Permanent Injunction replaces Willowbrook Consent Decree and all other orders in the Willowbrook litigation.



April 1993 - First statewide Consumer Council Conference held for family service providers in Albany.

April 1993 - JN Adam Developmental Center closes.

June 1993 - Long Island Developmental Center closes.

December 1993 - The Developmental Center census is 4,730. Approximately 27,000 persons live in community residences; nearly 34,500 receive Family Support Services; almost 46,000 are in day services programs; and over 3,450 are enrolled in the HCBS Waiver. More than 86,400 consumers receive services through OMRDD.

June 1994 - Center for Intensive Treatment opens on the campus of Sunmount Developmental Center.

May 1996 - 26,861 individuals are enrolled in the HCBS Waiver Program, an increase of nearly 25,000 in four years.

June 1996 - Letchworth Village Developmental Center marks closure.

June 1998 - Syracuse Developmental Center, one of the oldest facilities of its kind in North America becomes the latest facility to close.

July, 1998 - Nearly 31,900 persons live in the community; more than 58,600 receive day services. About 51,650 receive family support services. The Developmental Center census is just over 2,100 residents. More than 30,000 are enrolled in the HCBS. Nearly 109,550 consumers receive services through OMRDD.

August 1998 - Governor George E. Pataki announces "NYS-CARES" (NYS Creating Alternatives in Residential Environments and Services) a five-year plan to virtually eliminate the waiting list for out-of-home residential services for people with mental retardation and developmental disabilities.

November 1997 - Declaration of Self-Determination issued after the national conference of Self-Advocates. New York was one of the first states to have a Self-Determination program approved as part of its federal Medicaid Waiver program following a grant to the pilot the program in 1998.



Fall 2003 – New York State Options for People Through Services (OPTS) begins. The program was launched by OMRDD to accomplish the vision of moving to an organized health care delivery system

October 2005 - More than 35,000 people live in community residential settings and more than 36,000 people participate in day programs (more than 60,000 if day habilitation is included). Nearly 45,000 individuals receive family support services. The institutional (DC+Special Populations) census is around 1,600 residents. Over 50,000 individuals are enrolled in the HCBS Waiver. About 67,000 receive service coordination under OMRDD, most enrolled in MSC. About 124,000 individuals receive services through OMRDD.

July 2010- OMRDD renamed the New York State Office For People With Developmental Disabilities (OPWDD).

ACTIVITY #1: OPWDD

You just read that OPWDD has evolved over the years. Now, let's see how much you remember about OPWDD.



Q and A:

What is the vision of OPWDD?

What is the mission of OPWDD?

How can you put the OPWDD Mission and Values to life? How can you apply them?

How is OPWDD structured?

What is the relationship between OPWDD and the voluntary agencies?

Name 5 important milestones in the history of OPWDD. Why are they important?

Please note: There will be a discussion in class about the materials you just read and the questions you answered.

You have reviewed information on OPWDD. In the upcoming section, you will read about developmental disabilities; how they are defined; how does someone qualify for services; how service delivery has evolved; and types and locations of services.



SECTION 2

OVERVIEW OF DEVELOPMENTAL DISABILITIES

OPWDD was created to meet the needs of people who have 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.

DEFINITION OF DEVELOPMENTAL DISABILITIES:

- 1. Section 1.03 (22) of the NYS Mental Hygiene Law defines a developmental disability as:**



A disability of a person which is:

- (a)
 - 1. attributable to mental retardation, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia or autism;
 - 2. attributable to any other condition of a person found to be closely related to mental retardation because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of mentally retarded persons or requires treatment and services similar to those required for such persons, or
 - 3. attributable to dyslexia resulting from a disability described in subparagraph (1) or (2) of this paragraph.
- (b) Originates before such person attains age twenty-two;
- (c) Has continued or can be expected to continue indefinitely; and
- (d) Constitutes a substantial handicap to such person's ability to function normally in society.

At least **one** of the three criteria in (a) must be met in conjunction with the requirements of (b) (c) and (d) for a person to be considered to have a developmentally disability.

TYPES OF DEVELOPMENTAL DISABILITIES:

People with developmental disabilities have the capacity to learn and grow, to become economically productive and to be fully participating members of society. People with mental retardation show delays in learning, a slower pace of learning, and difficulty in applying learning. Mental retardation can result from a variety of factors: genetic abnormalities, malnutrition, and exposure to toxic agents or social deprivation. Mental retardation may or may not be associated with any of the following developmental disabilities:



Cerebral Palsy:

- Cerebral Palsy is a group of conditions that results in limited or abnormal functioning in the parts of the brain that control movement.
- Cerebral palsy usually is caused by brain injury before or during birth. However, brain damage or injury at any time in life can have the same effect (Note: if occurring after a person turns 22, the person would not be considered to have a developmental disability).

Epilepsy:

- The term epilepsy subsumes a number of brain-centered nervous system disorders characterized by sudden seizures, muscle convulsions, and partial or total loss of consciousness, due to abnormal patterns of electrical discharges of brain cells.

Neurological Impairments:

- Neurological impairments constitute a group of disabilities including disorders of the brain and central nervous system that considerably limit a person's development, understanding, memory, attention span, fine muscle control, use of language, or ability to adjust to new situations. Generally, these impairments begin during childhood and adolescence.
- People with neurological impairments may experience a variety of learning difficulties or social behavior problems. They may also have special care needs because of problems in muscle control. Neurological impairments can be difficult to diagnose and treat.

Familial Dysautonomia:

- Familial Dysautonomia (FD) is a genetic disease present at birth in male and female Jewish babies, primarily causing dysfunction of the autonomic and sensory nervous systems. Dysfunction is a result of an incomplete development of the neurons (nerve fibers) of the systems.



- Children with familial dysautonomia have an absence of overflow tears with emotional crying. Babies have poor muscle tone, weak or absent suck, respiratory congestions, blotchy skin and difficulty maintaining a normal body temperature.
- Older children may have a delay in developmental milestones, poor balance and unsteady gait, scoliosis, hypotension, breath holding, episodic vomiting, excessive drooling and sweating, a decreased sense of taste, inappropriate temperature control, poor weight gain and growth, frequent lung infections, decreased reaction to pain, cold, puffy hands and feet, extremes in blood pressure, corneal abrasions and dry eyes, gastric dysmotility, and dysautonomic “crisis” (incident of extreme psychological response of the body to stress).

Autism:

- Autism is a developmental disorder that limits learning and slows intellectual development. People with autism have great difficulty relating and responding to persons, events or objects. People with mild autism may demonstrate some repetitive actions and a marked lack of sensitivity to other people. People who have more severe autism have difficulty listening to and communicating with others. They may have multiple repetitive behaviors, for example rocking and unusual hand movements, and can be highly resistant to change. Services available for people with autism include diagnosis, parent training, highly structured recreation programs, specialized education, in-home and out-of-home residential services, and programs to develop daily living and social skills. Early diagnosis is important so that services such as highly structured behavioral programs can be used to improve each child’s chances for normal development.

For additional information on developmental disabilities, please go to:

<http://www.opwdd.ny.gov/node/396>

HISTORY OF SERVICES:

Why do we go through the history of serving people with developmental disabilities? Just like with other events, we need to understand what happened before and how we learn from it to not to not make the same mistakes. We also need to honor those who were in the institutions like Willowbrook by remembering them and what they went through to get us to where we are today.



The history of people with disabilities is a powerful, sometimes horrifying story of discrimination, segregation, abuse, ignorance, silence and good intentions that brought bad results. It is the history of people who often had no choices, no voices, and no champions.

Prior to the 18th century, eighty percent of the inhabitants of prisons and poorhouses were persons who had a disability. This was period of total neglect and the vulnerable members of society were shunted from the mainstream into virtual imprisonment, ignored and shut out of site.

Educational Residential Institutions 1800s:

At the beginning of the 19th century, pioneers in Europe and America championed the plight of the social outcast groups.

Expansion of Institutions 1920-1970:

From the 1920s to the 1970s, the population in these residential institutions grew to approximately 250, 000 people with mental retardation and developmental disabilities. During this period New York State operated a number of institutions. By the early 1970s there were 20 such institutions, usually called state schools, located in New York State.

Willowbrook and the Beginning of Deinstitutionalization 1971-1975:

Institutionalization in New York State came under scrutiny in 1971 when journalists exposed the horrific conditions at the Willowbrook State School on Staten Island. A lawsuit was filed on behalf of the 5,000 people living at Willowbrook. Further investigation of other state schools exposed similar conditions (e.g. Letchworth Village) throughout the state.

In 1974, the term state school was changed to developmental center. In 1975, the lawsuit 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 caseload; if you do, you should speak with your supervisor about the Willowbrook requirements and make sure that you are following them.



You or your supervisor should contact the person responsible in your DDSO catchment area for information about the Willowbrook Training Program. All Service Coordinators serving Willowbrook class members should attend.

For further information and listing of DDSO Willowbrook Liaisons, go to:

http://www.opwdd.ny.gov/opwdd_resources/willowbrook_class/opwdd_WBLiaison_contacts

De-institutionalization 1975 – Present:

During the mid 1970s and into the 1980s, OPWDD moved thousands of people from the developmental centers into the community. Community residential, day and recreational services were rapidly developed.

Chapter 978 of the Laws of 1977 was signed into law creating a separate Office of Mental Retardation and Developmental Disabilities (OMRDD). In April 1978, OMRDD officially began operations as a separate entity.

As the 1980s came to an end, there was a clear recognition on the part of OMRDD and the voluntary providers that not all people living in ICFs needed or wanted all the services they were required to receive by virtue of living in an ICF.

Once again, a federal funding source opened up which allowed for a more individualized approach to service delivery. This funding source, known as the Home and Community Based (HCBS) Waiver, revolutionized the service system allowing services to be more individualized and geared to people's needs and interests. It also helped to fuel the tremendous expansion of community services.

1990s – Present: Self Advocacy and Self Determination:

The concepts of consumer empowerment, civil rights activism, and the Americans with Disabilities Act (1966) all contributed to an important movement in the field of developmental disabilities known as **Self Determination**. Self Determination provides people with developmental disabilities the opportunity – with the help of a circle of support that includes chosen family members and friends – to have:

- the *freedom* to develop a personal life plan



- the *authority* to control a targeted amount of resources
- the *support* needed to obtain one’s personal goal
- the *responsibility* for contributing to one’s community and using public dollars wisely.

The Self Advocacy movement, which promoted autonomy and self-determination for people with mental retardation and developmental disabilities, has been growing steadily since the late 1980s. Today, OPWDD consults with the Self-Advocacy Association of New York State (SANYS; see www.sanys.org) before making policy and program decisions that affect individuals with intellectual and or developmental disabilities.

Effective July 13, 2010, OMRDD became the New York State Office For People With Developmental Disabilities (OPWDD).

A bill was signed into law, which changed the agency’s name and removed the “R” word from State statutes and regulations, excluding clinical references. The new name eliminates the stigmatizing language which was part of the agency’s name and reflects “Putting People First”. This is consistent with the Person First Language law enacted in 2007.

PLEASE NOTE:

As you have read, the service system for persons with developmental disabilities has changed from an institutional model to a community-based model with the majority of people now being served within their communities. New initiatives continue to be developed to allow services to be more individualized.

THE 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. For 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 people 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 people with developmental disabilities become a greater presence in the community!

Previously, it was believed that people 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 needed staff or family members to make decisions for them.

When OPWDD started placing people with developmental disabilities back in 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 people with developmental disabilities. Everything was uncertain and most clinicians and other staff were very nervous. For many it was an uncomfortable time because they did not know the new rules.

This was only the starting point. The system continued to make drastic changes in its philosophies about providing supports and services. So, today people 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 months or sometimes years. **But once the cycle is completed, there is a paradigm shift.** The staff who work with people 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.

In recent years, serving people with developmental disabilities 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 individual.

ACTIVITY #2:

HISTORY QUIZ ON THE HISTORY OF DEVELOPMENTAL DISABILITIES

Test your knowledge of the history of developmental disabilities. Please answer true or false to the following statements.

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



2. _____ *By 1875, in many states, custody in prison-like settings had replaced the goal of integration in the community.*
3. _____ *In the late 19th century and early 20th century, tens of thousands of people with disabilities were forcibly sterilized in the United States.*
4. _____ *The Office of Mental Retardation and Developmental Disabilities was established in 1923 to oversee institutional care.*
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."*
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.*
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.*
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.*
9. _____ *Today, there are more individuals with developmental disabilities living in institutions in New York than there are living in community residential settings.*

Answers



1. **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. **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. **True.** People with disabilities were forcibly sterilized because it was thought that they were moral menaces, who could potentially ruin the human species.
4. **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. **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. **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. **True.** This showed how little people with developmental disabilities were valued. In Massachusetts, children at the Walter E. Fernald School for the Feeble-minded 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. **True.** As a result of this expose, the public was outraged. New York State was forced to change the way it provided services to people with developmental disabilities.



9. **False.** In 2005, more than 35,000 individuals with developmental disabilities live 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 people away to large institutions to one that helps individuals live successful lives in the community. Some states are now institution free.



SECTION 3

PHILOSOPHIES AND CONCEPTS

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. During the classroom session, we will be focusing on the ISE and the Service Coordinator’s role in helping a person to develop and implement his or her ISE.



THE THREE I's and a P (IIIP):

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

INDIVIDUALIZATION: Making certain that each person's life is unique.

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:

OPWDD supports the rights of people 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. Choice making is not just for people with less severe forms of disabilities, but for all people. The choices we are talking about include major life choices, not just whether a person wants peas or carrots.

Service Coordinators help people to make informed choices so that people continue to develop and progress throughout their lives. Helping individuals make informed choices is a quality outcome expected in the provision of all MSC services.

A person can make an informed choice on his/her own or may ask family members, friends, or others for assistance if the person 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 the people involved in the person's life.

PERSON CENTERED PLANNING:

Basic Features of a Person Centered Planning Process:

- The focus is on dreams, hopes, gifts and capacities, not disabilities
- A small circle of support is formed, a group of people who care about the person and know him or her best.
- The person who is the focus of the plan has the opportunity to make choices and express preferences for a home, relationships, community activities, and leisure.
- Support for the person comes first from natural and typical community resources- only when those are not available or sufficient does the person or circle look toward formal paid service providers for supports.

BASIC STEPS TO A PERSON CENTERED PLANNING PROCESS:

- Getting to know people
- Looking for clues and discovering patterns from life experiences
- Developing a focus for where we want to go
- Taking action by trying things and working together
- Exploring community
- Developing constructive system supports

CHARACTERISTICS OF PERSON CENTERED MEETINGS:



- The meeting is usually comprised of a small group of people who know the person well and have come together to map out a future vision of the person's life based on the dreams and hopes that have been identified.
- The future vision is built around the person's expressed preferences, strengths, capacities, and needs.
- Action steps are drawn up that identify who will do what, and the group agrees to meet again soon to identify areas of progress, barriers that must be overcome, and the next steps of action to be undertaken.
- A facilitator may be identified to run these meetings.

COMMUNITY INCLUSION:

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, people 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.

How inclusion differs from integration:

- Community Integration was the precursor to Community Inclusion
- Integration stressed that people should come out from behind the walls of their residence and participate in the same activities that other community members enjoyed. However, in actual practice, integration usually meant the consumer entered the community, but they 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.

- Community Inclusion means the person is an accepted member of his or her community and rightfully belongs in the community just as we all do.
- It is important to remember that true inclusion builds upon activities that are meaningful and of interest to a person.
- The process of assisting people to become part of the community is called community building.

How does an MSC help people to become part of the community?

- Strengthen community relationships.
- Strengthen ties to associations and community organizations.
- Become regulars in the community.
- Build relationships through working and volunteering.

SELF ADVOCACY:

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.



SELF-DETERMINATION:

Self-Determination provides people with developmental disabilities the opportunity – with the help of a “Circle of Support”, to have the freedom to do the following:

- The freedom to develop a personal life plan
- The authority to control a targeted amount of resources
- The support needed to obtain personal goals
- The responsibility for contributing to one’s community and using public dollars wisely.

EMPLOYMENT FIRST:

The Employment First Platform promotes the idea that all people should have the opportunity to be a contributing community member. The Employment First philosophy is that all individuals can work with the proper supports in place. When developing an individualized, person-centered plan, Employment First sets the expectation that people with disabilities are held to the same employment standards and responsibilities of any working-age adult. However, if work is not the individual’s immediate choice, then we must support his or her decision while providing alternate opportunities for community contribution; recognizing that participation in one’s community is an essential part of life.

Supported Employment services provide job-related supports for people with significant disabilities to obtain or sustain their competitive employment in community settings. The work is performed in an integrated setting that provides opportunities for regular interactions with individuals who do not have disabilities and are not paid caregivers.

The supports and services provided in supported employment may include: job development/job finding, situational assessment and reassessment, job coaching, skill training, improving work behaviors, mobility training, work-related socialization skills, and employer/co-worker training and support.

In addition to Supported Employment, there are two services which help to provide community employment opportunities for people with developmental disabilities. The



Employment Training Program (ETP) and the Enhanced Supported Employment (ESEMP) pilot projects.

The ETP program provides internships and traineeships for students and young adults to learn skills through on the job work experience and develop job-readiness skills in a classroom setting. An ETP coordinator is located at each DDSO to assist you with further information and enrollment.

The ESEMP pilot project assists people who have had no work experience or previously unsuccessful work experiences to achieve their employment goals. ESEMP is an HCBS Waiver service that uses a person-centered approach to match an individual's interests, skills and abilities with a job in the community.



Activity #3: The Decision Tree

The information you just read emphasized that services and choices should follow a person-centered approach. The ISE and the IIP should also be reflected in these services and choices.

A decision made by an individual should be supported by relevant information; a weighting of options and consequences should have occurred. The person should be given the necessary supports to implement that decision. Moreover, the whole process should concentrate on the person’s strengths and abilities.

Taking all these ideas into consideration, please:

- Take a look at the decision tree below
- Review the different stories
- Tell us what you would do in each situation

[We will review and discuss your answers in class!](#)

The Decision Tree:

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

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.

Question:

How would you help Sally and Bob?

Were the story and the help you provided related to:

Harm/danger?

Disappointment/Embarrassment?

Personal taste and opinion?

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.

Question:

How would you help Nelson?

Were the story and the help you provided related to:

- Harm/danger?
- Disappointment/ Embarrassment?
- Personal taste and opinion?

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."

Question:

How would you help Nelson?



Were the story and the help you provided related to:

- Harm/danger?
- Disappointment/Embarrassment?
- Personal taste and opinion?

Be Prepared to discuss these situations in class!



SECTION 4

SUPPORTS AND SERVICES

Types and Locations of Supports and Services:

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

1. Residential Services:

Types of community-based certified housing include ICFs, IRAs, CRs, and Family Care. 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 Home and Community Based Services (HCBS) Waiver.

2. Day Services:

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)

3. Family Support Services:

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

4. 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:

Today, most (not all) services provided by OPWDD and voluntary agencies are funded through the Home and Community Based Services (HCBS) Waiver. The HCBS Waiver is a federal program that allows the States to use Medicaid dollars for community-based services; previously, this money had been available only for institutional services. The HCBS waiver has been in operation in New York State since September 1991.

NOTE:

Some services are still funded through other federal, state, and county sources. For example, Intermediate Care Facilities (ICFs), Day Treatment, and Family Support Services (FSS), are not funded under the HCBS Waiver.

OPWDD's Individualized Service Plan (ISP) instructions outline the required elements of an ISP, this document also includes an appendix which provides information on how the frequency for each Home and Community Based Waiver Service (HCBS) should be listed in the ISP. This document has been revised since its original publication, therefore we share with you the live version of the document from the www.opwdd.ny.gov website. The direct link to this document is:

http://www.opwdd.ny.gov/opwdd_services_supports/service_coordination/medicaid_service_coordination/documents/ISP_Instructions_Final.

OVERVIEW OF SERVICES OFFERED IN THE HCBS WAIVER:

Habilitation Services help the person to develop skills so that they may live as independently as possible and achieve independent goals. There are four distinct types of Habilitation services in this waiver.

Residential Habilitation is provided primarily in the person's home and community and occurs at a time that is usually considered part of the person's "non-working" hours.

Day Habilitation is provided primarily away from a person's home in a community setting.

Community Habilitation: intended as a more efficient mechanism for the delivery of habilitative services in the community (i.e. non-certified settings) to facilitate community inclusion, integration, and relationship building. Designed to offer a self-direction option to



provide individuals with enhanced opportunities to choose and manage their own staff to the extent possible.

Prevocational Services address the person’s vocational interests and are designed to prepare the person for the working world. They assist individuals who are interested in joining the world of work but are not expected to obtain competitive employment within a year.

Supported Employment services assist individuals in finding and keeping meaningful and paid employment. These services take place in integrated work settings where the person is competitively employed.

Respite provides short-term relief to caregivers who are responsible for the primary care and support of a person with a developmental disability. This service may be provided in the person and caregiver’s home or an approved site.

Family Education and Training provides education and training to caregivers of children under the age of 18 who are enrolled in the HCBS Waiver. The purpose is to enhance the family’s knowledge, skills, and decision making capacity to help them care for a child with developmental disabilities.

Consolidated Supports and Services is a highly individualized option where the participant can manage their own portable budget and direct their own services, including hiring their own staff support.

Fiscal Employer Agent is the service that supports people participating in CSS. The provider assists the person with managing their budget, paying providers, and acts as employer of record for the staff supports hired by the participant.

Transitional Supports are supports that assist waiver participants who are moving from an institutional residence to a less restrictive setting such as their own home, or a Family Care home. Transitional supports fund initial startup costs such as essential furnishings, moving expenses, and security deposits.

Plan of Care Support Services is provided to people who are enrolled in the HCBS Waiver and do not have monthly MSC. PCSS providers assist the person to maintain waiver eligibility by reviewing the ISP twice a year and performing the annual level of care evaluation.



Environmental Modifications Are adaptations to the home that are necessary to increase or maintain a person's ability to live at home with independence.

Adaptive Devices are aids, controls, appliances, or supplies which are necessary to enable the person to increase or maintain his or her ability to live at home and in the community with independence and safety.

Intensive Behavioral Services: intended to address the critical need for intensive behavioral supports (via short-term and intensive support) in the home for individuals at risk of placement in a more restrictive residential setting.



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 people with disabilities (e.g., Special Olympics and agency sponsored dance on Friday night).

This information will be shared in class in order to help fellow participants broaden their network of community resources.

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: _____

Be Prepared to Bring this List with you to Class!



SECTION 5

Medicaid Service Coordination

In the previous sections, you read about how OPWDD was created, its mission, and its relationships with voluntary agencies. You also saw how services have changed over the years, not only in nature but also in delivery methods. You reviewed how someone qualifies to receive services under the umbrella of OPWDD and the types and locations of services that are available.

One of such services is Medicaid Service Coordination (MSC).

Being a Service Coordinator is a rewarding and demanding job that has a great deal of responsibility. Remember, you are not alone. If you need help, talk to your supervisor and other more experienced Service Coordinators. You can also get assistance from your DDSO Service Coordination liaison.

Background of Medicaid Service Coordination:



OPWDD has a long history of providing service coordination/case management. In particular, Service Coordinators/case managers responded to the needs of people 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. Listed below is a brief history of MSC:

- **1980's:** NYS 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.
- **March 2000:** The Medicaid Service Coordination program (MSC) replaced both the CMCM and HCBS waiver service coordination program.
- **2008:** OPWDD, in partnership with the Informed Choice Design Team and other stakeholders, embarked on a review of the ten year old MSC Program. The goal of this effort was to develop recommendations to guide the future redesign of the MSC Program.
- **2010:** New York State's continued grim fiscal climate, extremely tight budget, and a rising number of individuals seeking services from OPWDD's system, required expedited implementation of a MSC restructuring plan to achieve required State Fiscal Year 2010-11 savings and to ensure the integrity and sustainability of MSC services for years to come.

MSC Redesign Goals:

- More efficient, flexible, and cost effective service delivery
- Enable services to be tailored to individualized needs and outcomes within the scope of the program
- Continue to ensure that choice and desires are taken into account to the greatest extent possible

For more information on MSC Restructuring, please go to:



http://www.opwdd.ny.gov/opwdd_services_supports/service_coordination/medicaid_service_coordination/redesign_information

Important Aspects of Service Coordination:

- Service Coordination is a separate and distinct service from all other services.
- The Service Coordinator works in partnership with the person and is not “in charge” or “in control”.
- The Service Coordinator helps the person achieve a balanced and integrated perspective of his or her life.
- The Service Coordinator is chosen by the person and advocate.
- The Service Coordinator is always assessing and attempting to maximize the person’s satisfaction.
- The Service Coordinator always promotes and monitors the person’s health and safety.
- The Service Coordinator always fosters inclusion (community membership) and self-determination. These are basic values of our service delivery system.
- The Service Coordinator is an advocate for the person. The Service Coordinator helps promote the person’s cause and defends the person’s rights when the person cannot do so alone.

Roles and Responsibilities of a Service Coordinator:

In order to help a person access necessary and available supports and services, a Service Coordinator provides:

Revised January 2015



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 person and his/her advocate identify and access specific service providers within the individual’s community.

Monitoring and follow-up:

Actions taken to oversee the person’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 person’s life in order to maintain a written record of major events, changes, issues and progress, and thereby provide person-centered services. Service documentation is an essential function of the position.

Please remember, Service Coordinators focus on helping people with developmental disabilities live richer and more successful lives in the community according to their own dreams, desires and plans. We hope you have a better understanding of the history of the MSC program, as well as more knowledge about the roles and responsibilities of the MSC career you are about to embark on.



This concludes your MSC CORE pre-reading responsibility.

In class, there will be a brief review of the pre-reading material and the instructor will answer any questions you may have. The course will then focus on the day-to-day responsibilities of a Medicaid Service Coordinator, the foundations an MSC needs, service documentation related to this function, and other general information including a presentation from a self advocate. We look forward to seeing you in class.



IN CLASS MATERIALS

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!"

Self Advocacy Materials



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!

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?
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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 your 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.

Top ten things *you should not 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 should 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!

ADDITIONAL RESOURCES

The purpose of this section is to provide tools that are useful in performing your role as a service coordinator. Please review the proceeding information, you may find it particularly helpful as you begin your career.

MSC Vendor Manual:



This is a manual written for service coordinators and administrative staff of vendors that provide Medicaid Service Coordination (MSC) services under contract with OPWDD. The MSC Vendor Manual is available on the OPWDD Website (www.opwdd.ny.gov).

The Key - The Home and Community-Based Services Provider Guide

This provider guide provides current administrative requirements of the Home and Community Based Services waiver. Administrative Memorandums (ADMs) pertinent to the HCBS Waiver are posted on the OPWDD Website.

MSC E-Visory

The MSC E-Visory is an electronic advisory and is available on the OPWDD Website. Each issue provides pertinent and timely information about programs and services available to individuals receiving MSC. Announcements about MSC training, conferences and meetings appear regularly.

Here are some “Tricks of the Trade” – advice from experienced service coordinators:

Use a “Trapper Keeper” or 3-ring binder with pockets:

- Keep a section for each person on your caseload
- Have a cover sheet for each person with:
 - The person’s address, phone #s, emergency contacts, etc.
 - ISP due dates, other due dates
 - Any other person specific information that you deem necessary
- Write case notes as you go
- Keep a checklist to make sure the following are included in the service coordination record:
 - Rights and Responsibilities
 - Contact phone numbers and addresses
 - Service Coordination Agreement
 - Activity Plan



- Keep a checklist to make sure the following are properly filed:
 - SCORs for Willowbrook class members
 - Incident Reports
 - Personal Expenditures (from Personal Allowance)
- Plan time for in-office work:
 - Make sure you plan for office time after ISP meetings
 - Prioritize your work
 - Set aside time in the morning or afternoon to make all your phone calls
- Make a Master To-Do List:
 - List all activities you must do for all your individuals and prioritize the list.
 - Make this a working/ever changing list - it should be revised when you complete assignments and when new priorities arise.
- Plan necessary visits with the individuals you serve early in the month.
 - Bunch as many visits together in a day as possible, based on travel, location, time, availability of individuals, etc.
 - Learn your caseload.
 - Leave enough time for each visit and follow-up.
- Plan your ISP reviews at the beginning of the month.
- Keep “to be filed” paperwork in an accordion file with a section for each person (alphabetized).
- Keep a travel log (for mileage, tolls, and public transportation expenses) and pen in your glove compartment or briefcase/backpack.

Common Mistakes Made by New Service Coordinators

1. The service coordinator provides residential or day habilitation services rather than coordinating these services.



2. The service coordinator tries so hard to make a good impression that he/she promises to do more than is possible.
3. The service coordinator gets too involved in the individual's life.
4. The service coordinator does things for the individual that the person is capable of doing on his or her own.
5. The service coordinator does not call to make sure forms/applications were received and completed by deadlines.
6. The service coordinator does not keep copies of applications and has to redo them when they are lost.
7. The service coordinator does not save the ISP in the computer and loses it after spending hours typing it.
8. The service coordinator makes value judgments about what the individual likes or how the person lives.
9. The service coordinator is reactive rather than proactive.
10. The service coordinator thinks he/she is the professional and knows best.
11. The service coordinator notes are written only about the person and not about the activities the service coordinator is doing on behalf of the person.
12. The service coordinator calls the individual by the wrong name.
13. The service coordinator does not track time sensitive information.
14. The service coordinator waits until she has an answer to call a parent back rather than calling to give periodic updates.

Further Reading:

1. Communicating with People with Developmental Disabilities



2. Strategies for Effective Collaboration with Families
3. Working with School Age Children
4. Cultural Competence
5. Five Accomplishments
6. Pathways to Inclusion
7. Strategies for Community Building
8. Funding of Services

Communicating with People with Developmental Disabilities:

1. Some people with developmental disabilities will make decisions without really understanding their choices or the consequences of their decisions. Sometimes they will pretend to understand because they don't want to be seen as different. They may start talking about unrelated topics rather than admit that they don't understand.
2. People with developmental disabilities may be easily influenced by other people and by television, magazines and movies. Be aware that some people with developmental disabilities will try to please those they perceive to be authority figures. Keep in mind that you may be seen as an authority figure.
3. Sometimes when people with mental retardation are upset, they will repeat the same words over and over again. They will tune everything else out and won't listen to what they are being asked or told.

The following are some communication tips that should help you when you are speaking with a person with developmental disabilities:

- Try to gain the person's trust. Help the person feel at ease. Use your manner to convey support, warmth, safety and trust.



- Make sure you are being understood. You can do this by:
 - Repeating a question when it isn't answered.
 - Asking open-ended questions.
 - Restating words until they are understood.
 - Using concrete terms and short, clearly stated sentences.
 - Using gestures or pictures that may help express an idea
 - Asking the person to repeat back what he/she understood.
 - Observing facial and non-verbal cues to see if the person is understanding
 - Gently guide the person back to the question or topic if the person goes off topic.
 - Encourage the person to ask questions.
 - Try to speak with the person in a quiet location with minimal interruptions.

- Be yourself and be respectful.

- Don't be put off or annoyed if a person seems angry. Often, under and angry façade, there is a person who really needs your help.

- Let the person finish what he/she is saying. If possible, do not supply the ending.

- Always make sure a person understands his/her choices before he/she makes an important decision.

A Checklist Strategy for Effective Parent-Professional Collaboration:

- Have I put myself in the parent's place and mentally reversed roles to consider how I would feel as the parent of a child with a disability?
- Do I see the person in more than one dimension and do I look beyond the diagnosis or disability?
- Am I able to keep in mind that the person is someone the parent loves?
- Do I really believe the parents are equal to me as a professional and, in fact, are experts on their child?
- Have I explained what service coordination is and what my role is as the individual's Service Coordinator?
- Do I consistently value the comments and insights of parents and make use of their reservoir of knowledge about the child's total needs and activities?



- Do I judge the person in terms of his or her progress and communicate hope to the parents by doing so?
- Do I communicate with my words, appropriate posture, gestures, and eye contact that I respect and value their insights?
- Do I ask questions of parents and listen to their answers and respond to them?
- Do I work to create an environment in which parents are comfortable enough to speak and interact?
- Do I make sure that I am informed about the person before an appointment or group session and do I place equal value on the parent's time with my own time?
- Do I treat parents I come in contact with as adults who understand areas that will be of concern to them regarding their child?
- Do I use plain language, avoiding medical, sociological, psychological or social work jargon?
- Do I make consistent effort to consider the person as part of a family and consult parents about the important people in their child's life and how their attitudes and reaction affect the child?
- Do I distinguish between fact and opinion when I discuss a child's problems and potential with a parent?
- Do I make every effort to steer parents toward solutions and resources providing both written and oral evaluations and explanations as well as brochures about potential services, other supportive arrangement, and financial aid?
- Do I tell each family about other families in similar situations and recognize parents as a major source of support and information and, at the same time, respecting their right to confidentiality?
- Do I provide information to parents when they request it and link parents to support networks as necessary?
- Do I express hope to parents through my attitude and my words and by avoiding absolutes like always and never?
- Do I see as my goal for interactions with parents the mutual understanding of a problem so that we can take action as a team to alleviate the problem?
- Do I actively involve the parents of each person in the establishment of a plan of action and continually review, evaluate and revise the plan with the parents?
- Do I make appointments and provide services at times and in places which are convenient for the family?
- Do I obtain and share information from other appropriate professionals to insure that services are not duplicated and that families do not expend unnecessary energy searching for providers and services?

(Adopted from Portland State University, Research and Training Center on Family Support and Children's Mental Health, Portland State University, Portland, Oregon. Questions for Revised January 2015



this checklist were stimulated by an article in *Social Work*, 32(4), 1987, by Rosemary Alexander and Patricia Tompkins-McGill, edited: *Notes to the Experts from the Parent of a Handicapped Child*).

Working with School Age Children:

As a Service Coordinator in the special education process, you need to be:

- Knowledgeable of the rights of parents of children with disabilities age 3-21.
- Knowledgeable of the IEP process and the role of the Committee on Special Education (CSE).
- Knowledgeable of 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.

Cultural Competence:

Being “culturally competent” is essential to forming a true partnership with the people we support. Our residences and service environments are filled with people whose backgrounds are sometimes far more important than the sum than the sum of their disability. You need to be conscious of these differences and find out more about the culture of the people you serve and how it affects their daily lives. No one is culturally neutral and my attitudes about food, family life, modesty, behavior, religion, etc. are different from yours and from the people we serve. Generalists can be dangerous; each of us is an individual as well as being a member of a group.

Cultural diversity should be appreciated. It makes our world a more interesting place. Understanding a person’s cultural background can help us understand why a person behaves differently from you or me. Culture is a thread which winds through generations and binds them together. It provides richness and value to life. We talk a great deal about



advocacy for people with disabilities, yet we do not always extend this to helping them express their sense of cultural identity. We can show respect for people’s cultural identity by helping them follow their cultural traditions. We can help individuals feel connected to their cultures and decrease their sense of isolation when they use services which are alien to their way of life.

Cultural Competence means:

- Recognizing and respecting that we come from various backgrounds and there are very significant differences from one culture to another.
- Helping individuals discover and explore their own culture.
- Celebrating the differences as well as the similarities.
- Recognizing that other cultures view disability in different ways.
- Acknowledging one’s lack of knowledge and understanding of a individual’s cultural background and being willing to ask for explanations and information.

Common Acronyms

ADA	Americans with Disabilities Act
CMS	Centers for Medicare and Medicaid Services
CR	Community Residence
CSS	Consolidated Supports and Services
DC	Developmental Center
DD	Developmental Disability
DDRO	Developmental Disabilities Regional Office
DDSOO	Developmental Disabilities State Operations Offices
DOH	Department of Health
DQM	Division of Quality Management
EI	Early Intervention
FSS	Family Support Services
HIPAA	Health Insurance Portability and Accountability Act



HCBS	Home and Community Based Services
HUD	Housing and Urban Development
ICF	Intermediate Care Facility
IEP	Individual Education Plan
IRA	Individualized Residential Alternative
ISE	Individualized Service Environment
ISP	Individualized Service Plan
ISS	Individualized Support Services
IWRP	Individualized Work Related Plan
LCED	Level of Care Eligibility Determination
MA	Medicaid
MSC	Medicaid Service Coordinator
OPWDD	Office for People with Developmental Disabilities
PCP	Person Centered Planning
PCSS	Plan of Care Support Services
SA	Self Advocacy
SCAP	Service Coordination Activity Plan
SCOR	Service Coordination Observation Report
SD	Self Determination
SEMP	Supported Employment
SSI	Supplemental Security Income



Five Accomplishments:

There are a number of leading writers in the field of community inclusion. Among them are John O'Brien and Connie Lyle O'Brien who produce a wide range of informational material on person-centered planning, community building, and innovative services and are probably best known for the *Five Accomplishments*. They ask us to focus upon five areas to build community:

- **Community Presence:** First, increase the individual's presence in the community. This may sound rather straightforward, but helping a person to be physically present in the community sometimes can be a difficult task for the habilitation provider. Usually, whenever a person is scheduled to go into the community, the provider must be concerned about how the person will be transported and ensure that sufficient staff to provide assistance are available. Whatever the Service Coordinator can do to help the habilitation provider overcome these obstacles will pay dividends for the individual in the long run.
- **Community Participation:** Second, help the individual to actively participate and develop friendships. Interacting with other, people in the community is an important goal. The interaction is what makes the individual a part of the community, not just an observer.
- **Valued Social Roles:** Third, help the individual find roles that are valued by other members of the community. Look for ways in which that people can give back to their community, be seen as a contributor and not someone who must always be given assistance.
- **Choice:** Fourth, promote choice. What can we do to empower the person to make informed choices about what he or she does throughout the day as well as in the community?
- **Contribution:** Finally, what can be done to support contribution by helping the person to be more competent? What are the skills the person can acquire and demonstrate to others that will make members of the community see him or her as making a contribution?



Pathways to Inclusion (from Beth Mount):

Personal Relationships

The first pathway is building personal relationships. Virtually everyone has special people from the past or present with whom he or she would like to spend time. We should expect that each person would have opportunities to make new friends in the future too. Whatever we can do to preserve and strengthen those personal relationships will lead in time to closer ties to the community.

Associational Relationships

Associational relationships refer to the numerous groups and organizations that exist in almost every community, that help us connect with others who share the same interests and beliefs. Even if you do not know where to find a community group that shares the same interests as the individual, the residential or day staff may know of a group - where to call, whom to contact.

Becoming a “Regular”

Becoming a regular in your community is another great way to build long-term community connections. Just as you and I are recognized by people we see frequently, individuals will build connections to the people they contact repeatedly - day in, day out.

Work and Volunteer Experiences

Fourth, we all make new friends through our jobs or when we volunteer and we should not overlook these opportunities to form natural ties to the community. We should support work or volunteer experience and try to strengthen those friendships wherever we can.

Special Events

Last, we have special events. Special events are a lot of fun. These are the big parties and special occasions that are out of the ordinary. They only take place once in a while and usually have no carry over into the future. That is how special events differ from the previous four pathways we have discussed. Special events shower the individual with a lot of special attention, but there is seldom an opportunity to build up long-term relationships. Once you go to the circus or the concert, it is done. Special events can become a way to build long term relationships or connections to the community by: (a) having the individual bring a friend to share in the event, or (b) if the individual begins to make a connection to a new friend at an event such as a block party or a ball game, being alert to see if there is an opportunity to have additional future contacts.



Beth Mount is a national consultant working with programs throughout the United States to support others to see capacities in people with disabilities.

Strategies for Community Building (from Lee and Caruso):

Look At Self

First, just look at yourself: how do you build ties to your community? Do you practice using a friendly smile when you meet someone new? When you join a group, do you try to find a task you can perform or bring snacks to a meeting to show you want to contribute? Do you go back to the same stores that make you feel welcome? Whatever you do, those are the same skills or “tricks of the trade” we should be encouraging individuals to use. If it works for us, then it should work for them as well.

Natural Bridge Builders

Some folks are natural bridge builders to the community. Look at the residential and day staff that have those natural skills to make connections. Encourage them to take more of a leadership role in finding activities individuals like the most. They enjoy the community, and their enthusiasm will make inclusion happen more often, and make it more enjoyable for everyone.

One Person At A Time

Approach community building one person at a time to make the supports more long lasting. If you try to get staff to do as much as possible for every person, all at once, staff will choose what *they* think is best and not take the time to learn about what the individual prefers. Encourage the residential and day staff to start with the few people for whom they have a clear understanding about what connections should be made in the community. Once you have them connected, then turn your attention to the next people who need to build stronger connections to the community. Remember, as a Service Coordinator you are advocating for the individual to build long lasting relationships, not just participate in community outings that may be meaningless in terms of building long-term relationships.

Shared Experiences

Belonging can come from sharing experiences with people in your group or neighborhood. If there is a windstorm and lots of tree limbs are down, let some of the individual join the neighbors in picking up the limbs and twigs. If the church or temple is collecting clothing



and canned food for earthquake victims, help the individual of that faith participate in the collection too.

Become a “Regular”

Lee and Caruso, like Beth Mount, also recommend a person be a “regular” in his or her community to build up visibility and become acquainted with the same people through frequent contacts.

Listen to People

Listening to people is very important. In the 1970s, community integration meant that staff chose where and when to go out - the individual had little or no input. True inclusion means listening and observing to learn which activities are meaningful and preferred by each person.

Involve Community Members

Involving community members in suggesting solutions to problems is a great strategy. Routine problems like arranging transportation, or deciding what is the best task for the individual to do for the club fund raiser, can probably be most effectively solved by community members that have begun to make a connection to an individual. Keep in mind, as long as the paid staff are viewed as the only ones capable of solving problems, the community people will feel like outsiders, like they are not permitted to get too close. So listen to the ideas of others; they may have better ideas.

Accepting of Differences

When residential and day staff are exploring the neighborhood and looking for interesting groups, they will find some are most accepting of new people. Help staff to understand that building community is hard enough. They may as well start by connecting with the people who are receptive to new people in their midst.

Building on Past Relationships

Building upon a person’s past relationships and heritage is a source of community building that is often overlooked. Almost everyone has family, friends, or neighborhood contacts from the past. Service Coordinators can often discover many excellent community opportunities for individuals just by finding out who are the important people from the individual’s past. Is the person interested in reestablishing contact? Would he or she like to make a visit?



Community Building a Priority

Making community building a priority is important. Any and all opportunities to be involved with the community make the person's life more complete. We do not want to minimize our responsibility to provide safeguards and foster an individual's skill acquisition. But community contacts are very important if we hope to make the individual's life well rounded. Without community connections, people are limited to relationships with paid staff and other people with disabilities. So community building is a priority and one of our most important responsibilities-when identifying the valued outcomes that habilitation staff will support, or when advocating for an individual at his or her residence or day service.

Funding of Services:

It is important that a person's choices receive support from the appropriate Federal, State, and local funding sources. Timely access and ongoing maintenance of a person's benefits and entitlements will greatly facilitate that person's ability to pursue his or her valued outcomes. The various funding sources and their eligibility criteria can be very complex. However, in any instance technical assistance is available from the local Revenue Support Field Office (RSFO). For a listing of RSFOs go to:

http://www.opwdd.ny.gov/opwdd_resources/benefits_information/revenue_support_field_offices

A. Medicaid State Plan Services

Medicaid:

Also known as Medical Assistance, Medicaid is a Federal program that helps disabled, elderly and blind individuals who cannot pay for their medical care. It is always the payer of last resort and any other appropriate source of medical payment must be used first (see below). Medicaid is normally administered by the county Social Services' office. However, depending on the person's place of residence, the program may be available through the OPWDD Revenue Support Field Office (RSFO). Medicaid is a needs-based program, which means the person's income and assets must be below thresholds to qualify.

Medicare:

This is a program administered by the Social Security Administration, which provides comprehensive health insurance to the disabled, elderly, and persons with end-stage kidney disease. Most persons with Social Security or Railroad Retirement benefits, and persons



over the age of 65, are eligible for Medicare benefits. Medicare has two components; Part A and Part B. Part A helps pay inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care. Part B pays for physician services, outpatient hospital services, outpatient physical therapy, and other medical services, supplies, and equipment not covered by Part A.

Third-Party Health Insurance (TPHI):

Health insurance may be available through a person's parents or grandparents as a covered dependent. Increasingly, persons with disabilities are finding health insurance through their own employment. Enrolling in an employer's health insurance plan is mandatory for Medicaid eligible individuals if there is no cost to the employee. If the plan requires employee contributions, enrollment will only be mandatory if Medicaid will pay the contributions for the employee based on a cost-benefit analysis conducted by the Medicaid district.

Low Income Families (LIF) and Single Individual/Childless Couples (S/CC) Programs:

Administered by local Social Services districts, the LIF and S/CC programs provide health insurance coverage for low income families and individuals not otherwise eligible for Medicaid in the aged, blind and disabled categories. While closely related to the financial assistance programs called Family Assistance and Safety Net Assistance, there are some differences in the eligibility criteria.

B. Federal or State Agency Funded Resources:

Supplemental Nutritional Assistance Program (SNAP)

The Supplemental Nutrition Assistance Program (SNAP) is the new name for the Food Stamp Program (effective August 29, 2012) and is designed to supplement the food budget of low-income persons and families. Like Medicaid, it is needs-based which means a person or family's household income and resources must be lower than the program's eligibility criteria. Applications are made to the county Social Services offices, except in NYC where the five counties have a single processing office in Manhattan. In OPWDD state-operated residences, the RSFO is the authorized representative for SNAP applications. SNAP benefits are redeemed by the recipient on a monthly basis and can be used like cash to purchase food at authorized retail food stores.



Adult Career and Continuing Education Services – Vocational Rehabilitation (ACCES-VR)

A unit of the State Education Department, ACCES-VR provides both educational and vocational rehabilitation services to persons with disabilities and their families. For children, ACCES-VR administers Early Childhood Direction Centers that assist families with children with disabilities, birth to age five, find programs and services. ACCES-VR also oversees special education in both public and private schools. In the working world, ACCES-VR offers vocational assessment, vocational counseling, assistance with transition from school to work, job training and placement, and job follow-up.

Commission for the Blind and Visually Handicapped (CBVH):

A unit of the NYS Office of Family Assistance, CBVH provides services to New York State residents who are legally blind. The services include employment training, business enterprise assistance in public buildings, independent living training for persons age 55 or older, and assistance to families with blind/visually impaired children. CBVH counselors are available in their regional offices.

- **Income Sources:**

- a. **Supplemental Security Income (SSI):**

SSI is a federal, needs-based, income program for the disabled, blind and elderly that is administered by the Social Security Administration (SSA). There are financial eligibility requirements that limit the amount of other income and resources a person may have. There are a number of exclusions available to an SSI recipient, including his or her home. Also, personal and household goods, a car and life insurance policies may not count, depending on their value. There is no retroactive eligibility in the SSI program, so prompt filing of an SSI application, either in person or by telephone, for a potentially eligible Individual is critical. Protective filing by telephone can be done by calling SSA at 1-800-772-1213.

- b. **Social Security Disability Income (SSDI):**

SSDI is a federal income program for persons with disabilities that is administered by SSA. There are no income or resources eligibility requirements for SSDI. The individual, his or her parents or adoptive grandparents must have worked long enough to have a qualifying Social Security work record. SSDI eligibility is generally retroactive no more than six months prior to application. Receiving SSDI for 24 consecutive months qualifies the recipient for Medicare.



- **Family Assistance (FA) and Safety Net Assistance (SNA):**

FA and SNA replaced respectively the Aid to Dependent Children and Home Relief programs in 1997. Low income individuals and families who don't qualify for other income support programs may receive cash payments if they meet the income and resource eligibility requirements. Applications must be filed with the local Social Services offices. Qualifying for FA or SNA does not mean automatic qualification for Medicaid under either the LIF or S/CC programs.

- a. **Other (VA, CSA, RRB trusts):**

There are also benefits available to qualified individuals from the Veterans' Administration, the Railroad Retirement Board and Civil Service annuities from the Federal Office of Personnel Management. In addition, persons with disabilities are increasingly benefiting from trusts, either as bequests from third parties or in the form of supplemental needs trusts formed with their own assets. Technical assistance in handling these benefits and entitlements can be obtained from the RSFO.

Other Financial Supports:

Home and Community Based Services (HCBS) Waiver: The HCBS Waiver is a Federally approved Medicaid program that is the primary funding support for the Individualized Service Environment (ISE). Under the waiver, the following services can be provided via Medicaid: residential habilitation, day habilitation, prevocational support, supported employment, respite, environmental modifications, adaptive equipment, family education and training, plan of care support services, live-in caregiver and consolidated supports and services. Enrollment in the HCBS Waiver is done through OPWDDs Developmental Disabilities Services Offices (DDSO).



Useful Information for Medicaid Service Coordinators:

Here are some links that will be useful to you in your role as an MSC:

- We encourage you to become familiar with the OPWDD Website at:

www.opwdd.ny.gov

- MSC Redesign Information – continually updated information on MSC including links to Administrative Memorandums, MSC Vendor Manual, ISP Forms, MSC E-Visory, etc.

http://www.opwdd.ny.gov/opwdd_services_supports/service_coordination

- MSC E-Visory: The MSC E-Visory is an electronic advisory distributed to MSC Supervisors. Each issue provides pertinent and timely information about programs and services available to individuals receiving MSC. Announcements about MSC training, conferences and meetings appear regularly.

http://www.opwdd.ny.gov/opwdd_services_supports/service_coordination/medicaid_service_coordination/msc_e-visories

- OPWDD Brochures:

http://www.opwdd.ny.gov/news_and_publications/brochures/general_information

- Consolidated Supports and Services:

http://www.opwdd.ny.gov/opwdd_services_supports/supports_for_independent_and_family_living/consolidated_supports_and_services

- Aging Services:

http://www.opwdd.ny.gov/opwdd_community_connections/aging_information_corner

- Self Advocacy Association of NY State (SANYS):

http://www.opwdd.ny.gov/opwdd_services_supports/itsyourchoice/self_advocacy_association_of_new_york_sanys



Other Resources Available at Your Agency:

Details about your responsibilities will come from a variety of sources, including:

- The appropriate policy manual or regulation
- Your supervisor
- Core training
- Continued training provided by your agency, other sources, and OPWDD
- The *Medicaid Service Coordination Vendor Manual*
- The Key – The Home and Community-Based Services Provider Guide
- *OPWDD Regulations: Part 624: Reportable Incidents, Serious Reportable Incidents and Abuse in Facilities Operated or Certified by OPWDD.*
- *OPWDD Regulations: Part 633: Protection of Individuals Receiving Services in Facilities Operated and/or Certified by OPWDD.*
- *OPWDD Regulations Part 635: General Quality Control and Administrative Requirements Applicable to Programs, Services or Facilities funded or Certified by OPWDD.*

Additional MSC job responsibilities can be found in the following sources:

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

Copies of the above should be available at your agency. Please check with your supervisor on where this information is located.



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: Bernard Fineson

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 or 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:	<input type="checkbox"/> Request for MSC APPROVED for TABS processing <input type="checkbox"/> Request for MSC WITHDRAWN by individual <input type="checkbox"/> Request for MSC DENIED
Reason for Denial:	
<input type="checkbox"/> Individual is not enrolled in Medicaid. <input type="checkbox"/> Individual does not have a diagnosis of a developmental disability. <input type="checkbox"/> Individual is permanently enrolled in another comprehensive Medicaid long term care service coordination program. <input type="checkbox"/> Individual currently resides in an ICF/MR, ICF/DD or in another Medicaid facility that provides service coordination. <input type="checkbox"/> Individual did not respond to request for information. <input type="checkbox"/> Individual does not meet the need for ongoing and comprehensive service coordination.	
Signature of DDSO MSC Coordinator:	Date:
Data Entry Person's Initials:	Date:



**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 pending 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 pending 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.**



Individual Request For Change of Medicaid Service Coordination Vendor			
Section I. Individual Information			
Name: Last	First	MI	TABS ID# (if known)
Address: (Street)		Date of Birth:	Social Security Number:
City:	State:	ZIP Code:	Phone:
		Medicaid Number:	
		DDSO: Bernard Fineson	
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?			
<input type="checkbox"/> Yes		<input type="checkbox"/> No	Effective Date:
TABS Program Code for New MSC Vendor:			
Program Code:			
Signature of DDSO MSC Coordinator			Date:
Data Entry Person's Initials:			Date:

Print Form



**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/DSO Information* : This section identifies the current MSC vendor/DSO. 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/DSO. 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

Print Form

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:
[]	NY	[]	[]	[]

Section II. Current MSC Vendor/DDSO Information

Vendor/DDSO Name:	[]		
Vendor address:	[]		
City:	State:	ZIP Code:	
[]	NY	[]	
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 deceased;

Individual is no longer enrolled in Medicaid;

Individual is now permanently residing in an ICF/MR or ICF/DD, or another Medicaid facility that provides service coordination;

Individual is enrolled in another Medicaid funded service coordination program;

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

Individual moved out of state;

Individual moved out of catchment area; []

Other reason (specify): []

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

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

Individual has been withdrawn from MSC. Effective Date: []

Individual voluntarily withdrew from MSC. Effective Date: []

Removal from Program Reason:

Individual is deceased;

Individual is no longer enrolled in Medicaid;

Individual is now permanently residing in an ICF/MR or ICF/DD, or another Medicaid facility that provides service coordination;

Individual is enrolled in another Medicaid funded service coordination program;

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

Individual moved out of state;

Individual moved out of catchment area; []

Other reason (specify): []

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:
[]	[]	[]	[]

**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 by 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.

If the Individual is participating in the HSBS Waiver, 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:*

Individual has withdrawn from MSC due to no longer meeting eligibility criteria: 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 sign and dates the form and forwards the form to the data entry person.

Individual Voluntarily Withdraws from MSC: 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.**

Add Individual to Plan of Care Support Services: If the Individual voluntarily withdraws from MSC or is found to no longer meet the need for ongoing and comprehensive service coordination 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.



MSC – Individual Withdrawal Verification Form

Section I. Individual Information

Name: Last	First	MI
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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 NA 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 NA 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 NA **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:
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STATE OF NEW YORK
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MSC4 - VER

Specify basis for DDSO denial:

A large, empty rectangular box intended for the user to specify the basis for a DDSO denial.



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.



STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

MSC5 – MSCA
October 1, 2012

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 Receiving MSC _____ **Date** _____

Family Member/Advocate _____ **Date** _____

MSC Vendor _____ **Date** _____

Service Coordinator _____ **Date** _____

Service Coordinator Supervisor _____ **Date** _____



**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 CCM 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).



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/DDS 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.



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MSC7 - SCOR

- B. Did you observe or become aware of any event or situation which may be considered abuse according to the definition in Part 6247
 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:**

- 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 , or 2nd and 3rd and 4th quarter cycle for completing an Individual's mandatory SCOR. (Refer to the MSC Vendor Manual for further guidance.)
- A SCOR should not be completed for an Individual living in his/her own family home or living in a non-OPWDD certified home.
- For all certified sites, a SCOR must be completed whenever a serious problem is identified during a home visit.
- 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.
- 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.
- 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.
- 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 facilitates 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.



Medicaid Service Coordination Activity Plan

Individual's Name:

Date of Initial
Activity Plan

Date of 6
Month Review

MSC's Name:

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		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>

Service Request or Personal Goal:

Activities to Complete	Who will complete Task				Start Date	Check if Task is Done
	MSC	Ind.	Fam.	Other		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>

Service Request or Personal Goal:

Activities to Complete	Who will complete Task				Start Date	Check if Task is Done
	MSC	Ind.	Fam.	Other		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>



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MSC9 - SCAP

Service Request or Personal Goal:		Who will complete Task				Start Date	Check if Task is Done
Activities to Complete	MSC	Ind.	Fam.	Other			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	

Service Request or Personal Goal:		Who will complete Task				Start Date	Check if Task is Done
Activities to Complete	MSC	Ind.	Fam.	Other			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	

Service Request or Personal Goal:		Who will complete Task				Start Date	Check if Task is Done
Activities to Complete	MSC	Ind.	Fam.	Other			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	

Service Request or Personal Goal:		Who will complete Task				Start Date	Check if Task is Done
Activities to Complete	MSC	Ind.	Fam.	Other			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	



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? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Date of ISP Review:
Was the Service Coordination Agreement reviewed this month? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Date of SCA Review:
Was the Individual Present at Review? <input type="checkbox"/> Yes <input type="checkbox"/> No	Initial & Date (mth/dy/yr):

ICF/MR Level of Care Eligibility Determination

Was the Level of Care Eligibility Determination (LCED) completed this month? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Date LCED was completed:	Initial & Date (mth/dy/yr):
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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.



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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)



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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	<p>Complete this section to include:</p> <ol style="list-style-type: none">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. <p>The monthly summary may also be used to document outcomes of an ISP review meeting and other relevant information.</p>
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.



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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? <input type="checkbox"/> yes <input type="checkbox"/> no	If Yes, Date of ISP Review:
Was the Service Coordination Agreement reviewed this month? <input type="checkbox"/> yes <input type="checkbox"/> no	If Yes, Date of SCA Review:
Was the Individual Present at Review? <input type="checkbox"/> yes <input type="checkbox"/> no	

ICF/MR Level of Care Eligibility Determination

Was the Level of Care Eligibility Determination (LCED) completed this month? <input type="checkbox"/> yes <input type="checkbox"/> 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: _____	Date (mth/dy/yr): _____
Printed Name: _____	Title: _____

Attach additional sheets if necessary

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



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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)



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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	<p>Complete this section to include:</p> <ol style="list-style-type: none"> 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. <p>The monthly summary may also be used to document outcomes of an ISP review meeting and other relevant information.</p>
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.



ISP Instructions and Appendix

- Please follow the link:

http://www.opwdd.ny.gov/opwdd_careers_training/training_opportunities/documents/ISPInstructions