

MSC E-VISORY

Issue #06-12

March 13, 2012

State of New York Office for People With Developmental Disabilities
Courtney Burke, Commissioner
Distributed by: Division of Person-Centered Supports
Gerald Huber, Acting Deputy Commissioner

The MSC E-Visory is an electronic advisory which provides pertinent and timely information about programs and services available to individuals receiving MSC. Announcements about MSC training, conferences and meetings appear regularly. **MSC Supervisors: Please share this issue with all MSC Service Coordinators and others as appropriate.** In order to receive an email notification when a new MSC E-Visory is posted, please sign up for our mailing list (listserv). Listserv information and past issues can be accessed via the following link:

http://www.opwdd.ny.gov/wt/publications/wt_publications_mscevisorios_index.jsp

In This Issue:

Habilitation Plan Requirements

Administrative Memorandum (ADM) #2012-01, dated March 7, 2012, with an effective date of April 1, 2012, has been issued by OPWDD. This ADM, entitled "Habilitation Plan Requirements" is designed to clarify the policy expectations and billing documentation requirements surrounding the development, issuance, review and retention of Habilitation Plans for individuals served by OPWDD Habilitation Services. Below are some highlights of this ADM:

1. Defines in clearer detail the timeframe for development of an initial Habilitation Plan and further defines the qualities that go into its development.
2. Provides additional guidance regarding what occurs during the review of an existing Habilitation Plan.
3. Changes the Habilitation Plan review to an "at least twice annually" timeframe in order to align with instructions from the revised ISP and clarifies that Habilitation Reviews should be coordinated with ISP reviews.
4. Discusses valued outcomes and indicates that valued outcomes in the Habilitation Plan do not need to be listed verbatim as they appear in the ISP. The expectation is that there is a match, a clear connection between the two, but absolute verbatim is not required.
5. Adds a component to allow for multiple services to be listed in one Habilitation Plan if the services are provided by the same provider, however, there must be separate sections that describes the supports and services associated with each service.
6. Provides a statement that the "Habilitation Plan with any addendums or revisions and services described remain in effect until a new Habilitation Plan is written".
7. Provides an optional format for Habilitation Plans similar to the ISP format.

Ongoing and Comprehensive Need for Medicaid Service Coordination

Attached to this e-visory is guidance designed to assist in determining whether an individual has an ongoing and comprehensive need for Service Coordination.

To receive Medicaid Service Coordination a person must demonstrate that they have a need for ongoing and comprehensive service coordination. The information attached provides clarification on what is meant by "ongoing and comprehensive" and is to be used as a guide in determining whether a particular individual meets that need. The worksheet may be used to assist when making such a determination. Any questions regarding this guidance may be directed to Eric Pasternak, OPWDD Division of Person-Centered Supports at 518 474-1274 or eric.pasternak@opwdd.ny.gov.

Division of Person-Centered Supports

Gerald Huber, Acting, Deputy Commissioner

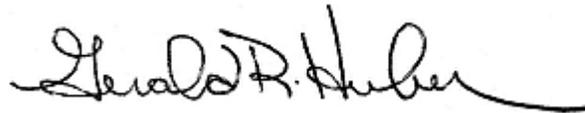
ADMINISTRATIVE MEMORANDUM - #2012-01

44 Holland Avenue
Albany, NY 12229-0001

TEL: 518-473-9697
FAX: 518-473-0054
TTY: 866-933-4889

www.opwdd.ny.gov

TO: Executive Directors of Voluntary Provider Agencies
Executive Directors of MSC Vendors
DDSO Directors



FROM: Gerald Huber, Deputy Commissioner
Division of Person-Centered Supports

SUBJECT: Habilitation Plan Requirements

DATE: March 7, 2012

EFFECTIVE DATE: April 1, 2012

Suggested Distribution:

Habilitation Program/Service Staff
Quality/Compliance Staff
Billing Department Staff
MSC Service Coordinators and Service Coordinator Supervisors

Applicability:

This information is applicable for all individuals currently receiving, or seeking to receive habilitation services through the OPWDD service system.

The information in the attached materials is effective April 1, 2012.

Purpose:

Effective April 1, 2012, this Administrative Memorandum (ADM) issued by the Office for People With Developmental Disabilities (OPWDD) describes the Habilitation Plan and the program standards and payment standards of the Habilitation Plan. This ADM also serves to bring Habilitation Plan review processes in line with ISP review processes changed in ADM #2010-04 "Program Standards: Individualized Service Plan (ISP) Format and Timeframes for Review and

ADMINISTRATIVE MEMORANDUM #2012-01
Habilitation Plan Requirements
Effective April 1, 2012

Distribution.” The requirements in this ADM apply to habilitation plans written or reviewed on or after April 1, 2012, and to the services delivered in accordance with those habilitation plans, whether the services are delivered to individuals who are enrolled in the Home and Community Based Services (HCBS) waiver or to non-waiver enrolled individuals. Requirements set forth in this Administrative Memorandum supersede OPWDD ADM #2003-03 and provisions of the “Key to Individualized Services” (OPWDD, 1997) related to Habilitation Plans.

Habilitation services include:

- (a) Residential Habilitation in certified sites: Individualized Residential Alternative (IRA), Community Residence (CR) and Family Care;
- (b) Day Habilitation;
- (c) Community Habilitation;
- (d) Prevocational Services; and
- (e) Supported Employment (SEMP).

This ADM also provides guidelines about the monthly summary note documentation.

Defining the Habilitation Service and Habilitation Plan:

Habilitation services are designed to assist participants in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation Plans describe what staff (this term includes family care providers) will do to help the person reach his/her valued outcome(s) that have been identified in the Individualized Service Plan (ISP). Habilitation services involve staff teaching a skill, providing supports and exploring new experiences. The regulations that govern habilitation services are 14 NYCRR Parts 624, 633, 635, 671, and 686.

Habilitation Plan Program Standards:

The Habilitation Plan Program Standards are designed to provide guidance to service providers regarding the expected level of a quality habilitation service. These standards will be reviewed by OPWDD’s Division of Quality Improvement and may be subject to corrective actions, however, they are not considered to be a specific requirement to justify billing, unless there is a separate standard identified in the Habilitation Plan Payment Standards section below.

Initial Habilitation Plan

The initial Habilitation Plan must be written by the habilitation service provider and should be developed in collaboration with the person, their advocate and service coordinator. The initial

Habilitation Plan must be written and forwarded to the service coordinator within 60 days of the start of the habilitation service.

General Guidance for Developing the Habilitation Plan

The Individual's Individualized Service Plan (ISP) describes who the person is, what he/she wants to accomplish and who or what will help the individual to accomplish these things. The details on how this will be accomplished are described in the Habilitation Plan. Therefore, Habilitation Plans are not developed merely by copying information directly from the ISP. It is expected that the ISP and the valued outcomes are the starting point to developing the Habilitation Plan

The next step to developing the Habilitation Plan is in listening, discovering and understanding the individual. The Habilitation Plan should be a collaborative process between habilitation staff and the individual. When getting to know the individual, habilitation staff should look at the individual's background, health, lifestyle, habits, relationships, abilities and skills, preferences, accomplishments, challenges, culture, places he or she goes, beliefs, and hopes and dreams. Staff should also ensure that the individual has opportunities for choice, community inclusion, and decision making.

After getting to know the individual and looking at what the individual needs and wants from the habilitation service, the agency should assess an individual's current skill level by observing the individual and collecting baseline data. After the assessment, the agency determines the methodology for the service(s) and/or support(s) that the agency provides.

It is through this process that the Habilitation provider is able to help the individual reach his/her outcomes and does not just simply continue repeating the past.

Habilitation Plan Reviews

Once the Habilitation Plan has been implemented, the Habilitation Plan must be reviewed at least twice annually. This review is the agency's and the individual's opportunity to reassess the plan and its services. During this review the habilitation provider should also consider an individual's progress and the prevention of regression.

The Habilitation Plan review should include discussion on the services and supports that have been provided up to this point and what the challenges have been and what new strategies or methodologies may need to be used. Those reviewing the Habilitation Plan should establish objectives to be met before the next periodic review and establish agreement on those objectives. Finally the review should include recognition of the accomplishments that the individual has achieved since the last review.

Revised Habilitation Plans, which are also written by the habilitation service provider, must be sent to the person's service coordinator no more than 30 days after either: (a) an ISP review date, or (b)

the date on which the habilitation service provider makes a significant change in the Habilitation Plan. If the habilitation provider fails to send the Habilitation Plan within the 30 day time frame, the habilitation provider is then responsible for distributing the Habilitation Plan to the service coordinator and all other required parties including other Waiver Service Providers, the individual being served and/or his/her advocate.

Each Habilitation Plan must be reviewed and revised as necessary when there is a significant change in the habilitation service. At a minimum, the Habilitation Plan must be reviewed (and revised as necessary) at least twice annually and should be coordinated with the ISP reviews. It is recommended that these occur at six month intervals. At least annually, one of the Habilitation Plan reviews must be conducted at the time of the ISP meeting arranged by the person's service coordinator. This meeting should include the individual, the advocate, and all other major service providers.

Four Required Sections of the Habilitation Plan

Every Habilitation Plan must include the following sections:

- 1) Identifying information. This must include the individual's name, the individual's Medicaid ID number, the name of the habilitation provider, identification of the habilitation service, the review date, and any other information that the agency deems useful.
- 2) Valued Outcomes. The person's valued outcome(s) are derived from the ISP. The habilitation service must relate to at least one of the individual's valued outcomes. Using these valued outcomes as a starting point, the Habilitation Plan describes the actions that will enable the person to reach the particular valued outcome(s). A single Habilitation Plan may address one or more valued outcomes.
- 3) Staff Services and Supports. A Habilitation Plan is individualized by using the person's valued outcomes as a starting point. The Habilitation Plan must address one or more of the following strategies for service delivery: skill acquisition/retention, staff support, or exploration of new experiences. The strategies are discussed below. The habilitation service provider should use its best judgment, and in consultation with the person and his/her service coordinator, decide which service strategies are to be addressed in the Habilitation Plan. The Habilitation Plan must be specific enough to enable new habilitation service staff to know what they must do to implement the person's Habilitation Plan.
 - a. Skill Acquisition/retention describes the services staff will carry out to make a person more independent in some aspect of life. Staff assess the person's current skill level, identify a method by which the skill will be taught and measure progress

ADMINISTRATIVE MEMORANDUM #2012-01
Habilitation Plan Requirements
Effective April 1, 2012

periodically. The assessment and progress may be measured by observation, interviewing staff or others who know the person well, and/or by data collection.

Skill acquisition/retention activities should be considered in developing the Habilitation Plan. Further advancement of some skills may not be reasonably expected for certain people due to a medical condition, advancing age or the determination that the particular skill has been maximized due to substantial past efforts. In such instances, based on an appropriate assessment by members of the habilitation service delivery team, activities specified in the Habilitation Plan can be directed to skill retention.

- b. Staff Supports are those actions that are provided by the habilitation staff when the person is not expected to independently perform a task without supervision and are essential to preserve the person's health or welfare, or to reach a valued outcome. Examples are assistance with personal hygiene or activities of daily living. Staff oversight of the person's health and welfare is also a part of the habilitation service (e.g., when staff accompanies people in the community or provides first aid).
 - c. Exploration of new experiences is an acceptable component of the Habilitation Plan when based on an appropriate review by the habilitation service provider. Learning about the community and forming relationships often require a person to try new experiences to determine life directions. This trial and error process eventually enables the person to make informed choices and, consequently, to identify new valued outcomes that then become part of the ISP and the Habilitation Plan.
- 4) Safeguards. The safeguards delineated in Section 1 of the ISP are used as the starting point for the habilitation service provider. Safeguards are necessary to provide for the person's health and safety while participating in the habilitation service. All habilitation staff supporting the person must have knowledge of the person's safeguards. Either including the safeguards in the Habilitation Plan or referencing the safeguards in an attached document is acceptable. For additional information on safeguards, see the memorandum "Supporting Individuals to Achieve Personal Safety and Wellbeing" issued on 10/17/2011 and is available on the OPWDD website at www.opwdd.ny.gov.
- a. Safeguards for persons receiving IRA Residential Habilitation must be addressed in the individual's Plan for Protective Oversight in accordance with 14 NYCRR Section 686.16. The individual's Plan for Protective Oversight must be *attached* to the IRA Residential Habilitation Plan.
 - b. For all other habilitation services (Residential Habilitation in Family Care and Community Residences, Community Habilitation, Day Habilitation, Prevocational Services, Consolidated Supports and Services, and Supported Employment)

safeguards must be *included* in the Habilitation Plan or the plan must *reference* other documentation that specifies the safeguards. *Information on the safeguards must be readily available to the habilitation service provider staff.*

For example:

- i. A safeguard *included* in the Habilitation Plan for a person with exercise-induced asthma might state that he or she must use an inhaler prior to any physical activity.
 - ii. The Habilitation Plan might *reference* the nutritional plan notebook located in the program office, which contains information on the individual's food allergies.
- c. As required in 14 NYCRR Part 633, the medication records are distinct and separate from the Habilitation Plan. The Habilitation Plan references the medication records as containing important health related information when applicable. If the habilitation service provider is teaching the person to self-administer medication, that activity and methodology should appear in the Habilitation Plan.
- d. Providers of residential habilitation must have written procedures for providing back-up supports to individuals when the absence of the provider's regularly scheduled staff would pose a threat to the person's health or safety. For IRAs, this information must be included in site-specific Plans for Protective Oversight and in Individual Plans for Protective Oversight as appropriate.

Habilitation Plan Format

An optional Habilitation Plan Format has been issued with this Memorandum. Providers may use this format or create their own; however, the Habilitation Plan must include the minimum information as described in this ADM. Habilitation providers are expected to write plans that not only include the information required by this memorandum, but also clearly communicate information to the habilitation staff and illustrate the steps staff are taking to address an individual's needs.

Habilitation Plan Payment Standards:

The following standards define the documentation which must be retained to support a service claim by the provider.

ADMINISTRATIVE MEMORANDUM #2012-01
Habilitation Plan Requirements
Effective April 1, 2012

For every habilitation service, an individual must have a Habilitation Plan that contains the following elements:

- 1) The individual's name.
- 2) The individual's Medicaid Identification Number (CIN), if the person is a Medicaid enrollee.
- 3) The habilitation service provider's agency name.
- 4) Identification of the habilitation service(s) provided.
- 5) The date on which the Habilitation Plan was reviewed.
- 6) Identification of at least one valued outcome that is derived from the individual's ISP (valued outcomes do not need to be verbatim from the ISP).
- 7) Description of the services and supports the habilitation staff will provide to the person.
- 8) The safeguards (health and welfare) that will be provided by the habilitation service provider.
- 9) The printed name, signature and title of the staff who wrote the Habilitation Plan.
- 10) The date that staff signed the Habilitation Plan.

In addition, there must be evidence that the Habilitation Plan was reviewed within 12 months prior to the month in which the service occurs. Evidence of a review may include but is not limited to a review sign-in sheet, a service note indicating a review, or a revised/updated Habilitation Plan. Evidence of reviews must include:

- 1) The individual's name.
- 2) The habilitation service(s) under review.
- 3) The staff's signature(s) from the habilitation service.
- 4) The date of the staff's signature.
- 5) Date of the review.

Service Claim Documentation

As noted, the initial Habilitation Plan must be in place within 60 days of the start of the habilitation service. Therefore, services that are provided within the first 60 days of the start of the habilitation service may not necessarily have a Habilitation Plan in place.

Habilitation Plans with Multiple Services

Habilitation Plans may include multiple habilitation services (such as residential habilitation, day habilitation, prevocational services, and SEMP), if the services are all provided by the same agency.

ADMINISTRATIVE MEMORANDUM #2012-01
Habilitation Plan Requirements
Effective April 1, 2012

For Habilitation Plans that incorporate multiple habilitation services, the Habilitation Plan must have a separate section that describes the supports and services associated with each service. When the same support/service is delivered in multiple habilitation services, the service/staff action must be identified in each supports and services section of the Habilitation Plan.

For each habilitation service described on the Habilitation Plan, one staff from each habilitation service should assist with writing the plan and include his/her name, title, signature, and signature date on the Habilitation Plan. Evidence of a habilitation review must include a staff signature from each habilitation service.

Documentation Retention

18 NYCRR Section 504.3(a) states that by enrolling in the Medicaid program, “the provider agrees...to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request, to...the Secretary of the United States Department of Health and Human Services, the Deputy Attorney General for Medicaid Fraud Control and the New York State Department of Health.” In addition, 18 NYCRR Section 517.3(b)(2) states that “All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. . . .” It should be noted that there are other entities with rights to audit Medicaid waiver claims as well, including OPWDD.

Additional Information

For additional information about the Habilitation Plan, please contact OPWDD Division of Person-Centered Supports at (518) 474-5647.

cc: Provider Associations
Jill Gentile
Eric Pasternak
Eugenia Haneman
Maryellen Moeser
Tricia Downes
Lisa Kennedy

Attachments: Habilitation Plan Template

[Insert Agency Name]
[Insert Individual's Name]

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

The following is an optional format for Habilitation Plans. Providers may, or may not, choose to use the outline as it appears here. The choice of whether or not to use the outline is an agency management decision that should be based on factors such as past success using their current plan format, review team comments about needed plan improvements and other pertinent factors. This is an optional Habilitation Plan format that may be followed by providers. The instructions under each header are provided for guidance and may be removed.

Insert Agency Name

Insert service(s) name(s) Habilitation Plan

Name of Person: _____ Medicaid Number (CIN#): _____
Habilitation Plan Review Date: _____

Valued Outcome(s)

The habilitation provider uses at least one of the valued outcomes stated in the Individualized Service Plan (ISP) as the starting point to develop the habilitation activities and periodic staff supports that will appear in the plan. The valued outcome does not need to be verbatim from the ISP.

Example - Kevin likes to have contact with his brother and his family.

Staff Services and Supports

This section contains the services the individual needs to reach his or her valued outcome or those supports in which the individual has maximized his/her skills.

Habilitation Activities

The plan can, and often should, address priority needs that may not be directly correlated to one or more valued outcomes. A plan may contain valued outcomes or habilitation activities to support the valued outcomes or staff supports. For example, a person with a valued outcome to spend time with a special friend may have a plan that contains activities to learn how to use a telephone, how to travel safely in the community, etc. The same plan may have staff supports to ensure the person is dressed appropriately for the weather when he/she goes out with the friend.

Example: Staff will teach Kevin to call his brother on the phone. Staff will teach Kevin to recognize the numbers: 0, 1, 2, 3, and 4 using verbal prompts, five days per week

Periodic Staff Supports

[Insert Agency Name]

[Insert Individual's Name]

This section may contain the supports a person needs for which the individual has reached his or her maximum skill level or the staff supports continue to be needed by the person, but the supports have very little relationship to a valued outcome. For example, an adult may have maximized his/her tooth brushing skills. The person still needs reminders or some physical assistance by staff to adequately brush his or her teeth. Recording such staff supports in the plan gives a more accurate picture of the person's needs and also allows the agency staff to take full credit for all the work they perform to properly care for people.

Safeguards

This section is also known as "Plan for Protective Oversight" in Individual Residential Alternatives (IRAs) regulated under 14 NYCRR Part 686.16 or Health and Welfare in other venues where waiver services are provided. As cited above, this section can list all the safeguard needs and the staff actions that will be taken or it can list the safeguard needs and refer the reader to other documents in the record that address each need.

Required Signature:

Habilitation plan author's Name: _____ Title: _____

Habilitation plan author's Signature: _____ Date: _____

Optional Signatures

Person: _____ Date: _____

Advocate: _____ Date: _____

Supervisor/reviewer: _____ Date: _____

What does the Need for “Ongoing and Comprehensive” Service Coordination Mean?

To receive Medicaid Service Coordination a person must demonstrate that they have a need for ongoing and comprehensive service coordination. The following information provides clarification on what is meant by “ongoing and comprehensive” and is to be used as a guide in determining whether a particular individual meets that need. Also included in this guidance is a worksheet that may be used to assist when making such a determination.

1. The person’s need for service coordination is clearly ongoing and not episodic.
 - MSC is not to be used solely for establishing eligibility for the HCBS Waiver in order to obtain Medicaid.
 - The individual requesting services does not already have their needs met through natural and other supports already in place.
 - The person has needs that are so significant as to need the ongoing assistance of a service coordinator to maintain/prevent setbacks that are likely to result in crisis or the need for higher level services or the loss of necessary supports and services.

2. The person’s need for service coordination is “comprehensive”, meaning all inclusive or covering widely. This means that the person demonstrates at least one of the following:
 - Unmet needs in multiple areas or life domains in which the assistance of a service coordinator is necessary.
 - Health and safety or the person’s general well-being would potentially be jeopardized if not for the ongoing interventions, monitoring, advocacy and assistance specifically provided by the service coordinator.
 - Major life changes or changes in the person’s daily life activities that have occurred over the last six months or are likely to occur within the next 12-18 months.
 - Reconfiguration of services that have occurred over the last six months or are likely to occur within the next 12-18 months.

Examples of reconfigured services and/or major life/daily life activity changes include but are not limited to: valued outcomes that indicate movement from a certified residence to one’s own home or apartment; seeking to obtain employment; and transitioning to more individualized self-directed services.

3. The ongoing assistance of a service coordinator is necessary for the timely and effective arrangement of needed services/supports (including health and safety related services/supports and monitoring/advocacy) and helping to sustain those services/supports and/or the ability to explore services/supports that will likely result in more individualized and less restrictive services/support options. This ongoing assistance is facilitated through activities associated with: (a) plan development, **AND** (b) plan implementation, **AND** (c) plan maintenance and monitoring.

- This means that it is likely that the service coordinator can successfully assist the person with their ongoing and comprehensive needs within a reasonable period of time by developing, implementing, and monitoring/maintaining the plan of care and arranging for service linkages for the person and providing other allowable service coordination interventions/actions (assessment, service plan development, implementation, monitoring, maintenance, referrals and linkages, and advocacy).
- This can also mean that the person needs the relationship, ongoing assistance, and encouragement provided by a service coordinator to be challenged to think about and explore more individualized and/or less restrictive service options (e.g., moving out of a certified residence) that they may not have ever considered in the absence of this relationship and ongoing communication with their service coordinator. These interactions and discussions must be clearly documented in the service coordination record.
- The service coordination records need to clearly indicate that without specific identified service coordination interventions, the person would be prevented from accessing and maintaining needed community resources necessary for health, safety, community integration, and quality of life and therefore health services, residential placement, and other needed supports/services would be in jeopardy and regression would occur or the person would be prevented from exploring options that would enable them to live a meaningful life.

Expectations for Ongoing and Comprehensive Service Coordination:

- Over time, through the ongoing and comprehensive service planning process, the service coordination records should show that unmet needs become met needs as a result of service coordination activities.
- Over time, a person's valued outcomes and service configurations will likely show changes due to the ongoing and comprehensive planning and implementation work between the person and their service coordinator.
- When individuals are already enrolled in MSC, if the service coordination records do not show any changes to valued outcomes and corresponding supports and services within a reasonable amount of time (e.g., such as 12-18 months) and/or there is no other indications in the service coordination records that indicate that progress is being made or that demonstrates that the service coordination staff interventions/activities are helping to sustain the person in his/her community or are otherwise, useful and not duplicative of what other services and supports are required to provide and/or what parents of minor children are reasonably expected to provide (e.g., health monitoring in 24 hour certified settings; for minor children under the age of 18, parents should be monitoring that routine health services are obtained/received), it can be reasonably assumed that the ongoing assistance of a service coordinator is not necessary.
- Individuals who are waiver enrolled and who are no longer eligible for MSC will be withdrawn from MSC and transferred to Plan of Care Support Services (PCSS). All withdrawals from MSC must be carried out in accordance with due process procedures as outlined in the MSC Vendor Manual.



Medicaid Service Coordination (MSC) Assessment of the Need for Ongoing and Comprehensive Service Coordination

This worksheet may be used to assist in making the determination as to whether a person meets the need for ongoing and comprehensive service coordination. Complete the following items and the accompanying checklist.

Name of Individual: _____

1. Identify all services and supports the person currently receives.

	Current Services/Supports Received	Funding Source	Describe how the person currently accesses these services, i.e. who helps the person obtain/maintain these services?
1.			
2.			
3.			
4.			
5.			

2. Identify the person's unmet needs for which the assistance of a service coordinator is necessary. For each unmet need describe anticipated actions by the service coordinator that will assist the person to meet this need, and the anticipated timeframe that is likely for this need to be met (in months).

	Unmet Need	Service Coordinator Actions	Time Frame
1.			
2.			
3.			
4.			
5.			

3. Clearly describe potential and/or likely consequences/implications for the individual if they were to not receive MSC.

	Yes	No
<p>1. Is the person's need for service coordination clearly ongoing and not episodic in nature?</p> <p>MSC is not to be used solely to establish eligibility for HCBS Waiver services to obtain Medicaid. The individual requesting services does not already have their needs met through natural or other supports that are already in place.</p>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the person's need for service coordination comprehensive?		
a. Does the person exhibit unmet needs in multiple areas or life domains?	<input type="checkbox"/>	<input type="checkbox"/>
b. Are the person's needs so significant as to need the ongoing assistance of a service coordinator to maintain/prevent setbacks that are likely to result in crisis or the need for higher level services or the loss of necessary supports and services if not for the interventions and assistance specifically provided by the service coordinator?	<input type="checkbox"/>	<input type="checkbox"/>
c. Would the person's health and safety or general well-being be potentially jeopardized if not for the <u>ongoing</u> interventions, monitoring, advocacy and assistance specifically provided by the service coordinator?	<input type="checkbox"/>	<input type="checkbox"/>
d. Has the person experienced major life changes or changes in daily life activities that have occurred over the last six months or are anticipated in the next 12-18 months?	<input type="checkbox"/>	<input type="checkbox"/>
e. Has the person experienced a reconfiguration of services over the last six months or is a reconfiguration of services anticipated in the next 12-18 months?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the ongoing assistance of a service coordinator necessary for the timely and effective arrangement of needed services/supports and helping to sustain those services/supports and/or the ability to explore services/supports that will likely result in more individualized and less restrictive services/support options?		
a. Is it likely that the service coordinator can successfully assist the person with their ongoing and comprehensive needs within a reasonable period of time by performing allowable service coordination functions?	<input type="checkbox"/>	<input type="checkbox"/>
b. Does the person need the relationship, ongoing assistance, and encouragement provided by a service coordinator to be challenged to think about and explore more individualized and/or less restrictive service options?	<input type="checkbox"/>	<input type="checkbox"/>
c. In the absence of service coordination, would the person be prevented from accessing and maintaining needed community resources necessary for health, safety, community integration, and quality of life and therefore health services, residential placement, and other needed supports/services would be in jeopardy and regression would occur or the person would be prevented from exploring options that would enable them to live a meaningful life?	<input type="checkbox"/>	<input type="checkbox"/>

The individual meets the need for ongoing and comprehensive service coordination if:

- The answer to 1 is yes.
AND
- At least one yes in a-e for number 2.
AND
- At least one yes in a-c for number 3.

Indicate whether the individual meets the need for ongoing and comprehensive service coordination?	
Yes <input type="checkbox"/>	No <input type="checkbox"/>

Completed by: _____ Title: _____ Date: ____ / ____ / ____

Agency: _____