Intensive Case Management Person Centered Planning Requirements

Habilitation person-centered planning process and documentation

	Federal Code 42 CFR ~441.725(b)(2)	1915(I) State Plan HCBS-Habilitation	1915(i) State Plan HCBS-Habilitation, Quality Improvement Strategy	Iowa Code 441.78	DHS Habilitation Services Provider Manual
Service plan overview	The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.	The service plan or treatment plan is developed by the participant and his or her interdisciplinary team based on information from the needs-based assessment, and taking into account the participant's social history, and treatment and service history. The case manager, integrated health home coordinator or MCO community-based case manager acts as an advocate for the participant in this process and is a source of information for the participant and the team.		Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes	The comprehensive person-centered service plan must be developed through a person-centered planning process driven by the member in collaboration with the member's interdisciplinary team, as established with the case manager or integrated health home coordinator.
Service plan- reviewed and revised	The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.	The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.	SP-10: Number and percent of service plans, which were revised when warranted by a change in the member's needs.	Comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.	The member's comprehensive service plan must be updated at least annually and when a change in the member's circumstances or needs change significantly, and at the request of the member. Assessing and revising the comprehensive service plan at least annually to determine achievement, continued need, or change in goals or intervention methods. The review shall include the member and shall involve the interdisciplinary team as listed in the person-centered service planning section.

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Revised before due date			SP-9: Number and percent of service plans which are revised on or before member's annual due date.	The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.	
Request updates	Includes a method for the individual to request updates to the plan as needed.	Includes a method for the individual to request updates to the plan			Provides a method to request updates.
Interdisciplinary team and member engagement	The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. Includes people chosen by the individual. The person-centered planning process should provide necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.	The interdisciplinary team includes the participant, his or her legal representative if applicable, the case manager, Integrated health home coordinator or MCO community-based case manager, and any other persons the participant chooses, which may include service providers.		The case manager or the integrated health home care coordinator shall establish an interdisciplinary team for the member. The team shall include the case manager or integrated health home care coordinator and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved.	Includes people chosen by the member. Includes individuals important in supporting the member.
Time and location	Is timely and occurs at times and locations of convenience to the individual.	Occurs at times and locations. Convenient to the participant		The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.	Is timely and occurs at times and locations of convenience to the member.

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Understandable and reflects cultural considerations	Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with ~435.905(b) of this chapter. Be understandable to the individual receiving services and supports and the individuals important in supporting him or her. At minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and person who are limited English proficient, consistent with 435.905(b) of this chapter.	Reflects cultural considerations of the individual.			Reflects cultural considerations and uses plain language. Is written in plain language and understandable to the member.
Reporting abuse			HW-4: Number and percent of service plans that indicate the members were informed of how to report suspected abuse, neglect, or exploitation.		Explaining to the member what abuse is and how to report abuse.
Making a complaint					Explaining to the member how to make a complaint about the member's services or providers.
Solving conflict	Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.	Includes strategies for solving conflict or disagreement within the process including clear conflict of interest guidelines for all planning participants.			Includes strategies for solving disagreements.

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Risk factors and plan to minimize. Individualized back up plans. Emergency Plans.	Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.	Includes risk factors and the measures in place to minimize them including individualized back up plans.	SP-1: Number and percent of service plans reviewed which address the member's assessed health risks. SP-2: Number and percent of service plans which address the member's assessed safety risks. SP-14: Number and percent of service plans with a plan for supports available to the member in the event of an emergency.	*Emergency plan.* The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows: (1) The member's interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment. (2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change. (3) Providers of applicable services shall provide for emergency backup staff.	Includes risk factors and plans to minimize them. Includes risk factors and measures in place to minimize risk. Includes individualized backup plans and strategies when needed: • Identifying any health and safety issues applicable to the member based on information gathered before the team meeting, including a risk assessment. • Identifying an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change. • Including applicable services providers shall administer for emergency backup staff.

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Integrated setting. Employment setting.	Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting is chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS. Records the alternative home and community-based settings that were considered by the individual.	All residential settings where Habilitation services are provided must document the following in the member's service or treatment plan: a. The setting is integrated in, and facilitates the individual's full access to, the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, like individuals without disabilities. b. The setting is selected by the individual among all available alternatives and identified in the person-centered service plan. c. An individuals' essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected d. Individual initiative, autonomy and independence in making major live choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented; and e. Individual choice regarding services and supports, and who provides them, is facilitated		For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.	Identifies for a member receiving home-based habilitation: • The member's living environment, • The number of hours per day of on-site staff supervision needed by the member, and • The number of other members who will live with the member in the living unit. Identifies for member's receiving prevocational or supported employment services: • The member's prevocational or supported employment setting • The number of hours per day of on-site staff support needed by the member, and - For prevocational services where the member is earning subminimum wages, documentation that counseling, information, and referral regarding integrated community employment has been provided. - For small group employment, the number of members working in the group with the member and the number of hours of work per week. - For individual supported employment, the number of hours of employment per week and the number of hours of on-site staff support needed by the member per week.

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HCBS setting requirements		Residential settings that are provider owned or provider controlled or operated including licensed Residential Care Facilities (RCF) for 16 or fewer persons must document the following in the member's service or treatment plan: f. Any modifications of the conditions (for example to address the safety needs of an individual with dementia) must be supported by a specific assessed need and documented in the person-centered services plan; g. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord tenant laws do not apply, there must be a lease, residency agreement, or other form of written agreement in place for each HCBS participant, and that the document provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law; h. Each individual has privacy in their sleeping or living unit. i. Units have entrance doors lockable by the individual, with only appropriate staff having keys to doors; j. Individuals sharing units have a choice of roommates in that setting; k. Individuals have the freedom to furnish and decorate their sleeping or living units within the lease or other agreement; l. Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time; m. Individuals are able to have visitors of their choosing at any time; and n. The setting is physically accessible to the individual.	SR-1: Number and percent of service plans which indicate that the member resides in a setting that meets the HCBS setting requirements. SR-2: Number and percent of service plans which indicate that the member is receiving services in a setting that meets the HCB setting requirements		

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Strengths and preferences. Clinical and support needs.	Reflect the individual's strengths and preferences. Reflect clinical and support needs as identified through an assessment of functional need.	The participant and the team identify the participant's strengths, needs, preferences desired outcomes, and his or her desires in order to determine the scope of services needed.		The comprehensive service plan shall reflect desired individual outcomes.	Assuring that all unmet needs of the member are identified in the comprehensive service plan. Is conducted to reflect what is important to the member to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare. Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the member. Reflects the member's strengths and preferences. Reflects clinical and support needs.
Goals	Include individually identified goals and desired outcomes.	The participant is encouraged to choose goals based on his or her own desires while recognizing the need for supports to attain those goals. Includes the goals related to community living.	SP-3: Number and percent of service plans which reflect the member's assessed personal goals.	Identify observable or measureable individual goals. Identify interventions and supports needed to meet those goals with incremental actions steps, as appropriate.	Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education, and others.

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Freedom of choice	Offers informed choices to the individual regarding the services and supports they receive and from whom.	Individual choice regarding services and supports, and who provides them, is facilitated. The case manager, MCO community-based case manager or integrated health home care coordinator informs the participant and his or her interdisciplinary team of all available qualified providers. This is part of the interdisciplinary team process when the service plan is developed, and again whenever it is renewed or revised. Participants are encouraged to meet with available providers before choosing a provider.	SP-15: Number and percent of service plans that indicate the member was provided a choice of providers for service delivery.	With the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers. Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.	Offers choices to the member regarding services and supports the member receives and from whom. Case management assists members in gaining access to needed home- and community-based habilitation services, as well as medical, social, educational, and other services, regardless of the funding source for the services to which access is gained. This includes the following activities: Explaining the member's right to freedom of choice.

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Services, funding, providers, natural supports.	Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of State plan HCBS. Prevent the provision of unnecessary or inappropriate services and supports	The IHH care coordinator informs the individual of all available Medicaid and non-Medicaid services.	SP-5: Number and percent of service plans which list all services received by the member. SP-6: Number and percent of service plans which list all of the member's providers. SP-7: Number and percent of service plans in which all funding sources are listed. SP-8: Number and percent of service plans, which list the amount of services to be received by the member.	List all Medicaid and non-Medicaid services received by the member and identify: 1. The name of the provider responsible for delivering the service; 2. The funding source for the service; and 3. The number of units of service to be received by the member. (5) Identify for a member receiving home-based habilitation: 1. The member's living environment at the time of enrollment; 2. The number of hours per day of on-site staff supervision needed by the member; and 3. The number of other members who will live with the member in the living unit. Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.	Reflects providers of services and supports, including unpaid supports provided voluntarily in lieu of waiver or state plan HCBS including: • Name of the provider • Service authorized • Units of service authorized
Discharge plan				Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.	

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Right Restrictions	Document that any modification of the additional conditions, under §441.710(a)(1)(vi)(A) through (D) of this chapter, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan: (i) Identify a specific and individualized assessed need. (ii) Document the positive interventions and supports used prior to any modifications to the person-centered service plan. (iii) Document less intrusive methods of meeting the need that have been tried but did not work. (iv) Include a clear description of the condition that is directly proportionate to the specific assessed need. (v) Include a regular collection and review of data to measure the ongoing effectiveness of the modification. (vi) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. (vii) Include informed consent of the individual; and (viii) Include an assurance that the interventions and supports will cause no harm to the individual.	All residential settings where Habilitation services are provided must document the following in the member's service or treatment plan: Individual initiative, autonomy and independence in making major life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented. An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected.		Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of: (1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications; (2) The need for the restriction; and (3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.	Documents the informed consent of the member for any restrictions on the member's rights, including: • Maintenance of personal funds and self–administration of medications, • The need for the restriction, and • Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate. Any rights or restrictions must be implemented in accordance with 441 IAC 77.25(4).

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Monitoring of plan. Informed consent. Signatures.	Identify the individual and/or entity responsible for monitoring the plan. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.	The plan is signed by all individuals and providers responsible for its implementation.	SP-4: Number and percent of service plans, which include signature of member on the service plan.	The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved [by the IME medical services unit in ISIS] [or MCO specific] before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager, integrated health home care coordinator, or service worker within 30 calendar days after plan approval.	Is signed by all individuals and providers responsible for its implementation and a copy of the plan must be provided to the member and the member's representative. Includes the names and signatures of the individuals and providers responsible for monitoring the service plan.
Distribution of plan	Be distributed to the individual and other people involved in the plan.	The participant and others involved in the plan are provided a copy of the plan.			Is distributed to the member and others involved in the service plan.

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Assessor qualifications		There are educational/ professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):* - Has a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field and at least one year of experience in the delivery of relevant services, or - Has an Iowa license to practice as a registered nurse and at least three years of experience in the delivery of relevant services, or - Is a Licensed master's level mental health professional (LISW, LMHC, or LMFT) See State Plan Amendment (SPA) for care coordinator qualifications		The member's case manager or integrated health home care coordinator has completed an assessment of the member's need for service See State Plan Amendment (SPA) for care coordinator qualifications	

Intensive Case Management Person Centered Planning Requirements

Children's Mental Health Waiver person-centered planning process and documentation

	Federal Code 42 CFR ~441.301(c)(2)(ii)	1915(c) CMH Waiver	1915(c) State Plan HCBS- CMH Waiver, Quality Improvement Strategy	Iowa Administrative Code Chapter 83: HCBS Waivers (CMH Waiver) Chapter 90: Targeted Case Management	Home – and Community-Based Services (HCBS) Provider Manual
Service Plan- overview	The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports.	In accordance with 42 CFR 441.301 and the Iowa Administrative Code 441-90.5(1)b and 441-83, service plans must reflect the services and supports that are important for the participant to meet the needs identified through the needs assessment, as well as what is important to the participant with regard to preferences for the delivery of such services and supports. The service plan, developed through a "person-centered" planning process, must reflect the participant's needs and preferences and how those needs will be met by a combination of covered services and available community supports. The person-centered process is holistic in addressing the full array of medical and non-medical services and supports to ensure the maximum degree of integration and the best possible health outcomes and participant satisfaction. Moreover, participants are given the necessary information and support to ensure their direction of the process to the maximum extent possible, and to empower them to make informed choices and decisions regarding the services and supports received.		The case manager shall develop and periodically revise a comprehensive service plan based on the comprehensive assessment, which shall include a crisis intervention plan based on the risk factors identified in the risk assessment portion of the comprehensive assessment. The case manager shall ensure the active participation of the member and work with the member or the member's legally authorized representative and other sources to choose providers and develop the goals.	Services must be included in a comprehensive person-centered service plan. The comprehensive person-centered service plan must be developed through a person-centered planning process driven by the member in collaboration with the member's interdisciplinary team, as established with the service worker, case manager or integrated health home coordinator. Conducted to reflect what is important to the member to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare.

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Service plan- reviewed and revised	The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.	Service plans are completed prior to services being delivered, and are reevaluated at least annually, whenever there is a significant change in the member's situation or condition, or at a member's request.	SP–1c: Number and percent of service plans which are revised on or before waiver member's annual due date. SP-2c: Number and percent of service plans reviewed which were reviewed when warranted by a change in the member's needs.	The service plan shall be developed annually or when there is significant change in the consumer's situation or condition. Be revised at least annually, and more frequently if significant changes occur in the member's medical, social, educational, housing, transportation, vocational or other service needs or risk factors.	Be revised at least annually and more frequently if significant changes occur
Request updates	Includes a method for the individual to request updates to the plan as needed.	Include a method for the member to request updates to the plan as needed.			Provides method to request updates.

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Interdisciplinary team and member engagement	The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. Includes people chosen by the individual. The person-centered planning process should provide necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.	Include the use of team of professionals and non-professionals with adequate knowledge, training and expertise surrounding community living and person-centered service delivery. Allow the member to choose which team member shall serve as the lead and the participant's main point of contact. Includes people chosen by the individual. Promote self-determination principles and actively engages the participant. Provide necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.		Document the parties participating in the development of the plan. The service plan shall be developed through an interdisciplinary team process.	Document who is involved in developing the plan. Includes people chosen by the member. Provides necessary information and support to the member to ensure that the member directs the process to the maximum extent possible. An interdisciplinary team must include the member and either the case manager, integrated health home, or service worker, and other persons designated by the member. Other persons on the team may be: • The parents when the member is a minor. • The member's legally authorized representative. • The member's family, unless the family's participation is limited by court order or is contrary to the wishes of the adult member who has not been legally determined to be unable to make decisions independently. • All current service providers. • Any other professional representation including, but not limited to: ○ Vocational rehabilitation counselors, ○ Court appointed mental health advocates, ○ Correction officers, ○ Educators, and ○ Other professionals as appropriate. • Persons identified by the member or family, provided the family's wishes are not in conflict with the desires of the member. The team shall be convened to develop the initial service plan and annually to revise the service plan, at least annually or whenever there is a significant change in the items addressed in it member's needs or conditions.

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Time and location	Is timely and occurs at times and locations of convenience to the individual.	Be timely and occur at times and locations of convenience to the participant.			Is timely and occurs at times and locations of convenience to the member.
Understandable and reflects cultural considerations	Be understandable to the individual receiving services and supports and the individuals important in supporting him or her. At minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and person who are limited English proficient, consistent with 435.905(b) of this chapter.	Reflect cultural considerations of the individual and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with 42 CFR 435.905(b). Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her.			Reflects cultural considerations and uses plain language. Is written in plain language and understandable to the member.
Solving conflict	Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.	Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.			Includes strategies for solving a disagreement.

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Risk factors and plan to minimize. Individualized back up plans. Emergency Plans.	Reflect risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed.	Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed. Include a plan for emergencies. The service plan must identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change. Interdisciplinary teams must identify in the service plan, as appropriate for the individual participant health and safety issues based on information gathered prior to the team meeting, including a risk assessment. This information is incorporated into the service plan.	SP-1a: Number and percent of service plans which address the member's assessed health risks. SP-2a: Number and percent of service plans which address the member's assessed safety risks. SP-6b: Number and percent of service plans for supports available to the member in the event of an emergency.	Include an individualized crisis intervention plan that identifies the supports available to the member in an emergency. A crisis intervention plan shall identify: 1. Any health and safety issues applicable to the individual member based on the risk factors identified in the member's comprehensive assessment. 2. An emergency backup support and crisis response system, including emergency backup staff designated by providers, to address problems or issues arising when support services are interrupted or delayed or the member's needs change. The interdisciplinary team shall determine which of the following options will be included in the crisis intervention plan: • After-hours contact information for all persons or resources identified for the member and an alternate contact to be used in the event that an individual provider not employed by an agency is not present to provide services as scheduled; or • After-hours contact information for an on-call system for the provider of case management to ensure that in the event of an emergency, members have access to a case manager 24 hours per day, including weekends and holidays.	Includes risk factors and plans to minimize them. Includes a crisis intervention plan based on risk factors identified in the assessment Include crisis intervention plan - Health and safety issues based on risk factors identified in the assessment - Emergency backup support and crisis response system After-hours contact info for all persons and resources identified for the member w/ an alternative contact or contact info for an on-call system Includes individualized backup plans and strategies when needed. Identify any health and safety issues that apply to the member based on information gathered before the team meeting, including a risk assessment. Identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change. Providers of applicable services shall provide for emergency backup staff.

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Settings	Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting is chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS. Records the alternative home and community-based settings that were considered by the individual.	Record the alternative home and community-based settings that were considered by the participant. Reflect that the setting in which the individual resides is chosen by the participant.			
Strengths and preferences. Clinical and support needs.	Reflect the individual's strengths and preferences. Reflect clinical and support needs as identified through an assessment of functional need.	Reflect the participant's strengths and preferences. Reflect the clinical and support needs as identified through the needs assessment	SP-3a: Number and percent of service plans which reflect the member's assessed personal goals.	Service plan is based on the Core Standardized Assessment (interRAI). The case manager shall develop and periodically revise a comprehensive service plan based on the comprehensive assessment, which shall include a crisis intervention plan based on the risk factors identified in the risk assessment portion of the comprehensive assessment.	Service plan is based on the core standardized assessment. Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the member.

	Federal Code 42 CFR ~441.301(c)(2)(ii)	1915(c) CMH Waiver	1915(c) State Plan HCBS- CMH Waiver, Quality Improvement Strategy	Iowa Administrative Code Chapter 83: HCBS Waivers (CMH Waiver) Chapter 90: Targeted Case Management	Home – and Community-Based Services (HCBS) Provider Manual
Goals	Include individually identified goals and desired outcomes.	Include individually identified goals and desired outcomes which are observable and measurable. Include the identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.	SP-3a: Number and percent of service plans which reflect the members assessed personal goals.	Specify the goals and actions to address the medical, social, educational, housing, transportation, vocational or other services needed by the member.	Includes active participation of the member and will work with the member or member's representative and other sources to choose providers and develop the goals. Have goals and actions to address medical, social, educational, housing, transportation, vocational, or other services needed by the member. Includes individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, education and others. Includes observable and measureable goals and desired outcomes: Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate. Identify the staff people, businesses, or organizations responsible for carrying out the interventions or supports.

	[Federal Code 42 CFR ~441.301(c)(2)(ii)]	[1915(c) CMH Waiver]	[1915(c) State Plan HCBS- CMH Waiver, Quality Improvement Strategy]	[Iowa Administrative Code Chapter 83: HCBS Waivers (CMH Waiver)] [Chapter 90: Targeted Case Management]	[Home – and Community-Based Services (HCBS) Provider Manual]
Freedom of choice	Offers informed choices to the individual regarding the services and supports they receive and from whom.	Offer informed choices to the member regarding the services and supports they receive and from whom. Participants are encouraged to meet with available providers before making a selection, and participants are not restricted to choosing providers within their community	SP-3e: Number and percent of case manager attestations found in service plan that provider choice was offered to the member during service plan development.		Offers choices to the member regarding services and supports the member receives and from whom.
Services, funding, providers, natural supports.	Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of State plan HCBS. Prevent the provision of unnecessary or inappropriate services and supports.	Reflect the services and supports, both paid and unpaid, that will assist the individual to achieve identified goals, the frequency of services and the providers of those services and supports, including natural supports. Include the names of providers responsible for carrying out the interventions or supports including who is responsible for implementing each goal on the plan and the timeframes for each service. Prevent the provision of unnecessary or inappropriate services and supports.	SP-2d: Number and percent of service plan reviewed reporting the receipt of all services identified in the plan. SP-3b: Number and percent of service plans reviewed which list all of the member's providers. SP-4b: Number and percent of service plans reviewed in which all funding sources are listed. SP-5b: Number and percent of service plans which list the amount of services to be received by the member.	The service plan shall specify the type and frequency of the waiver services and the providers that will deliver the services. Identify a course of action to respond to the member's assessed needs, including identification of all providers, services to be provided, and time frames for services. Document services identified to meet the needs of the member which the member declined to receive.	Document any declined services Includes observable and measureable goals and desired outcomes: Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate. Identify the staff people, businesses, or organizations responsible for carrying out the interventions or supports. Reflects providers of services and supports, including unpaid supports provided voluntarily in lieu of waiver or state plan HCBS, including: name of the provider, service authorized, units of service authorized Excludes unnecessary or inappropriate services and supports

	Federal Code 42 CFR ~441.301(c)(2)(ii)	1915(c) CMH Waiver	1915(c) State Plan HCBS- CMH Waiver, Quality Improvement Strategy	Iowa Administrative Code Chapter 83: HCBS Waivers (CMH Waiver) Chapter 90: Targeted Case Management	Home – and Community-Based Services (HCBS) Provider Manual
Discharge Plan				Include a discharge plan.	

	Federal Code 42 CFR ~441.301(c)(2)(ii)	1915(c) CMH Waiver	1915(c) State Plan HCBS- CMH Waiver, Quality Improvement Strategy	Iowa Administrative Code Chapter 83: HCBS Waivers (CMH Waiver) Chapter 90: Targeted Case Management	Home – and Community-Based Services (HCBS) Provider Manual
Right Restrictions	Document that any modification of the additional conditions, under paragraph (c)(4)(vi) (A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan: (i) Identify a specific and individualized assessed need. (ii) Document the positive interventions and supports used prior to any modifications to the person-centered service plan. (iii) Document less intrusive methods of meeting the need that have been tried but did not work. (iv) Include a clear description of the condition that is directly proportionate to the specific assessed need. (v) Include a regular collection and review of data to measure the ongoing effectiveness of the modification. (vi) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated. (vii) Include informed consent of the individual; and (viii) Include an assurance that the interventions and supports will cause no harm to the individual.	Include a description of any restrictions on the participant's rights, including the need for the restriction and a plan to restore the rights (for this purpose, rights include maintenance of personal funds and self-administration of medications).		The service plan shall identify and justify any restriction of the consumer's rights. Member rights may be restricted only with the consent of the member or the member's legally authorized representative and only if the service plan includes: *a.* Documentation of why there is a need for the restriction; *b.* A plan to restore those rights or a reason why restoration is not necessary or appropriate; and *c.* Documentation that periodic evaluations of the restriction are conducted to determine continued need.	Documents the informed consent of the member for any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications, the need for the restriction, and either a plan to restore those rights or written documentation that a plan is not necessary or appropriate. Any rights restrictions must be implemented in accordance with 441 IAC 77.25(4).

	Federal Code 42 CFR ~441.301(c)(2)(ii)	1915(c) CMH Waiver	1915(c) State Plan HCBS- CMH Waiver, Quality Improvement Strategy	Iowa Administrative Code Chapter 83: HCBS Waivers (CMH Waiver) Chapter 90: Targeted Case Management	Home – and Community-Based Services (HCBS) Provider Manual
Monitoring of plan. Informed consent. Signatures.	Identify the individual and/or entity responsible for monitoring the plan. Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.	Identify the individual and/or entity responsible for monitoring the plan. Be finalized and agreed to, with the informed consent of the participant in writing, and signed by all individuals and providers responsible for its implementation	SP-1b: Number and percent of service plans reviewed which include signature of member on the service plan.		Documents who is responsible for monitoring the plan. Includes the names of the individuals responsible for monitoring the plan. Is signed by all individuals and providers responsible for its implementation and a copy of the plan must be provided to the member and the member's representative. Includes the signatures of all individuals and providers responsible
Distribution of plan	Be distributed to the individual and other people involved in the plan.	Be distributed to the participant and other people involved in the plan.			Is distributed to the member and others involved in the plan

	Federal Code 42 CFR ~441.301(c)(2)(ii)	1915(c) CMH Waiver	1915(c) State Plan HCBS- CMH Waiver, Quality Improvement Strategy	Iowa Administrative Code Chapter 83: HCBS Waivers (CMH Waiver) Chapter 90: Targeted Case Management	Home – and Community-Based Services (HCBS) Provider Manual
Case manager qualifications		Qualified case managers and supervisors are required to have the following qualifications: "(1) a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field (including, but not limited to, psychology, social work, mental health counseling, marriage and family therapy, nursing, education, occupational therapy, and recreational therapy) and at least one year of experience in the delivery of services to the population groups that the person is hired as a case manager or case management supervisor to serve; or (2) an Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population group the person is hired as a case manager or case management supervisor to serve.			