

ISP Instructions

I. SECTION BY SECTION INSTRUCTIONS

The Header

Name of the person:

Name of the person for whom the ISP is written.

ISP Effective Date:

Date the service coordinator wrote the ISP. This date does not change until a new ISP is written.

Medicaid Number or CIN Number:

The person's Medicaid number, also known as the person's Client Identification Number.

ISP Review Dates:

List each date the ISP was reviewed. The ISP is reviewed at least every 6 months, first from the month of the initial plan and then from the month of the last review date.

Section 1:

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

Profile:

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

The profile tells the reader about the person and his/her current needs and wants. It assists those helping the person provide supports and services with an understanding and sensitivity to what is important to the person. This information is necessary to successfully put the plan into action.

The Person's Valued Outcomes:

List the person's valued outcomes that derive from the profile. They are the person's chosen life destinations. There must be at least one valued outcome for each waiver habilitation service (residential habilitation, day habilitation, prevocational services, and supported employment) that the person will be receiving. The Habilitation Service is "authorized" only where the service relates to at least one of a person's valued outcomes. List the outcome again for each appropriate waiver habilitation service in the "HCB Waiver Service Summary."

Safeguards:

State the safeguards that must be in place to keep the person safe from harm. Safeguards are actions to be taken when the health or welfare of the person is at risk. The Habilitation Plans, or referenced documents, will provide greater detail about how safeguards are ensured within the context of the respective service. The "Individual Plan for Protective Oversight" can be referenced in the safeguards section for people who live in an IRA. Fire safety must be discussed in the safeguard section of all ISPs unless it is discussed in the attached Individual Plan for Protective Oversight for people who live in IRAs.

Section 2:

The Person's Individualized Service Environment

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

Natural Supports and Community Resources:

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

List people, places, or organizational affiliations that are a resource to the person by providing supports or services, such as family, friends, neighbors, associations, community centers, spiritual groups, school groups, volunteer services, self-help groups, clubs, etc. Include the name of the person, place or organization and a brief statement about what is being done to help the person.

Assistance related to achieving a valued outcome should be noted. It is not required to include the frequency, duration, and effective date for the support or service as you would for the funded services.

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

Funded Services:

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

Medical, nursing, or dental state plan service provided in an Article 16, 28, or 31 Clinic should be described in this section.

Medicaid State Plan Services – Article 16, 28, and 31 Clinics Long-Term Therapies Only, (e.g., Physical, Occupational, Speech, Rehabilitation Counseling, Nutrition, Psychology, Social Work, and Psychiatry), are services that are provided through clinics. In this section, the Service Coordinator must indicate which type of Clinic (e.g., 16, 28, or 31), is providing the service. Also include at what location the service is being provided, (e.g., main clinic site, day or residential program).

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

HCBS Waiver Services are those services funded by the Home and Community-Based Waiver. These are residential habilitation, day habilitation, prevocational services, supported employment, respite, adaptive devices, environmental modifications, family education and training, plan of care support services, consolidated supports and services, fiscal/employer agent, and transitional services.

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

Required Information for Medicaid State Plan Services; Federal, State and County Funded Resources; HCB Waiver Services; and Other or 100% OMRDD Funded Services:

- **Name of the provider or agency** (e.g., Dr. Smith, Community General Hospital, VESID, Housing and Urban Development, Sunshine County ARC, or DDSO).
- **Type of provider or type of service** (e.g., physician, cardiologist, educational, residential habilitation, housing, day treatment, or MSC).
- **Frequency of the support or service.** (e.g., daily; 3 days a week, monthly, twice a year, as needed, or one time purchase.) **The frequency of an HCB Waiver Habilitation Service must correspond to the billing unit of service.**
- **Duration of the support or service.** This means for how long the assistance is expected to last. If the service does not have an expected end date, write "on-going."
- **Effective date of the support or service.** This is the date the current provider first provided the service. Effective dates may be difficult to obtain for some Medicaid State Plan Services; Federal, State and County Funded Resources; or 100% OMRDD Funded Services. In this situation, enter the approximate time frame (last few years, over 10 years, within the past year, etc.) However, HCB Waiver Services and Medicaid Service Coordination must have the exact and correct effective date. A HCB Waiver Service provider's billing will be jeopardized if the date the provider billed for the service is prior to the effective date on the ISP.

For a one time service or purchase, such as environmental modifications and adaptive devices, the anticipated purchase/completion date is used.

- **The reason or valued outcome** for receiving the support or service. e.g., to monitor seizure activity, to help obtain an apartment, to learn how to get from home to work.

If a service or support is helping the person to achieve a valued outcome (person's chosen life destination) as identified in the profile, then the outcome is required information for this entry.

If a service or support is not directly helping the person to achieve a valued outcome as identified in the profile, then a "reason" for why the person is buying a particular support or service is required information for this entry.

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

- List in each entry any clinical services received by the person within a service. For example, a person may receive psychology, physical therapy, or nursing as part of day treatment, residential habilitation, day habilitation, or an Article 16 Clinic. Coordination of Medicaid funded clinical services is critical and must not be unnecessarily duplicated. Ensure that Article 16, 28, and 31 Clinical services are coordinated with and do not duplicate other identical clinical services. For example, ensure that psychological services from an Article 16 Clinic do not duplicate identical psychological services within HCBS Waiver residential habilitation.

Names of Service Providers receiving copy(s) of the ISP and attachments:

The MSC should list who has received a copy of the ISP and when it was sent.

Signatures:

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

Signature lines must not be blank. If the person is unable or unwilling to sign, this should be noted on the signature line. If the person is a self-advocate and the advocate is not signing, "self-advocate" should be written on the line. Signatures must be dated.

Attachments:

- waiver residential habilitation plan
- waiver day habilitation plan
- waiver prevocational services plan
- waiver supported employment plan
- waiver consolidated supports and services (CSS) plan
- individual plan for protective oversight if the person lives in an IRA
- Medicaid Service Coordination Activity Plan
- Clinic treatment plan (or written recommendations from Article 16, 28 or 31 clinics)

II. FORMAT AND TIME FRAMES

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

Updating the ISP

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

If the ISP is not re-written and dated, changes may be made by attaching an **addendum**. The addendum must include the name of the person, the date of the ISP to which it is attached, the date of the change, the new or changed information, and the signature of the service coordinator.

The addendum requires new signatures if there are changes to HCB Waiver Services or the change is considered "significant" by the person, advocate, and service coordinator.

Changes in the ISP must be communicated to day treatment providers and HCB Waiver Habilitation service providers (residential habilitation, day habilitation, prevocational services and supported employment). If an addendum is used, distribute copies.

Reviews of the ISP

The ISP is reviewed at least every 6 months, first from the month of the initial plan and then from the month of the last review date. ISP reviews must be held by the end of the 6th month.

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

At least annually, the ISP review must be a face-to-face meeting with the service coordinator, consumer, advocate and major service providers (residential habilitation, day habilitation, prevocational, supported employment, or day treatment). Each major provider invited must send a representative.

Maintenance, Retention, and Distribution of the ISP:

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

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

the person,
his/her advocate,
waiver residential habilitation,
waiver day habilitation,
waiver prevocational services,
waiver supported employment,
day treatment,
respite,
article 16, 28, or 31 clinics,
fiscal/employer agent (CSS participants only)
and others, (with the consent of the person)

HCBS Waiver habilitation providers (residential, day, prevocational, and supported employment) have 30 days from the date of the ISP review to make any necessary revisions to the habilitation plan and send the completed and revised plan to the service coordinator.

The service coordinator has 45 days from the date of the ISP review to send the full ISP or addendum and any revised habilitation plans to the consumer, advocate, and appropriate service providers. If the 45 day time frame cannot be met because of delays in obtaining the necessary signatures, the MSC service coordinator can send copies of the ISP to all parties without signatures. The ISP must be sent with a note indicating that the original document with the required signatures can be found in the individual's Service Coordination record.