Division of Disability and Rehabilitative Services

Bureau of Developmental Disabilities Services

Person-Centered Individualized Support Plan (PCISP) Guide

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The Division of Disability and Rehabilitative Services (DDRS) is pleased to announce completed enhancements to the Person-Centered Individualized Support Plan (PCISP) process, including development of tools and a system that reflects these improvements. Since the development of the previous Individualized Support Plan, we have focused on self-advocates and families' desire for change, placed emphasis on the Home and Community Based Services (HCBS) Final Rule on Settings, and created a new emphasis on self-determination and choice for individuals with intellectual and developmental disabilities. Modernizing and refreshing our planning process is the logical next step to our core belief:

All people have the right to live, love, work, learn, play, and pursue their dreams in their community.

The Person-Centered Individualized Support Plan process begins with an individual's vision for a preferred life and will take the concept of self-determination from theory to practice. The new PCISP process will:

1. Provide individuals with the opportunity and ability to make the PCISP a more person centered, living document that reflects their hopes and dreams;
2. Create a supportive environment that encourages the use of common and understandable language to assist individuals and their families to engage in robust discussion to create meaningful plans;
3. Promote greater opportunities for individuals to exercise choice and self- determination;
4. Emphasize outcomes and strategies/activities that relate to the individual's vision for a preferred life; and
5. Enhance and promote collaboration among Individualized Support Team (IST) members by providing discussion guidance, more consistent expectations, and a PCISP document that creates a clear road map for the IST to follow in support of the individual.

We look forward to working with you as we move forward in supporting Hoosiers with intellectual and developmental disabilities.

Kylee B. Hope
Director
Division of Disability and Rehabilitative Services

Cathy Robinson
Director
Bureau of Developmental Disabilities Services

Person-Centered Individualized Support Plan Guide

Introduction

Conceptual Framework

With Indiana's adoption of the LifeCourse Framework, BDDS has chosen to utilize the framework's principles and philosophy in the development of the Person-Centered Individualized Support Plan (PCISP). One of the most important supports Case Managers provide to individuals is a robust and thoughtful planning process - one that culminates in a Person-Centered Individualized Support Plan (PCISP) that clearly articulates the hopes, desires, and needs of the individual, describes their life circumstance, and charts a path for the Individualized Support Team (IST) to follow in supporting the individual to achieve their vision of a preferred life. The PCISP is intended to capture a moment in time by describing the present and strategizing for the future. Case Managers are responsible for ensuring the individual's voice is clearly heard while balancing desires and needs. For example, an individual may clearly articulate a desire to spend time alone, yet be unsafe in crossing streets or assessing risks in the community. Guardians may prefer that the individual be protected rather than taking a chance on something new that has a risk of failure. Service providers may be more focused on their scope of service delivery and their specific contributions than to the overall planning process. All of these elements need to be taken into account and integrated by the Case Manager into a PCISP that keeps the person and their vision of a preferred life at the center of the process and provides clear direction to team members during the next year.

PCISP Process Overview

The development of the PCISP document reflects a person-centered planning process. It involves as many team members as needed to achieve the personal outcomes for each individual. The person-centered planning process helps people achieve their life goals and evolves as the individual's life evolves.

The Individualized Support Team (IST) helps each individual develop their PCISP. A strong IST builds and sustains relationships. Team members have community contacts, relationships, experiences, and resources to contribute in supporting action steps towards an individual's preferred life. Team members cooperate in solving problems and helping individuals obtain their potential, achieve life goals, and realize their dreams. The IST includes the individual, guardian (if applicable), family members, the Case Manager, service providers, and other members **selected by the individual and/or guardian to contribute to the person-centered planning process**. It is important for the individual to receive necessary information and supports from team members to ensure that he or she can direct and contribute to the process to the maximum extent possible, and is empowered and supported to make informed choices and decisions.

The Case Manager works with the individual and their guardian, if applicable, to:

- Prepare for the IST meeting;
- Schedule the IST meeting;
- Work with the IST to gather necessary information to inform the IST discussion;
- Ensure the IST meeting remains focused on the individual's preferences and priorities;
- Complete the PCISP document with the information gathered during the IST meeting; and
- Distribute the PCISP to the IST.

The IST meeting is facilitated by a person selected by the individual which may, or may not be, the Case Manager. Meetings are to occur at times and locations comfortable and convenient to the individual.

Service providers implement the PCISP and report progress on the outcomes and strategies to the Case Manager and individual and/or guardian at least quarterly. To ensure IST meetings promote effective collaboration among the members of the team, comprehensive preparation is required of all IST members.

Person-Centered Individualized Support Plans are developed annually and reviewed at least semi-annually by the IST. Following each team meeting, the Case Manager will complete an Update PCISP to reflect team discussion within the "Team Discussion on Outcomes" section located within each life domain, as well as any modifications or adjustments to the plan. The Case Manager will also complete a case note indicating that a team meeting took place, a statement referring the reader to the PCISP for notes on team discussion on outcomes and, if applicable, notes not otherwise captured in the "Team Discussion on Outcomes" sections of the PCISP. For example, the case note may indicate:

"Sally Johnson's team met at her home on October 31, 2017. Team members present, as well as team discussion on outcomes, is reflected in her updated PCISP. In addition, the team also discussed upcoming staffing changes within Sally's home."

Understanding Communication Styles

To support others in self-determination, team members must be experienced in listening to and understanding the individual's communication style. All communication is purposeful, and all people have a need to communicate. Some individuals have difficulty communicating. Most people express ideas, feelings and desires through words, gestures and body language to convey messages and respond to others. In some situations, the individual's method of communication may be perceived as inappropriate. Communication requires a willingness to use all available means in order to understand and to be understood (e.g. pictures, sign language, gestures, body language, augmentative devices, interpreters, etc.) Alternative methods, including interpreters, as needed for communication, should always be available at the planning meeting.

Flexibility in Supporting Individuals

Consistent with the PCISP's person-centered approach, the Division is also providing individuals and families with more flexibility in quarterly visits or face-to-face contact requirements with their Case Managers, as well as with the frequency of team meetings. Effective January 1, 2018, quarterly face-to-face contacts between the Case Manager and the individual will continue to be required every 90-days with a focus on building and fostering the relationship between the individual, family, and Case Manager. However, also effective January 1st, the team meeting requirement will be reduced from every 90-days to semi-annually or when requested by the individual, family, BDDS, or other team members. Along with these changes, the Division will require a minimum of one unannounced home visit per year ONLY for individuals residing in provider-owned or controlled settings. The following table summarizes these changes.

Activity	Previous Minimum Requirements	Requirements Effective 01/01/18
Quarterly Visits / Face-to-face Contact	• Every 90 Days • One unannounced home visit per year per person	• Every 90 Days • One unannounced home visit per year only for individuals residing in provider owned or controlled settings
Team Meetings Annual / Non-Annual	• Every 90 Days	• Semi-annually or • When requested by the individual, family, BDDS, or other team members
Please note, face-to-face contact and team meeting requirements for individuals with high risk or health needs remain the same.		

Previously, the minimum requirements required Case Managers to complete four face-to-face visits per year and one unannounced visit. In addition, Case Managers were also required to complete at least four quarterly Team Meetings per year. Assuming the Case Manager was face-to-face with the individual during these meetings, the team meetings consumed all of the minimum face-to-face contact opportunities. As a result, the opportunity for the individual, their family, and the Case Manager to develop and build their relationship is significantly hindered and which in turn may interfere with the Case Manager's ability to serve as expert navigator, advocate, and partner in the process.

Effective January 1, 2018, the current minimum quarterly face-to-face visit requirement will continue, however the team meeting requirements will be reduced to semi-annually (or as requested by the individual or other team member). Assuming the individual only requires two meetings per year and that the Case Manager is present with the individual for those meetings, this change should provide flexibility by enabling the Case Manager to use the remaining two face-to-face visits required for the year to be more informal.

For example, the Case Manager could use those remaining visits to observe the individual at their home, at their day service setting, or in a community-based activity, like a Special Olympics event. In addition, those visits could be used to meet informally with the individual and/or their family at a location of their choosing to discuss progress on their current PCISP. As detailed in the PCISP Implementation and On-Going Meeting Preparation section, information gathered from and/or observed by the Case Manager during these visits should be used to inform the PCISP.

PCISP Requirements

The purpose of the PCISP is to ensure that people who support the individual have a clear picture of the individual's vision for their future and their current circumstances. It is to include both paid and natural supports, with emphasis on the present and preferred life. Person-Centered Individualized Support Plans are developed annually and reviewed at least semi-annually by the IST.

The PCISP must be understandable to the individual and those supporting him or her. At a minimum, it must be written in plain language and in a manner accessible to individuals with disabilities and persons with limited English proficiency.

The use of Federal Medicaid funds may only be approved for HCBS waiver services that are provided based upon a person-centered plan. Therefore, all BDDS waiver participants, regardless of services received, require a PCISP.

Initial PCISP

An Initial PCISP must be developed and finalized within forty-five (45) days of BDDS on-boarding an individual's file to a case management company, even if Case Management is the only service at that time. Additional services may be added through updating the PCISP when other services and providers are selected.

Update PCISP

An update to the PCISP is required when:

- The needs or circumstances of the individual changes;
- Services are added or removed;
- Requested by the individual and/or guardian; or
- For non-annual team meetings to record team discussion on outcomes and any related plan changes.

Annual PCISP

The Annual PCISP is written for the same 365 day cycle as the individual's Cost Comparison Budget (CCB). While the PCISP drives the development of the CCB, it is necessary to finalize the CCB first to allow the PCISP author to select the appropriate date range, services, and providers for the PCISP.

First Person Perspective

Consistent with the Charting the LifeCourse Booklet, the Person-Centered Individualized Support Plan is written to reflect a "first person" perspective in order to represent the viewpoint of the person with a disability and their on-going journey toward achieving their life goals, preferences, and aspirations.

PCISP Components

About Me

The About Me section introduces the person to the reader in a strengths-based manner. It provides the individual and those closest to them the opportunity to share and describe their gifts, assets, and competencies; the things they do well, sources of pride, and qualities about them that are most valued, appreciated, and respected. Also articulated and described in this section is a vision of their good life, i.e., where they want to be and what they want to do. This sets the stage for how Medicaid and home and community based services should be utilized to best support the individual. This vision may include portions of the individual's current reality that s/he wants to preserve and sustain, as well as desired changes.

Profile Information

Information from the profile screens of the BDDS Portal ("Portal") will automatically populate within the final PCISP document. Demographic information such as address, telephone numbers, legal status, and diagnoses are among the fields that will require review. A full list of the profile information included can be found in the PCISP Guidance section of this document.

Provider Owned or Controlled Settings

In 2014, the Centers for Medicare and Medicaid Services' (CMS) published a Final Rule defining the qualities of Home and Community-Based Settings. The Settings Rule also includes additional conditions that must be met if a residential setting is provider owned or controlled. (42 CFR §441.301(4)(VI)) For purposes of complying with these requirements, Indiana defines provider owned or controlled settings to include those residential settings that are owned by a provider or in those residential settings in which individuals, who are not living in their family home, and utilize Residential Habilitation and Support – Level Two, Residential Habilitation and Support - Daily (RHS Daily), or Structured Family Caregiving.

In order to ensure the IST addresses these additional conditions, the Living Arrangement within the Profile includes a question as to whether the individual lives in a provider owned or controlled residential settings. If selected, the PCISP will prompt the IST to address questions related to the additional conditions (See Appendix A for additional guidance).

Life Stages

When developing a PCISP it is important for the IST to consider the life stage of the individual for whom the plan is being written. What happens to us early in our lives can have a significant impact on our quality of life and well-being in the future. It is important to help people have positive, healthy experiences, adequate support, and ample opportunities to learn and make mistakes so that they can have better outcomes later in life. In addition, identifying the individual's life stage allows the individual, family, and other team members to use resources like the **Charting the LifeCourse: Experiences and Questions Booklet** to explore key issues relevant to a particular life stage and domain.

Infancy: Early years, wondering if meeting developmental milestones.

Early Childhood: Preschool age, getting a diagnosis.

School Age: Everyday life during school years.

Transition: Transitions from school to adult life – realizing school is almost over.

Adulthood: Living life as an adult.

Aging: Getting older and preparing for end of life.

Life Domains

People lead whole lives made up of specific, connected, and integrated life domains that are important to a good quality of life. Our lives as everyday citizens are complex and multi-faceted. What happens in one area of our life (for example, in our job) affects another (our family or housing situation). It is important to recognize the interconnectedness of everyday life so we can work to make our whole lives as complete and fulfilling as possible.

Each PCISP life domain has a unique purpose that should provide the reader with a written picture of what is currently happening, what the individual's vision for a preferred life is for that area, and what the IST is doing to support the individual to move closer to living their preferred life.

Daily Life and Employment: What a person does as part of everyday life – school, employment, volunteering, communication, routines, and life skills.

Community Living: Where and how someone lives – housing and living options, community access, transportation, home adaptation and modification.

Safety and Security: Staying safe and secure – finances, emergencies, well-being, decision making supports, legal rights and issues.

Healthy Living: Managing and accessing health care and staying well – medical, mental health, behavior, developmental, wellness and nutrition.

Social and Spirituality: Building friendships and relationships, leisure activities, personal networks and faith community.

Citizenship and Advocacy: Building valued roles, making choices, setting goals, assuming responsibility and driving how one's own life is lived.

Other Areas of Importance: To be utilized in those rare situations when what the individual desires does not fit into one of the life domains listed above.

Life Domain Sections

Within the life domains are identical questions that are to be answered based on the domain and the desires of the individual for that area of life. Below is an overview of these sections, including a brief description of each section's purpose. Appendix A includes more detailed guidance and helpful hints that may aid the Case Manager through the PCISP process. It is offered as a guide or prompt for team discussions and to gather information relevant to the PCISP. The prompts should not be used as a "checklist" of questions that must be addressed.

Each of these sections provides critical information that enables the team to support the individual in identifying their vision for a good life within each domain and what can be accomplished in the next year in support of that vision. Before reviewing the section descriptions, here are a few examples of the outcomes this information should yield.

Outcomes: Examples		
Social & Spirituality	**Desired Outcome:**	I will participate in meaningful activities of my choice.
	Strategies for Implementation:	I will participate in activities such as walking, running, and swimming at a location near me.
	Action Steps Needed:	I will visit gyms, the YWCA and clubs and choose one to join.
	How progress will be measured:	Visiting and obtaining membership. Participation in activities.
	Who / When:	Mom and me by 5/1/2018.
Safety & Security	**Desired Outcome:**	I will maintain my personal safety when in the community.
	Strategies for Implementation:	I will learn to use coping skills when in large, crowded, noisy environments and during transitions.
	Action Steps Needed:	DSP will help me practice coping skills like deep breathing and sensory activities to use when I am anxious.
	How progress will be measured:	I am successfully using coping skills when needed.
	Who / When:	DSP and me by 7/1/18.
Daily Life & Employment	**Desired Outcome:**	I will communicate my needs and wishes.
	Strategies for Implementation:	I need support to explore various communication techniques I may be interested in learning, such as picture cards; sign language, or electronic devices.
	Action Steps Needed:	Support staff will assist me in learning the desired techniques and/or obtaining electronic device.
	How progress will be measured:	I will communicate at least one need or wish each day when prompted.
	Who / When:	DSP and me by 9/1/2018.

Life Domain Section Descriptions

Section	Description
Personal Focus	Each life domain section of an individual's PCISP starts with identifying what is important to and what is important for the individual within that domain. What's ***important to*** the individual is usually related to comfort, happiness, contentment, fulfilment and satisfaction. ***Important for*** generally includes what is necessary to maintain the individual's health and safety. The PCISP combines and balances the two. Keep in mind, people usually don't do what is important for them unless there is also a reason it is important to them. If the individual is an adult with a guardian, viewpoints may differ and both should be included, however it should be easy to distinguish the difference between what is important to the individual from what is important to others. The question "What others need to know to support me" also crosses all domains. The support information in the PCISP is a crucial component to ensure assessed needs are met consistently. This area identifies how supports need to be provided day to day based on the individual's preferences. Additional questions appear within the Daily Life & Employment and Healthy Living domains. Guidance for those questions appears within the specific life domains.
Vision of a Preferred Life	Everyone wants a good life, and defines their good life in their own way. Forming a vision and beginning to plan for the future in each of the life domains helps plot a trajectory for a full inclusive, quality life in the community. A person's vision may include aspects of their current life which they want to preserve and continue. LifeCourse Framework tools are not required in development of the PCISP, but Case Managers may find the **Tool for Developing a Vision** and the **Life Trajectory Worksheet**, individual or family versions, helpful in defining the individual's vision for a preferred life.
Team Discussion on Outcomes	The PCISP must be central to all team meetings, with IST members continuously evaluating progress towards identified outcomes and strategies, celebrating successes and working through challenges. The outcomes from these discussions will be recorded within the PCISP to provide an on-going history of progress and changes.
Actions/Activities for My Safety	Exposure to risk is part of life. It is only through making choices and developing good judgement that we all learn and mature. Risk management emphasizes instruction and the development of strategies and safeguards geared specifically to the individual to manage reasonable risk whenever possible. Identifying and addressing unreasonable risk should be respectful of the individual's rights while addressing competency and capacity to make informed choices. The determination of risk should include those who know the individual best and be based on the understanding of any cultural and linguistic issues. It is to be included in the PCISP in each domain as applicable.
HCBS Required Questions	The CMS HCBS Settings Final Rule requires specific questions to be asked at least annually but as often as the PCISP is updated for individuals who reside in provider owned or controlled settings. These questions appear within five (5) of the life domains. If any of the HCBS questions are answered no, additional questions must be discussed and the remediation information included within the HCBS section for that domain. Guidance on these questions will be included under the applicable life domains.

Supports and Services	All people need support to lead good lives. Using a combination of many different kinds of support helps to plot a trajectory toward an inclusive, quality, community life. Again, while the use of LifeCourse tools is not required, the **Integrated Supports Star Worksheet**, **Integrated Support Options Guide**, and **Integrated Long Term Service and Support Needs Template** may assist the individual, guardian and team to consider a broader range of options and determine the natural supports and paid services needed to achieve their good life.
Supports and Services: Natural Supports	Natural supports are those personal associations and relationships developed in the community that enhance the quality of life of the individual. They may include family, friends, neighbors, community associations, clubs, etc. Technology (e.g. smart phone apps) may also be a potential natural support for the individual and should not be overlooked. The availability and utilization of natural supports should be considered before paid services.
Supports and Services: HCBS Waiver Services	HCBS waiver services will automatically populate on the PCISP Service Plan page based on the Cost Comparison Budget (CCB) selected for the PCISP. The CCB and PCISP should be developed in tandem, however the CCB must be finalized first to be selectable in the PCISP.

Cultural Competency

Cultural competency is a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance and respect for cultural differences and similarities within and among groups, and the sensitivity to know how these differences influence relations with others. It is a set of complementary behaviors, attitudes, and policies that help Case Managers work effectively with people of different cultures**.**

The culture in which a person lives impacts their attitudes, thoughts, feelings and actions, whether or not they have an intellectual or developmental disability. Being able to bridge the gap between our own culture and the cultural background of the individuals we support will strengthen, support and facilitate our role in assisting people as they plan their preferred life. The benefits of being culturally competent include:

- Fostering more understanding of how the individual feels, works, and the ways in which they live their life;
- Letting people know they are thought of as individuals;
- Effectively communicating culturally sensitive choices and any consequences; and
- Being aware of the many possibilities and responding appropriately.

The sum of these benefits is the ability to be responsive to the needs of individuals and families as they make choices and plan for the future.

Appendix

The Appendix includes a section for historical information about the individual. While intentionally included at the end of the PCISP, it is important all relevant information be included. If applicable, this section should include criminal background or requirements, such as registering as a sexual offender or restrictions on associations with others.

Additionally, within the Appendix the Case Manager will record:

- The individual's choice for Case Manager contact and team meeting frequency. At a minimum, Case Managers are required to complete a face-to-face contact every 90 days. For individuals residing in a provider owned or controlled setting, at least one of the face-to-face contacts is to be unannounced at the individual's home. Team meetings are required at least semi-annually and as needed or determined by the individual and/or guardian or other team members.
- Frequency of notification regarding medical condition, developmental and behavioral status, risk of treatment, and the right to refuse treatment. When provided, these notifications should be completed in a manner that promotes informed decision-making.
- The entity responsible for maintaining the individual's personal file.

Service Plan

The needs, outcomes, strategies, and actions to be addressed by Medicaid HCBS Waiver services are to be reflected in the action steps within each life domain. Services are requested through the Cost Comparison Budget (CCB) and will auto-populate on the Service Plan page. The providers approved for authorized services are responsible for carrying out the PCISP and meeting the health and personal safety needs of the individual.

The Service Plan list will include the waiver service name, service code, provider name, provider code, start and end dates, unit rate, number of units, and cost. Next to each service the Case Manager will enter a brief description of the need for the service. When the service listed has Outcomes, Strategies and Action Steps included within a domain, the Case Manager may enter "See (name of) life domain."

Team Meetings

Team meetings provide an opportunity for the Individualized Support Team to engage in meaningful discussion that results in a PCISP reflective of the individual's preferences and priorities. This means there shall be opportunities for open discussion about an individual's life, rather than dialogue that is rooted in technical jargon and focused on completing procedural requirements. With this in mind, Case Managers should encourage team members to exchange information like most recent appointments, medication lists, etc. via e-mail versus during the team meeting. The team meeting discussion should first and foremost be dictated by the individual and/or guardian's preferences and then integrate other team members recommendations framed with references to the PCISP.

Annual Team Meetings

In general, IST members should expect annual meetings to include an opportunity for the individual and/or guardian to discuss with the team their dreams, desires, and what they would like their future to be like. The Case Manager will provide support and opportunity for the individual to address how they would like the following areas to be reviewed:

- Complete (or if done, review) the About Me section and obtain input;
- Review each Life Domain;
- Identify any changes or modifications based on what was learned over the past year, including:
  - Recommendations from assessments; and
  - Trends and/or changes in health status, behavioral needs, and safety concerns.
- Discuss current progress on outcomes and strategies by individual or provider; and
- Update outcomes and strategies based on discussion, with specific attention to:
  - Ensure the needs and preferences of the individual are addressed and reflected in the individual's schedule;
  - Refine and build on the individual's preferred outcomes and strategies;
  - Identify potential risks and barriers to achieving the identified outcomes and strategies, as well as strategies for overcoming or minimizing risks and barriers;
  - Discuss how each provider will align their services with the individual's preferences;
  - Identify timelines for reaching outcomes and strategies; and
  - Identify type and level of support for reaching outcomes and strategies.

Non-Annual Team Meetings

For other team meetings, IST members should expect an opportunity for the individual and/or guardian to discuss with the team their dreams, desires, and what they would like their future to be like. The Case Manager will provide support and opportunity for the individual to address how they would like the following areas to be reviewed:

- Assess the individual's typical week to verify it accurately reflects the activities, timeframes, preferences, and needs of the individual.
- Have a meaningful discussion regarding implementation of the PCISP based on summaries of provider reports, incident reports, health and behavioral needs, and current services.
- Share celebrations towards progress on outcomes and strategies.
- Identify any updates or modifications needed to the PCISP.

Face-to-Face Visits

Face-to-face visits provide an opportunity for the individual, their family (if appropriate), and their Case Manager to engage in informal discussion that helps to build their relationship and supports the Case Manager in developing a better understanding of the individual's preferences and priorities. These visits also provide an opportunity for the individual and/or their family to:

- Discuss progress on their current PCISP;
- Share their perspective on what is working or not working with their PCISP; and
- Identify changes that may be needed to improve alignment with their preferences.

Face-to-face visits take place at a time and place convenient to the individual and/or their family. As a result, these visits can take place in a variety of locations which provides the Case Manager with an opportunity to observe how supports are being implemented in a variety of settings, as well as to understand any differences in needs based on different settings. Examples of face-to-face visits includes observing the individual at their home, at their day service setting, or in a community-based activity, like a Special Olympics event. At least one face-to-face visit or team meeting per year must be held in the individual's home.

PCISP Implementation and On-Going Meeting Preparation

The Case Manager has the primary, foundational role in creating, maintaining, and updating a person-centered individualized support plan. Thoughtful and on-going engagement and preparation is the key to a successful PCISP that acknowledges the individual's abilities, strengths and needs and creates a plan that will support the individual to achieve his or her vision of a preferred life. All IST members must participate to the fullest extent possible, and as desired by the individual and guardian, in the development, review and implementation of the PCISP.

Once the individual's PCISP is finalized, their Case Manager should begin a continuous cycle of activities that help to gather information related to implementation of their plan. These activities include, but are not limited to:

- Face-to-Face visits with the individual, at least every 90-days, within their home and other service settings, as appropriate;
- On-site record and documentation review;
- Phone and e-mail contact with the individual, guardian (if applicable), family, and providers;
- Review of provider quarterly reports and other documentation and/or assessments; and
- Review of incident reports and other documentation related to the individual.

In reviewing this information, the individual's Case Manager is evaluating:

- Whether and to what extent the individual's PCISP is being implemented;
- What obstacles are being encountered relative to plan implementation;
- What changes have occurred with the individual that impacts their PCISP;
- What additional information about the individual is needed in order to refine the PCISP;
- What issues need to be addressed immediately and what actions will the Case Manager take to address these immediate issues; and
- Items to be celebrated or addressed during the next team meeting.

In order to gather the information needed for effective evaluation of PCISP implementation, an individual's Case Manager should explore various areas (see below) during face-to-face visits and contacts with the individual and/or guardian. In exploring these issues, the Case Manager is seeking feedback and input from the individual and/or guardian regarding the delivery and satisfaction of waiver services as they fit into the other activities of the individual's life. The questions, outlined in each area below, should not be presented as a checklist of information to be included within the PCISP, but rather should be asked in a conversational format as the Case Manager builds and maintains their relationship with the individual and/or guardian. Things learned about the individual should be incorporated into the PCISP.

Overall Status of the Individual	What is the individual's demeanor? How does the individual look? Do they appear to be healthy, happy, wearing appropriate clothing for weather, well kept, etc.? Review details of the individual's typical week (Monday-Sunday) and other records that define what actually is taking place and how the person currently spends their time each day to monitor movement toward their preferred life. Is the individual doing more of "what works" for them?
Community Involvement	What activities have they done and want to do again? What new connections did they make? Did they go out as often as they wanted – why or why not? Who did they spend time with?
PCISP Implementation	Are they working on things that support their desired accomplishments for the year? If not, why not? If so, what are they learning about those areas? Is the PCISP available to the individual and staff? What was observed about implementation of outcomes and strategies identified in the PCISP? Do staff appear knowledgeable about the individual's PCISP?
Health/Medical	Have there been any changes in their health? Any new medications changes or new medical needs? Changes in PRN medication usage?
Satisfaction & Concerns	Are they having any issues with providers or staff who work with them or other people around them? How are things going? Do staff demonstrate they understand and respond to the individual's communication style? Are staff interactions respectful, attentive, and positive?
Friendship and Social Interactions	Ask about friendships. Are they talking to their friends, able to hang out with them, need help making friends, etc.? Do they have internet access, use social media or email to stay in touch with friends?
Self-Determination	Are they making their own choices, choosing places to go? Are people listening to them? What was observed in terms of the individual making choices and determining their activities for the day and when and with whom they engage? Do staff ask the individual about their needs and preferences? Are they knowledgeable about the individual's capabilities, interests, and preferences?
Employment	Do they want to look for a job? Or if working, how is their job going? Is it a job they like to do? Any issues? Do they want to look for a different job or doing something else at work?
Environment	Is the home well kept? Is the individual satisfied with their bedroom and other personal space? What type of tasks does the individual complete or assist with in the household? What was the individual doing when the CM arrived?
School Attendance & Satisfaction (for school age persons)	How is school going? Any extended absences or barriers to school involvement? Anything happening in school that should be incorporated into the PCISP? Are strategies in the PCISP consistent with the IEP (e.g. behavior plans)?
Financial (for individuals with representative payees who are not family members)	Are they able to access money when needed for personal expenses? Do they know where their spending money is kept? Do they have input on how it is spent? Do they express any concerns with manner in which their money is being managed? When applicable, can the individual show where recently purchased items are located? ***It is important to note, bank statements should never be uploaded to the document library.***

In completing documentation reviews (on-site documentation, provider reports, incident reports, etc.), Case Managers should be noting the following issues for follow-up and/or discussion with the IST:

- Progress and/or obstacles related to outcomes and strategies identified in the PCISP;
- Any trends and/or concerns relative to incident reports, medical needs/indicators, behavior needs, PRN usage, etc.; and
- Changes in types / frequency of an individual's behavior.

In preparing for a team meeting, the Case Manager will assist the individual and guardian to identify:

- Desired outcomes, dreams, employment, and service utilization over the plan year;
- Non-waiver services, traditional services, and potential providers and technology to meet desired outcomes;
- The amount of time they would like to spend in each service;
- Who should be at the meeting and the date of team meeting; and
- What sections of the support plan the individual and/or guardian would like to present at the meeting.

In addition, the Case Manager will:

- Review assessments and summarize recommendations, notable comments, strengths, weaknesses, learning style, behavioral concerns;
- Review and consider trends regarding incident reports, medical needs, health and safety, and behavior needs;
- Summarize progress toward outcomes and strategies, areas to celebrate, areas of concern or lack of progress and suggestions for development; and
- Maintain on-going contact with providers seeking feedback on how services are going? Any concerns regarding the individual, outings, behavior, health, etc.? And, follow-up on incident reports and/or issues identified by the Case Manager during visits, contact with the individual or guardian, and documentation review.

Case Managers will maintain an on-going record by documenting the outcomes from these activities, including immediate action items and/or items to address during the next team meeting, in their case notes.

Prior to team meetings, the Case Manager will work with the individual and guardian on developing the agenda. In completing this activity, the Case Manager will ensure the following is used to inform the agenda:

- Review the current PCISP with the individual and their guardian to identify changes and updates; determining what is working and not working for the individual;
- Review of issues identified in the Case Manager's on-going record of contact and documentation reviews; and
- Review all available assessments, including Life Course Tools, person-centered planning MAPs, level of care assessment, recent medical examinations, etc.

The following questions may be useful in supporting the individual and/or guardian in identifying issues to include in the agenda:

- What are other people your age doing (for work, fun, etc.) and what adaptations or accommodations are needed so you can have similar life experiences?
- Are you learning how to create or maintain community connections and social capital?
- How could assistive technology, adaptations or accommodations assist you in living the life you want?
- Are you learning how to access and integrate a variety of types of support (relationships, community assets, technology) in addition to any paid supports you receive?
- Do you have someone to talk to about your feelings, emotions, and concerns, so that you don't feel alone?
- Do you feel empowered to ask questions or disagree with professionals, and do you have support to know questions to ask and how to assert your wishes/opinions to professionals and supporters?

- Are you supported in creating a vision for your own life and have the life experiences to get you there?
- How are you being encouraged to be self-determined at all ages, stages, and aspects of your life?
- How are you supported in keeping an eye to the future or the next stages of life?

Appendix A: PCISP Guidance

Profile Review / Update

Profile information for the individual will automatically populate within the PCISP document. Before finalizing a PCISP, the Case Manager must ensure the information in the Profile information in the BDDS Portal is complete and current. The following table identifies profile fields that require review and possible updates. Once the PCISP is finalized, this information cannot be changed within the PCISP document.

Profile Field	System Requirement
Legal Name First and last name of individual; middle initial if used.	Required
Residential Address Complete residential address: Street address including house number, City, State and Zip Code.	Required
County Country of residential address.	Required
Home Phone Number Home phone number of the individual, including area code.	Required
Mobile Phone Number Mobile phone number of the individual, including area code.	When applicable
Email Address	When applicable
Date of Birth	Required
Living Arrangement	Required
Provider Owned or Controlled Setting	Required
RID Number	Required
Preferred Name or Nickname Name the individual prefers to be addressed by, e.g. T.J. rather than Thomas Joseph.	If desired by waiver participant
Legal Status Emancipated, minor, power of attorney, protected person, or ward of a court.	Required
Guardian or Legal Representative Name First and last name of the Guardian. *The profile will allow more than one guardian entered, however, only the first entry will populate in the PCISP.*	Required, based on legal status
Guardian Relationship Parent, sibling, court appointed guardian, etc.	Required, based on legal status
Guardian Address Complete mailing address: Street address including house number, City, State and Zip Code.	Required, based on legal status
Guardian Phone Number Preferred phone number of the guardian, including area code.	Required, based on legal status
Guardian Email Address Complete email address of the guardian.	When applicable
Race	Required
Ethnicity	Required
Gender Gender recorded by Medicaid.	Required
Language Primary language or method of communication.	Required
Individualized Support Team Member Contact Information	Required

Includes full name, company name, if applicable, relationship, complete mailing address, telephone number including area code, and email address.	
Primary/Emergency Contact Information Includes full name, relationship, complete mailing address, telephone number including area code, and email address, if applicable.	Required
Healthy Living Providers At a minimum, full name and telephone number for the individual's primary care physician and dentist. Additional healthy living providers should be entered when applicable.	Required
Qualifying I/DD Diagnosis: The qualifying I/DD diagnosis is entered separately from other mental health or medical diagnoses. Limited to Primary, Secondary, and Tertiary fields.	Required
Diagnosis: Mental Health and Medical Mental health and medical diagnoses must be entered separately from the qualifying I/DD diagnosis.	When Applicable

About Me

The About Me section should be a detailed strengths-based introduction of the individual. The following questions may be used to prompt discussion.

What people like and admire about me:	• Compliments and nice things other people say about me, especially when I'm "at my best." • The qualities about me and my personality that other people most value and respect. • The reasons people like or love me. • What people appreciate most about me.
My strengths and assets are:	• What I do well. • All the things I CAN do. • Portions or parts of big things that I CAN do (like make my salad at dinner; set the washer and dryer, etc.). • The qualities about myself I'm proud of. • Qualities or actions I have been recognized or awarded for. • If I were asked to brag about myself a little, I would say . . . • Some things I'm good at that my support staff might not know about.
My good life includes:	When I picture what I would like my life in the future to be like: • Where, how, and with whom I would be living. • What my home would be like. • Who I would spend my time with – when and how. • What I would be doing for fun. • How I would spend my days; evenings; weekends. • How I would be making my contributions to this world; my community; the people I care about. • What I would be doing to feel a sense of purpose and accomplishment. • The things I would be doing that bring me joy. • Things that I really like about my current life that I want to continue in the future. • Things about my current life that I want to change.

Life Stages

Life Stage Selection
Life stages are not assigned to an individual based on age, but should be a reflection of the individual's current experience. While one individual may remain in school until the age of 21, another may enter the transition stage earlier. An older person may be living with a diagnosis that hastens the Aging life stage. Having a team that knows, understands, and supports the individual in their current life stage is important to achieving the preferred life the individual desires. The individual, their family, and other team members can use resources like **Charting the LifeCourse: Experiences and Questions Booklet** to explore key issues relevant to an individual's particular life stage and domain.

Guidance by Life Domain

Within the seven life domains are identical questions that are to be answered based on the domain and the desires of the individual for that area of life. The guidance developed for each domain is not to be used as a "checklist" of questions, rather as prompts used for team discussion and to gather information relevant to the development of the PCISP.

Daily Life and Employment

What a person does as part of everyday life – school, employment, volunteering, communication, routines, and life skills.

Personal Focus

What's important to me and for me and what do others need to know to support me in the area of daily life and employment?

Based on discussion with the individual and his or her guardian, this section should include a description of what the individual thinks is important to have a good life in the area of daily life and employment.

When reading the plan, it should be easy to distinguish the difference between what is important to the individual from what is important to others. An effective person-centered plan combines and balances the two.

- ***Important to*** the individual is usually related to joy, comfort, purpose, happiness, contentment, fulfilment and satisfaction.
- ***Important for*** generally includes what is necessary for maintain the individual's health and safety.

"What others need to know to support me" crosses all domains. The support information in the PCISP is a crucial component to ensure assessed needs are met consistently. This area identifies how supports need to be provided day to day.

In the domain of daily life and employment, information recorded should include the role of the supporter and specifics about what works and does not work for the individual. Including these important facts can:

- Provide information to new staff working with the individual or family; and
- Assist with routines such as traveling to and from work; change in schedules; and transitioning from weekday to weekend.

What assessment tools were used in identifying these?

Assessment tools may include, but are not limited to:

- Functional need assessments;
- Level of Care screening tool;
- Inventory for Client and Agency Planning (ICAP);
- Clinical Assessments;
- Medical Assessments;
- Vocational Assessments;
- School Individualize Education Plan (IEP);
- Informal assessment and observations
- Informal conversation with the individual, guardian, family, friends, and providers; or
- Person-Centered Planning MAPs and/or LifeCourse Tools, including:
  - My Typical Week (What I actually do each day of the week currently);
  - My Preferences (What Works for Me; What Doesn't Work for Me);
  - Places I Go;
  - My Gifts and Competencies;
  - LifeCourse Trajectory;
  - LifeCourse Integrated Support Star; and
  - Tools for Developing a Vision.

Person-centered planning MAPs and/or LifeCourse tools may be attached to the PCISP for distribution using the link in the Appendix.

Specify how I communicate with others and the best way to communicate with me.

All communication is purposeful, and all people have a need to communicate. Some individuals have difficulty communicating. Most people express ideas, feelings and desires through words, gestures and body language to convey messages and respond to others. In some situations, the individual's method of communication may be perceived as inappropriate. Communication requires a willingness to use all available means in order to understand and to be understood (e.g. pictures, sign language, gestures, body language, augmentative devices, interpreters, etc.) Within this

section, provide information on how the individual communicates with others. Include general information, any variations or changes, words, gestures or other actions that might be important for the caregiver to know.

Vision of a Preferred Life

What is currently happening in this domain?

This section is to include information that will inform the reader about the current daily activities of the individual. Questions to prompt discussion might include:

- Does he or she attend school, a day service program, volunteer at a favorite place, or work a part-time or full-time job? If the individual is employed, include the name of the employer and if the work is competitive and in an integrated setting.

What I prefer for this life domain.

This section is to include information that will inform the reader about the individual's preferred vision for daily life and employment. Questions to prompt discussion might include:

- What are other people in this life stage doing for work or in school?
- What does the individual want to do during the day?
- What kind of job or career might they like – now or in the future?
- What areas of the individual's current daily life and employment experience would they like to change or maintain?
- What new opportunities would he or she like to explore?
- What needs or conditions must be in place to achieve the individual's good life?

To further explore daily life and employment possibilities based on the life stage of the individual, ISTs may find the following resources helpful:

- *Charting the LifeCourse: Experiences and Questions Booklet*
- *Charting the LifeCourse: Focus on Transition*
- *Daily Life and Employment: Transition Life Stage*
- *Charting the LifeCourse: Focus on Aging*
- *Charting the LifeCourse: Exploring Life Possibilities*

What is the desired outcome? ("I Want to…..In Order to Move to My Vision")

The desired outcome is a functional statement that includes what an individual would like to LEARN, PARTICIPATE, IMPROVE UPON, MANTAIN or ACCOMPLISH toward their preferred vision. The individual with assistance as needed from the IST, develops their own outcomes. Outcomes represent a specifiable intermediate point in movement from what is currently happening in the individual's life to the individual's preferred vision. Outcomes:

- Reflect what is important to and important for a person;
- Are specific and measurable;
- Support progress toward the Vision of a Preferred Life; and
- Can be derived from what is working and not working in a person's life.

For Daily Life and Employment, outcomes are designed to support individuals to make informed choices and encourage self-direction in pursuing daily activities of their choice while exploring the full range of options including employment, volunteering, use of free time, and participating in activities of their choice.

Strategies for implementation ("I Need…..to Support me with this Outcome")

In situations where there are different people implementing the outcome, strategies can assist all supporters to know what is needed to consistently implement each outcome. Strategies shall focus on:

- How the individual learns best (if teaching is involved);
- Instructions to teach defines what it takes to reach the action;
- How to best document progress;
- Addressing barriers; and
- Building on what is working and overcoming what isn't working.

Strategies provide information needed to understand the individual's expectations, family / team expectations, staff / agency expectations, etc., to implement each action.

Action steps needed ("I Will…..to Achieve this Outcome")

Action steps are stepping stones toward outcome. They include tasks that needs to be carried out in order to support an individual in achieving an outcome. Action steps are SMART:

- SPECIFIC
- MEASURABLE
- ATTAINABLE
- REALISTIC
- TIMELY

How will progress be measured? ("I Did…..to Achieve this Outcome")

Identifying how progress will be measured helps the individual and their IST determine if progress is occurring, what needs to continue to occur, if more time is needed to achieve the action taken, if the means of measuring progress is working or not working and if the timeline makes sense.

Who/When?

Describes who is responsible for a specific action step and within what timeframe. Should include the individual and both natural and paid supports.

Team Discussion on Outcomes

The purpose of team meetings is to review and assess as a team whether or not the plan is working as written and if not to discuss what the team can do to make it work. As shared earlier, to accomplish this purpose, team meetings should include:

- Opportunity for the individual and/or guardian to address the team on the dreams, desires, and what they would like their future to be like;
- Review schedules to verify they accurately reflect the activities, timeframes, preferences, and needs of the individual;
- Meaningful discussion regarding implementation of the PCISP based on summaries of provider reports, incident reports, health and behavioral needs, and current services; and
- Celebrations towards progress on outcomes and strategies.

Following this discussion, the Case Manager will use this section to capture key discussion points and team decisions relative to modifying the plan and/or strategies to ensure outcomes and strategies stay on track or get back on track.

Actions/Activities for my Daily Life and Employment Safety

If not addressed elsewhere in Actions/Activities, this section provides an opportunity for the team to document actions or activities within the domain of Daily Life and Employment needed for the individual's safety. This section:

- Identifies potential risks through assessments or as reflected as "Important For" in the Personal Focus section; and
- Specifies the actions needed to address, manage, or alleviate the risk, including the type, frequency, and location of supports and services needed. In specifying these actions, the IST should:
  - Identify the risk;
  - Clarify the problem they are trying to solve;
  - Describe what would happen if nothing was done; and
  - Identify the action the IST decided to take to manage this risk.

When a risk plan is needed for a risk in this domain, it is to be attached to the PCISP for distribution using the link in the Appendix.

Has informed consent and HRC approval been received and uploaded into the Document Library?

Restrictions require informed consent and Human Rights Committee approval. Case Managers will confirm the receipt of informed choice and Human Rights Committee (HRC) approval, or indicate it is not applicable in this life domain.

Supports and Services: Natural Supports

Need

The needs, outcomes, strategies and actions to be addressed by natural supports summarized in this section are reflected in the Action Steps above. Technology (e.g. smart phone apps) may also be a potential natural support and should not be overlooked.

Natural Support(s)

The name of the person or technology providing the natural support.

Relationship
The relationship of the person providing support to the individual. For example, “friend and fellow volunteer”.
Frequency
How often and when the support is provided.

Community Living

Where and how someone lives – housing and living options, community access, transportation, home adaptation and modification.

Personal Focus

What's important to me and for me and what do others need to know to support me in the area of community living?

Based on discussion with the individual and his or her guardian, this section should include a description of what the individual thinks is important to have a good life in the area of community living.

When reading the plan, it should be easy to distinguish the difference between what is important to the individual from what is important to others. An effective person-centered plan combines and balances the two.

- ***Important to*** the individual is usually related to joy, comfort, purpose, happiness, contentment, fulfilment and satisfaction.
- ***Important for*** generally includes what is necessary for maintain the individual's health and safety.

"What others need to know to support me" crosses all domains. The support information in the PCISP is a crucial component to ensure assessed needs are met consistently. This area identifies how supports need to be provided day to day.

In the domain of community living, information recorded should include the role of the supporter and specifics about what works and does not work for the individual. Based on the individual served, it may include rituals or routines important to and for the individual and how the individual learns best. Including these important facts can:

- Provide matching characteristics of the individual to staff;
- Teaching and learning tools developed by those who know and care about the individual; and
- Assist with routines such as changes in staff or schedules.

What assessment tools were used in identifying these?

Assessment tools include, but are not limited to:

- Functional need assessments;
- Level of Care screening tool;
- Inventory for Client and Agency Planning (ICAP);
- Clinical Assessments;
- Medical Assessments;
- Vocational Assessments;
- Informal Conversation with the individual, guardian, family, friends, and providers; or
- Person-Centered Planning MAPs and/or LifeCourse Tools, including:
    - My Preferences (What Works for Me; What Doesn't Work for Me);
    - Places I Go;
    - People in My Life/Relationships;
    - How I Communicate (Used when an individual' communication's is not readily understood or the individual does not seem to understand the communication of others. Describes how I make myself and my wants and needs understood and how I best understand what others are communicating to me);
    - LifeCourse Trajectory;
    - LifeCourse Integrated Support Star; and
    - Tools for Developing a Vision.

Person-centered planning MAPs and/or LifeCourse tools may be attached to the PCISP for distribution using the link in the Appendix.

Vision of a Preferred Life

What is currently happening in this domain?

This section is to include information that will inform the reader about where and how the individual lives. Questions to prompt discussion might include:

- Does he or she live at home with family, in a supported living setting, or foster care?

- How do they access their community?
- Are home modifications or adaptations necessary?
- Is the individual learning to create or maintain community connections and social capital?

What I prefer for this life domain

This section is to include information that will inform the reader about the individual's preferred vision for community living. Questions to prompt discussion might include:

- Is the individual happy where he or she lives?
- Does he or she like who they live with?
- Are there changes anticipated that may impact where, or with whom, the individual lives?
- Is the individual able to get out and about to explore and learn about the community?
- Could assistive technology, adaptations or accommodations assist the individual in living the life desired?

For additional community living questions and information based on the life stage of the individual, ISTs may find the following resources helpful:

- *Charting the LifeCourse: Experiences and Questions Booklet*
- *Charting the LifeCourse: Focus on Transition*
- *Charting the LifeCourse: Focus on Aging*
- *Charting the LifeCourse: Exploring Life Possibilities*

What is the desired outcome? ("I Want to…..In Order to Move to My Vision")

The desired outcome is a functional statement that includes what an individual would like to LEARN, PARTICIPATE, IMPROVE UPON, MANTAIN or ACCOMPLISH toward their preferred vision. The individual with assistance as needed from the IST, develops their own outcomes. Outcomes represent a specifiable intermediate point in movement from what is currently happening in the individual's life to the individual's preferred vision. Outcomes:

- Reflect what is important to and important for a person;
- Are specific and measurable;
- Support progress toward the Vision of a Preferred Life; and
- Can be derived from what is working and not working in a person's life.

For Community Living, outcomes emphasize individuals being leaders in selecting the community and home of their choice; living in homes designed to meet their unique needs; and actively choosing who they live with and where.

Strategies for implementation ("I Need…..to Support Me with the Outcome")

In situations where there are different people implementing the outcome, strategies can assist all supporters to know what is needed to consistently implement each outcome. Strategies shall focus on:

- How the individual learns best (if teaching is involved);
- Instructions to teach defines what it takes to reach the action;
- How to best document progress;
- Addressing barriers; and
- Building on what is working and overcoming what isn't working.

Strategies provide information needed to understand the individual's expectations, family / team expectations, staff / agency expectations, etc., to implement each action.

Action steps needed ("I Will…..to Achieve this Outcome")

Action steps are stepping stones toward outcome. They include tasks that needs to be carried out in order to support an individual in achieving an outcome. Action steps are SMART:

- SPECIFIC
- MEASURABLE
- ATTAINABLE
- REALISTIC
- TIMELY

How will progress be measured? ("I Did…..to Achieve this Outcome")

Identifying how progress will be measured helps the individual and their IST determine if progress is occurring, what needs to continue to occur, if more time is needed to achieve the action taken, if the means of measuring progress is working or not working and if the timeline makes sense.

Who/When?

Describes who is responsible for a specific action step and within what timeframe. Should include the individual and both natural and paid supports.

Team Discussion on Outcomes

The purpose of team meetings is to review and assess as a team whether or not the plan is working as written and if not to discuss what the team can do to make it work. As shared earlier, to accomplish this purposes, team meetings should include:

- Opportunity for the individual and/or guardian to address the team on the dreams, desires, and what they would like their future to be like;
- Review schedules to verify they accurately reflect the activities, timeframes, preferences, and needs of the individual;
- Meaningful discussion regarding implementation of the PCISP based on summaries of provider reports, incident reports, health and behavioral needs, and current services; and
- Celebrations towards progress on outcomes and strategies.

Following this discussion, the Case Manager will use this section to capture key discussion points and team decisions relative to modifying the plan and/or strategies to ensure outcomes and strategies stay on track or get back on track.

Actions/Activities for my Community Living Safety

If not addressed elsewhere in Actions/Activities, this section provides an opportunity for the team to required actions or activities within the domain of Community Living needed for the individual's safety. This section:

- Identifies potential risks through assessments or as reflected as "Important For" in the Personal Focus section; and
- Specifies the actions needed to address, manage, or alleviate the risk, including the type, frequency, and location of supports and services needed. In specifying these actions, the IST should:
  - Identify the risk;
  - Clarify the problem they are trying to solve;
  - Describe what would happen if nothing was done; and
  - Identify the action the IST decided to take to manage this risk.

When a risk plan is needed for a risk in this domain, it is to be attached to the PCISP for distribution using the link in the Appendix.

Has informed consent and HRC approval been received and uploaded into the Document Library?

Restrictions require informed consent and Human Rights Committee approval. Case Managers will confirm the receipt of informed choice and Human Rights Committee (HRC) approval, or indicate it is not applicable in this life domain.

HCBS Required Questions

In addition to the qualities that all home and community based settings are required to meet, the Centers for Medicare and Medicaid Services (CMS) requires, that provider owned or controlled residential settings must meet additional conditions. Specific to the life domain of community living, if the individual lives in a provider-owned or controlled home, the following questions must be asked and answered at least annually:

- Does the individual have privacy in their sleeping or living quarters?
- Does the individual's living quarters have lockable entrance doors, with the individual and appropriate staff having keys to doors as needed?
- If the individual shares living quarters, did the individual have a choice of roommates?
- Does the individual have the freedom to furnish and decorate their sleeping or living quarters within the lease or other agreement?

HCBS Remediation

Consistent CMS regulation, the IST must address and include the following elements within this section of the PCISP for **each** HCBS required question that is answered "no" by the IST:

- Identify a specific and **individualized assessed need**;

- Document the **positive interventions and supports used prior** to any modifications to the person-centered service plan;
- Document **less intrusive methods** of meeting the need that have been **tried** but did not work;
- Include **a clear description of the condition** that is directly proportionate to the specific assessed need;
- Include a **regular collection and review of data** to measure the ongoing effectiveness of the modification;
- Include **established time limits for periodic reviews** to determine if the modification is still necessary or can be terminated;
- Include **informed consent of the individual**; and
- Include **an assurance that interventions and supports will cause no harm** to the individual.

Supports and Services: Natural Supports
Need
The needs, outcomes, strategies and actions to be addressed by natural supports summarized in this section are reflected in the Action Steps above. Technology (e.g. smart phone apps) may also be a potential natural support and should not be overlooked.
Natural Support(s)
The name of the person or technology providing the natural support.
Relationship
The relationship of the person providing support to the individual.
Frequency
How often the support is provided.

Safety and Security

Staying safe and secure – finances, well-being, decision making supports, legal rights and issues.

Personal Focus

What's important to me and for me and what do others need to know to support me in the area of safety and security?

Based on discussion with the individual and his or her guardian, this section should include a description of what the individual thinks is important to have a good life in the area of safety and security.

When reading the plan, it should be easy to distinguish the difference between what is important to the individual from what is important to others. An effective person-centered plan combines and balances the two.

- ***Important to*** the individual is usually related to joy, comfort, purpose, happiness, contentment, fulfilment and satisfaction.
- ***Important for*** generally includes what is necessary for maintain the individual's health and safety.

"What others need to know to support me" crosses all domains. The support information in the PCISP is a crucial component to ensure assessed needs are met consistently. This area identifies how supports need to be provided day to day.

In the domain of Safety and Security, information recorded should include the role of the supporter and specifics about what works and does not work for the individual. Including these important facts can:

- Provide information to reader on the individual's financial needs and supports (for example, representative payee, power of attorney, etc.); and
- Provide clear and concise information necessary for the individual's well-being.

What assessment tools were used in identifying these?

Assessment tools include, but are not limited to:

- Functional need assessments;
- Level of Care screening tool;
- Inventory for Client and Agency Planning (ICAP);
- Clinical Assessments;
- Medical Assessments;
- Vocational Assessments;
- Informal Conversation with the individual, guardian, family, friends, and providers; or
- Person-Centered Planning MAPs and/or LifeCourse Tools, including:
    - My Preferences (What Works for Me; What Doesn't Work for Me);
    - People in My Life/Relationships;
    - Choices/Decisions That I Make vs. Others Make for Me;
    - LifeCourse Trajectory;
    - LifeCourse Integrated Support Star; and
    - Tools for Developing a Vision.

Person-centered planning MAPs and/or LifeCourse tools may be attached to the PCISP for distribution using the link in the Appendix.

Vision of a Preferred Life

What is currently happening in this domain?

This section is to include information that will inform the reader about the safety and security needs as they relate to finances, general well-being, and decision making. Questions to prompt discussion might include:

- Does he or she have a guardian, representative payee, or power of attorney?
- How are the individual's finances protected?
- What is currently happening to ensure freedom from emotional, physical or sexual harm?
- How is self-determination being encouraged?

What I prefer for this life domain

This section is to include information that will inform the reader about the individual's preferred vision for Safety and Security. Questions to prompt discussion might include:

- Is the individual empowered and supported to make decisions?
- Are there assistive devices or safety measures that can be utilized to keep the individual safe at home or in the community?
- Is the individual given the opportunity to spend discretionary funds as desired?

For additional safety and security questions and information based on the life stage of the individual, ISTs may find the following resources helpful:

- *Charting the LifeCourse: Experiences and Questions Booklet*
- *Charting the LifeCourse: Focus on Transition*
- *Charting the LifeCourse: Focus on Aging*
- *Charting the LifeCourse: Exploring Life Possibilities*

What is the desired outcome? ("I Want to…..In Order to Move to My Vision")

The desired outcome is a functional statement that includes what an individual would like to LEARN, PARTICIPATE, IMPROVE UPON, MANTAIN or ACCOMPLISH toward their preferred vision. The individual with assistance as needed from the IST, develops their own outcomes. Outcomes represent a specifiable intermediate point in movement from what is currently happening in the individual's life to the individual's preferred vision. Outcomes:

- Reflect what is important to and important for a person;
- Are specific and measurable;
- Support progress toward the Vision of a Preferred Life; and
- Can be derived from what is working and not working in a person's life.

For Safety and Security, outcomes emphasize individuals living free from harm, being educated about their rights and living in healthy environments where safety and security are a high priority, while supporting the individual's rights to live independently, make personal choices and take some risks.

Strategies for implementation ("I Need…..to Support Me with the Outcome")

In situations where there are different people implementing the outcome, strategies can assist all supporters to know what is needed to consistently implement each outcome. Strategies shall focus on:

- How the individual learns best (if teaching is involved);
- Instructions to teach defines what it takes to reach the action;
- How to best document progress;
- Addressing barriers; and
- Building on what is working and overcoming what isn't working.

Strategies provide information needed to understand the individual's expectations, family / team expectations, staff / agency expectations, etc., to implement each action.

Action steps needed ("I Will…..to Achieve this Outcome")

Action steps are stepping stones toward outcome. They include tasks that needs to be carried out in order to support an individual in achieving an outcome. Action steps are SMART:

- SPECIFIC
- MEASURABLE
- ATTAINABLE
- REALISTIC
- TIMELY

How will progress be measured? ("I Did…..to Achieve this Outcome")

Identifying how progress will be measured helps the individual and their IST determine if progress is occurring, what needs to continue to occur, if more time is needed to achieve the action taken, if the means of measuring progress is working or not working and if the timeline makes sense.

Who/When?

Describes who is responsible for a specific action step and within what timeframe. Should include the individual and both natural and paid supports.

Team Discussion on Outcomes

The purpose of team meetings is to review and assess as a team whether or not the plan is working as written and if not to discuss what the team can do to make it work. As shared earlier, to accomplish this purposes, team meetings should include:

- Opportunity for the individual and/or guardian to address the team on the dreams, desires, and what they would like their future to be like;
- Review schedules to verify they accurately reflect the activities, timeframes, preferences, and needs of the individual;
- Meaningful discussion regarding implementation of the PCISP based on summaries of provider reports, incident reports, health and behavioral needs, and current services; and
- Celebrations towards progress on outcomes and strategies.

Following this discussion, the Case Manager will use this section to capture key discussion points and team decisions relative to modifying the plan and/or strategies to ensure outcomes and strategies stay on track or get back on track.

Actions/Activities for my Safety and Security

If not addressed elsewhere in this Action Plan, this section provides an opportunity for the team to required actions or activities within the domain of Safety and Security needed for the individual's safety. This section:

- Identifies potential risks through assessments or as reflected as "Important For" in the Personal Focus section; and
- Specifies the actions needed to address, manage, or alleviate the risk, including the type, frequency, and location of supports and services needed. In specifying these actions, the IST should:
  - Identify the risk;
  - Clarify the problem they are trying to solve;
  - Describe what would happen if nothing was done; and
  - Identify the action the IST decided to take to manage this risk.

When a risk plan is needed for a risk in this domain, it is to be attached to the PCISP for distribution using the link in the Appendix.

Has informed consent and HRC approval been received and uploaded into the Document Library?

Restrictions require informed consent and Human Rights Committee approval. Case Managers will confirm the receipt of informed choice and Human Rights Committee (HRC) approval, or indicate it is not applicable in this life domain.

HCBS Required Questions

In addition to the qualities that all home and community based settings are required to meet, the Centers for Medicare and Medicaid Services (CMS) requires, that provider owned or controlled residential settings must meet additional conditions. Specific to the life domain of community living, if the individual lives in a provider-owned or controlled home, the following questions must be asked and answered at least annually:

- Is the individual's dwelling/unit owned, rented, or occupied under a legally enforceable agreement?
- Does the individual have the same responsibilities/protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity?

HCBS Remediation

Consistent CMS regulation, the IST must address and include the following elements within this section of the PCISP for **each** HCBS required question that is answered "no" by the IST:

- Identify a specific and **individualized assessed need**;
- Document the **positive interventions and supports used prior** to any modifications to the person-centered service plan;
- Document **less intrusive methods** of meeting the need that have been **tried** but did not work;
- Include **a clear description of the condition** that is directly proportionate to the specific assessed need;
- Include a **regular collection and review of data** to measure the ongoing effectiveness of the modification.
- Include **established time limits for periodic reviews** to determine if the modification is still necessary or can be terminated;
- Include **informed consent of the individual**; and

- Include **an assurance that interventions and supports will cause no harm** to the individual.

Supports and Services: Natural Supports
Need
The needs, outcomes, strategies and actions to be addressed by natural supports summarized in this section are reflected in the Action Steps above. Technology (e.g. smart phone apps) may also be a potential natural support and should not be overlooked.
Natural Support(s)
The name of the person or technology providing the natural support.
Relationship
The relationship of the person providing support to the individual.
Frequency
How often the support is provided.

Healthy Living

Managing and accessing health care and staying well – medical, mental health, behavior, developmental, wellness and nutrition.

Personal Focus

Medication administration needs:

Record all information necessary to provide a complete picture of the individual's needs regarding medication administration. Questions to prompt discussion may include, but are not limited to, the following:

- Does the individual self-administer medications? If so, are verbal prompts required?
- If medications are not self-administered, who is responsible for medication administration?
- Who is responsible for filling prescriptions?
- Is the individual able to swallow oral medications? If not, do pills need to be crushed or taken with a food such as pudding or applesauce?
- How are medications stored in the home? Are locks, or double locks, required?
- Is a medication administration record maintained?

What's important to me and for me and what do others need to know to support me in the area of healthy living?

Based on discussion with the individual and his or her guardian, this section should include a description of what the individual thinks is important to have a good life in the area of healthy living.

When reading the plan, it should be easy to distinguish the difference between what is important to the individual from what is important to others. An effective person-centered plan combines and balances the two.

- ***Important to*** the individual is usually related to joy, comfort, purpose, happiness, contentment, fulfilment and satisfaction.
- ***Important for*** generally includes what is necessary for maintain the individual's health and safety.

"What others need to know to support me" crosses all domains. The support information in the PCISP is a crucial component to ensure assessed needs are met consistently. This area identifies how supports need to be provided day to day.

This information should include the role of the supporter and specifics about what works and does not work for the individual, and keeps him or her in optimum health. It is essential this section include all health issues, conditions, risks, and related supports. Any recommended prevention measures for the individual should also be included.

What's important to me in regards to helping manage my health care?

Questions to prompt discussion might include:

- What does the individual like to do to stay healthy?
- Can the individual make and communicate decisions regarding their health care?
- Does he or she need or want help with making choices about their health care?

What assessment tools were used in identifying these?

Assessment tools include, but are not limited to:

- Functional need assessments;
- Level of Care screening tool;
- Inventory for Client and Agency Planning (ICAP);
- Clinical Assessments;
- Medical Assessments;
- Vocational Assessments;
- Informal Conversation with the individual, guardian, family, friends, and providers; or
- Person-Centered Planning MAPs and/or LifeCourse Tools, including:
    - My Preferences (What Works for Me; What Doesn't Work for Me);
    - My Typical Week;
    - LifeCourse Trajectory;
    - LifeCourse Integrated Support Star; and
    - Tools for Developing a Vision.

Person-centered planning MAPs and/or LifeCourse tools may be attached to the PCISP for distribution using the link in the Appendix.

Person responsible for coordinating my healthcare:

If applicable, include the name and contact information of the person responsible for coordinating the individual's health care.

Allergies: List food, drug, and other allergies:

Based on discussion with the individual, guardian, and IST, and any collateral information available, list all food, drug, and other allergies.

Mealtime: List food likes and dislikes, special diets, dining issues, weight issues, etc.

Include food preferences, special diet requirements or needs around weight, and adaptive equipment. Questions to prompt discussion may include:

- What foods and beverages does the individual enjoy most?
- What foods and beverages should be enjoyed in moderation?
- Are there any foods or beverages that must be avoided?
- Does the individual need assistance with eating or drinking?
- Are adaptive cups or utensils needed?
- Does the individual require a special diet for health or weight issues?

What's important for me to be healthy and safe at mealtime?

As part of ongoing support to meet the individual's healthy living needs, it is essential this section include all health issues, conditions, risks, and related supports. Discussion topics should include, but are not limited to:

- Chewing difficulties;
- Swallowing difficulties;
- Other dining difficulties; and
- Use of, or need for, dentures.

Vision of a Preferred Life

What is currently happening in this domain?

Include information that will inform the reader about the individual's medical, mental health, behavioral, nutritional and wellness needs. Include any new diagnoses, recent visits to the emergency room, hospitalizations, and any follow-up care received or needed. Additional questions to prompt discussion may include:

- Does he or she know how to ask for help or tell they are sick?
- Can the individual make and communicate decisions regarding medical treatment?
- Is medical or adaptive equipment utilized or needed? Does the individual engage in behavior that is injurious to them or others?
- Does the individual feel empowered to ask questions, disagree with professionals and know how to assert their wishes/opinions to professionals and supporters?

What I prefer for this life domain

This section is to include information that will inform the reader about the individual's preferred vision for Healthy Living. Questions to prompt discussion might include:

- Does the individual like to make healthy meals and snacks?
- Does the individual participate in exercise or other physical activity as desired?
- Is there technology that can monitor sleep patterns, exercise or activity and other related information? (For example, Fitbit, Dropcam, FuelBand, etc.)

For additional healthy living questions based on the life stage of the individual, ISTs may find the following resources helpful:

- *Charting the LifeCourse: Experiences and Questions Booklet*
- *Charting the LifeCourse: Exploring Life Possibilities*
-

What is the desired outcome? ("I Want to…..In Order to Move to My Vision")

The desired outcome is a functional statement that includes what an individual would like to LEARN, PARTICIPATE, IMPROVE UPON, MANTAIN or ACCOMPLISH toward their preferred vision. The individual with assistance as needed

from the IST, develops their own outcomes. Outcomes represent a specifiable intermediate point in movement from what is currently happening in the individual's life to the individual's preferred vision. Outcomes:

- Reflect what is important to and important for a person;
- Are specific and measurable;
- Support progress toward the Vision of a Preferred Life; and
- Can be derived from what is working and not working in a person's life.

For Healthy Living, outcomes emphasize the individual's right to receive physical, emotional and mental health care from the practitioner of their choice. Individuals receive information and education on ways to maintain their health and well-being. Individuals are supported in making healthy choices.

Strategies for implementation ("I Need…..to Support Me with the Outcome")

In situations where there are different people implementing the outcome, strategies can assist all supporters to know what is needed to consistently implement each outcome. Strategies shall focus on:

- How the individual learns best (if teaching is involved);
- Instructions to teach defines what it takes to reach the action;
- How to best document progress;
- Addressing barriers; and
- Building on what is working and overcoming what isn't working.

Strategies provide information needed to understand the individual's expectations, family / team expectations, staff / agency expectations, etc., to implement each action.

Action steps needed ("I Will…..to Achieve this Outcome")

Action steps are stepping stones toward outcome. They include tasks that needs to be carried out in order to support an individual in achieving an outcome. Action steps are SMART:

- SPECIFIC
- MEASURABLE
- ATTAINABLE
- REALISTIC
- TIMELY

How will progress be measured? ("I Did…..to Achieve this Outcome")

Identifying how progress will be measured helps the individual and their IST determine if progress is occurring, what needs to continue to occur, if more time is needed to achieve the action taken, if the means of measuring progress is working or not working and if the timeline makes sense.

Who/When?

Describes who is responsible for a specific action step and within what timeframe. Should include the individual and both natural and paid supports.

Team Discussion on Outcomes

The purpose of team meetings is to review and assess as a team whether or not the plan is working as written and if not to discuss what the team can do to make it work. As shared earlier, to accomplish this purposes, team meetings should include:

- Opportunity for the individual and/or guardian to address the team on the dreams, desires, and what they would like their future to be like;
- Review schedules to verify they accurately reflect the activities, timeframes, preferences, and needs of the individual;
- Meaningful discussion regarding implementation of the PCISP based on summaries of provider reports, incident reports, health and behavioral needs, and current services; and
- Celebrations towards progress on outcomes and strategies.

Following this discussion, the Case Manager will use this section to capture key discussion points and team decisions relative to modifying the plan and/or strategies to ensure outcomes and strategies stay on track or get back on track.

Actions/Activities for my Healthy Living Safety

If not addressed elsewhere in this Action Plan, this section provides an opportunity for the team to required actions or activities within the domain of Healthy Living needed for the individual's safety. This section:

- Identifies potential risks through assessments or as reflected as "Important For" in the Personal Focus section; and
- Specifies the actions needed to address, manage, or alleviate the risk, including the type, frequency, and location of supports and services needed. In specifying these actions, the IST should:
  - Identify the risk;
  - Clarify the problem they are trying to solve;
  - Describe what would happen if nothing was done; and
  - Identify the action the IST decided to take to manage this risk.

When a risk plan is needed for a risk in this domain, it is to be attached to the PCISP for distribution using the link in the Appendix.

Has informed consent and HRC approval been received and uploaded into the Document Library?

Restrictions require informed consent and Human Rights Committee approval. Case Managers will confirm the receipt of informed choice and Human Rights Committee (HRC) approval, or indicate it is not applicable in this life domain.

HCBS Required Questions

In addition to the qualities that all home and community based settings are required to meet, the Centers for Medicare and Medicaid Services (CMS) requires, that provider owned or controlled residential settings must meet additional conditions. Specific to the life domain of Healthy Living, if the individual lives in a provider-owned or controlled home, the following questions must be asked and answered at least annually:

- Is the setting physically accessible to the individual?
- Does the individual have access to food at any time?

HCBS Remediation

Consistent CMS regulation, the IST must address and include the following elements within this section of the PCISP for **each** HCBS required question that is answered "no" by the IST:

- Identify a specific and **individualized assessed need**;
- Document the **positive interventions and supports used prior** to any modifications to the person-centered service plan;
- Document **less intrusive methods** of meeting the need that have been **tried** but did not work;
- Include **a clear description of the condition** that is directly proportionate to the specific assessed need;
- Include a **regular collection and review of data** to measure the ongoing effectiveness of the modification;
- Include **established time limits for periodic reviews** to determine if the modification is still necessary or can be terminated;
- Include **informed consent of the individual**; and
- Include **an assurance that interventions and supports will cause no harm** to the individual.

Supports and Services: Natural Supports

Need

The needs, outcomes, strategies and actions to be addressed by natural supports summarized in this section are reflected in the Action Steps above. Technology (e.g. smart phone apps) may also be a potential natural support and should not be overlooked.

Natural Support(s)

The name of the person or technology providing the natural support.

Relationship

The relationship of the person providing support to the individual.

Frequency

How often the support is provided.

Social and Spirituality

Building friendships and relationships, leisure activities, personal networks and faith community.

Personal Focus

What's important to me and for me and what do others need to know to support me in the area of social and spirituality?

Based on discussion with the individual and his or her guardian, this section should include a description of what the individual thinks is important to have a good life in the area of social and spirituality.

When reading the plan, it should be easy to distinguish the difference between what is important to the individual from what is important to others. An effective person-centered plan combines and balances the two.

- ***Important to*** the individual is usually related to joy, comfort, purpose, happiness, contentment, fulfilment and satisfaction.
- ***Important for*** generally includes what is necessary for maintain the individual's health and safety.

"What others need to know to support me" crosses all domains. The support information in the PCISP is a crucial component to ensure assessed needs are met consistently. This area identifies how supports need to be provided day to day.

Keep in mind that caring for and about other people and having other people care for and about us is what makes our lives meaningful. Many people who receive services have lost touch with or never developed relationships with people who are not paid to be with them. It is important to know about the individual's social support network. This includes who is important to the individual, what the individual likes to do with them and about how often. The information discussed during this part of the planning may assist individuals in maintaining relationships, as well as discovering desires to develop new relationships.

What assessment tools were used in identifying these?

Assessment tools include, but are not limited to:

- Functional need assessments;
- Level of Care screening tool;
- Inventory for Client and Agency Planning (ICAP);
- Clinical Assessments;
- Medical Assessments;
- Vocational Assessments;
- Informal Conversation with the individual, guardian, family, friends, and providers; or
- Person-Centered Planning MAPs and/or LifeCourse Tools, including:
    - My Preferences (What Works for Me; What Doesn't Work for Me);
    - My Typical Week;
    - Places I Go;
    - People in My Life/Relationships;
    - LifeCourse Trajectory;
    - LifeCourse Integrated Support Star; and
    - Tools for Developing a Vision.

Person-centered planning MAPs and/or LifeCourse tools may be attached to the PCISP for distribution using the link in the Appendix.

Vision of a Preferred Life

What is currently happening in this domain?

This section is to include information that will inform the reader about the social and spiritual needs as they relate to friendships and relationships, leisure activities, personal networks and faith community. Questions to prompt discussion might include:

- Does the individual have family and friends?
- Is social medial used to make or keep in touch with friends?
- Does the individual have someone to talk with about their feelings, emotions, and concerns?
- What hobbies or interests does the individual participate in?

What I prefer for this life domain

This section is to include information that will inform the reader about the individual's preferred vision for social and spirituality. Questions to prompt discussion might include:

- What kind of relationships does the individual want in their life?
- What activities does the individual want to do in the community for fun and friendship?
- Does the individual want to get involved in civic engagement or leadership?
- Does the individual participate in faith-based practices of their choosing?

For additional social and spirituality questions and information based on the life stage of the individual, ISTs may find the following resources helpful:

- *Charting the LifeCourse: Experiences and Questions Booklet*
- *Charting the LifeCourse: Exploring Life Possibilities*

What is the desired outcome? ("I Want to…..In Order to Move to My Vision")

The desired outcome is a functional statement that includes what an individual would like to LEARN, PARTICIPATE, IMPROVE UPON, MANTAIN or ACCOMPLISH toward their preferred vision. The individual with assistance as needed from the IST, develops their own outcomes. Outcomes represent a specifiable intermediate point in movement from what is currently happening in the individual's life to the individual's preferred vision. Outcomes:

- Reflect what is important to and important for a person;
- Are specific and measurable;
- Support progress toward the Vision of a Preferred Life; and
- Can be derived from what is working and not working in a person's life.

For Social and Spirituality, outcomes are about presence and participation in the community, based on interests determined by the individual; being integrated into the community, including community service, in the same way as neighbors and fellow community members; and having natural supports in their lives and relationships that are not based on their disability.

Strategies for implementation ("I Need…..to Support Me with the Outcome")

In situations where there are different people implementing the outcome, strategies can assist all supporters to know what is needed to consistently implement each outcome. Strategies shall focus on:

- How the individual learns best (if teaching is involved);
- Instructions to teach defines what it takes to reach the action;
- How to best document progress;
- Addressing barriers; and
- Building on what is working and overcoming what isn't working.

Strategies provide information needed to understand the individual's expectations, family / team expectations, staff / agency expectations, etc., to implement each action.

Action steps needed ("I Will…..to Achieve this Outcome")

Action steps are stepping stones toward outcome. They include tasks that needs to be carried out in order to support an individual in achieving an outcome. Action steps are SMART:

- SPECIFIC
- MEASURABLE
- ATTAINABLE
- REALISTIC
- TIMELY

How will progress be measured? ("I Did…..to Achieve this Outcome")

Identifying how progress will be measured helps the individual and their IST determine if progress is occurring, what needs to continue to occur, if more time is needed to achieve the action taken, if the means of measuring progress is working or not working and if the timeline makes sense

Who/When?

Describes who is responsible for a specific action step and within what timeframe. Should include the individual and both natural and paid supports.

Team Discussion on Outcomes

The purpose of team meetings is to review and assess as a team whether or not the plan is working as written and if not to discuss what the team can do to make it work. As shared earlier, to accomplish this purposes, team meetings should include:

- Opportunity for the individual and/or guardian to address the team on the dreams, desires, and what they would like their future to be like;
- Review schedules to verify they accurately reflect the activities, timeframes, preferences, and needs of the individual;
- Meaningful discussion regarding implementation of the PCISP based on summaries of provider reports, incident reports, health and behavioral needs, and current services; and
- Celebrations towards progress on outcomes and strategies.

Following this discussion, the Case Manager will use this section to capture key discussion points and team decisions relative to modifying the plan and/or strategies to ensure outcomes and strategies stay on track or get back on track.

Actions/Activities for my Social and Spiritual Safety

If not addressed elsewhere in this Action Plan, this section provides an opportunity for the team to required actions or activities within the domain of Healthy Living needed for the individual's safety. This section

- Identifies potential risks through assessments or as reflected as "Important For" in the Personal Focus section; and
- Specifies the actions needed to address, manage, or alleviate the risk, including the type, frequency, and location of supports and services needed. In specifying these actions, the IST should:
  - Identify the risk;
  - Clarify the problem they are trying to solve;
  - Describe what would happen if nothing was done; and
  - Identify the action the IST decided to take to manage this risk.

When a risk plan is needed for a risk in this domain, it is to be attached to the PCISP for distribution using the link in the Appendix.

Has informed consent and HRC approval been received and uploaded into the Document Library?

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HCBS Required Questions

In addition to the qualities that all home and community based settings are required to meet, the Centers for Medicare and Medicaid Services (CMS) requires, that provider owned or controlled residential settings must meet additional conditions. Specific to the life domain of Social and Spirituality, if the individual lives in a provider-owned or controlled home, the following questions must be asked and answered at least annually:

- Is the individual allowed visitors at any time?

HCBS Remediation

Consistent CMS regulation, the IST must address and include the following elements within this section of the PCISP for **each** HCBS required question that is answered "no" by the IST:

- Identify a specific and **individualized assessed need**;
- Document the **positive interventions and supports used prior** to any modifications to the person-centered service plan;
- Document **less intrusive methods** of meeting the need that have been **tried** but did not work;
- Include **a clear description of the condition** that is directly proportionate to the specific assessed need;
- Include a **regular collection and review of data** to measure the ongoing effectiveness of the modification;

- Include **established time limits for periodic reviews** to determine if the modification is still necessary or can be terminated;
- Include **informed consent of the individual**; and
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Supports and Services: Natural Supports
Need
The needs, outcomes, strategies and actions to be addressed by natural supports summarized in this section are reflected in the Action Steps above. Technology (e.g. smart phone apps) may also be a potential natural support and should not be overlooked.
Natural Support(s)
The name of the person or technology providing the natural support.
Relationship
The relationship of the person providing support to the individual.
Frequency
How often the support is provided.

Citizenship and Advocacy

Building valued roles, making choices, setting goals, assuming responsibility and driving how one's own life is lived.

Personal Focus

What's important to me and for me and what do others need to know to support me in the area of citizenship and advocacy?

Being known and valued in one's community gives a person a sense of worth and of being a contributor and good citizen, not just someone who needs assistance. Learning to make choices, set goals, and knowing how to speak up for wants and needs leads to being more self-determined in life and essential to becoming and advocate for yourself or others.

Based on discussion with the individual and his or her guardian, this section should include a description of what the individual thinks is important to have a good life in the area of citizenship and advocacy.

When reading the plan, it should be easy to distinguish the difference between what is important to the individual from what is important to others. An effective person-centered plan combines and balances the two.

- ***Important to*** the individual is usually related to joy, comfort, purpose, happiness, contentment, fulfilment and satisfaction.
- ***Important for*** generally includes what is necessary for maintain the individual's health and safety.

"What others need to know to support me" crosses all domains. The support information in the PCISP is a crucial component to ensure assessed needs are met consistently. This area identifies how supports need to be provided day to day.

What assessment tools were used in identifying these?

Assessment tools include, but are not limited to:

- Functional need assessments;
- Level of Care screening tool;
- Inventory for Client and Agency Planning (ICAP);
- Clinical Assessments;
- Medical Assessments;
- Vocational Assessments;
- Informal Conversation with the individual, guardian, family, friends, and providers; or
- Person-Centered Planning MAPs and/or LifeCourse Tools, including:
    - My Preferences (What Works for Me; What Doesn't Work for Me);
    - Places I Go;
    - Decisions and Choices I Make vs. Others Make for Me;
    - My Gifts and Competencies;
    - LifeCourse Trajectory;
    - LifeCourse Integrated Support Star; and
    - Tools for Developing a Vision.

Person-Centered Planning MAPs and/or LifeCourse tools may be attached to the PCISP for distribution using the link in the Appendix.

Am I registered to vote?

This is a yes or no response for all individuals 18 or older. A not applicable option is available for those under the age of 18. This question can be used as a discussion starter for citizenship and advocacy.

Vision of a Preferred Life

What is currently happening in this domain?

This section is to include information that will inform the reader about the citizenship and advocacy needs as they relate to personal value, making choices, setting goals and assuming responsibility for how one's own life is lived. Questions to prompt discussion might include:

- Is the individual encouraged and supported to participate in and/or lead person-centered planning meetings?
- Is the individual encouraged and supported to make choices and decisions about his or her life?

- Does the individual understand his or her rights and responsibilities when it comes to dealing with providers, agencies and other sources of support?

What I prefer for this life domain

This section is to include information that will inform the reader about the individual's preferred vision for Citizenship and Advocacy. Questions to prompt discussion might include:

- Is the individual interested in learning self-advocacy skills or in joining a self-advocacy group?
- Is the individual able to be assertive without being aggressive?
- Does the individual's family and others understand what the individual wants and what is important to him or her?

For additional citizenship and advocacy questions and information based on the life stage of the individual, ISTs may find the following resources helpful:

- *Charting the LifeCourse: Experiences and Questions Booklet*
- *Charting the LifeCourse: Exploring Life Possibilities*

What is the desired outcome? ("I Want to…..In Order to Move to My Vision")

The desired outcome is a functional statement that includes what an individual would like to LEARN, PARTICIPATE, IMPROVE UPON, MANTAIN or ACCOMPLISH toward their preferred vision. The individual with assistance as needed from the IST, develops their own outcomes. Outcomes represent a specifiable intermediate point in movement from what is currently happening in the individual's life to the individual's preferred vision. Outcomes:

- Reflect what is important to and important for a person;
- Are specific and measurable;
- Support progress toward the Vision of a Preferred Life; and
- Can be derived from what is working and not working in a person's life.

For Citizenship and Advocacy, outcomes emphasize the importance of self-advocacy. Training and ongoing support are often required to assist an individual in developing their self-advocacy skills.

Strategies for implementation ("I Need…..to Support Me with the Outcome")

In situations where there are different people implementing the outcome, strategies can assist all supporters to know what is needed to consistently implement each outcome. Strategies shall focus on:

- How the individual learns best (if teaching is involved);
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Who/When?

Describes who is responsible for a specific action step and within what timeframe. Should include the individual and both natural and paid supports

Team Discussion on Outcomes

The purpose of team meetings is to review and assess as a team whether or not the plan is working as written and if not to discuss what the team can do to make it work. As shared earlier, to accomplish this purposes, team meetings should include:

- Opportunity for the individual and/or guardian to address the team on the dreams, desires, and what they would like their future to be like;
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- Celebrations towards progress on outcomes and strategies.

Following this discussion, the Case Manager will use this section to capture key discussion points and team decisions relative to modifying the plan and/or strategies to ensure outcomes and strategies stay on track or get back on track.

Actions/Activities for my Citizenship and Advocacy Safety

If not addressed elsewhere in this Action Plan, this section provides an opportunity for the team to require actions or activities within the domain of Citizenship and Advocacy needed for the individual's safety. This section

- Identifies potential risks through assessments or as reflected as "Important For" in the Personal Focus section; and
- Specifies the actions needed to address, manage, or alleviate the risk, including the type, frequency, and location of supports and services needed. In specifying these actions, the IST should:
  - Identify the risk;
  - Clarify the problem they are trying to solve;
  - Describe what would happen if nothing was done; and
  - Identify the action the IST decided to take to manage this risk.

When a risk plan is needed for a risk in this domain, it is to be attached to the PCISP for distribution using the link in the Appendix.

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HCBS Required Questions

In addition to the qualities that all home and community based settings are required to meet, the Centers for Medicare and Medicaid Services (CMS) requires, that provider owned or controlled residential settings must meet additional conditions. Specific to the life domain of Social and Spirituality, if the individual lives in a provider-owned or controlled home, the following questions must be asked and answered at least annually:

- Does the individual have the freedom and support to control their own schedules and activities?

HCBS Remediation

Consistent CMS regulation, the IST must address and include the following elements within this section of the PCISP for **each** HCBS required question that is answered "no" by the IST:

- Identify a specific and **individualized assessed need**;
- Document the **positive interventions and supports used prior** to any modifications to the person-centered service plan;
- Document **less intrusive methods** of meeting the need that have been **tried** but did not work;
- Include **a clear description of the condition** that is directly proportionate to the specific assessed need;
- Include a **regular collection and review of data** to measure the ongoing effectiveness of the modification;
- Include **established time limits for periodic reviews** to determine if the modification is still necessary or can be terminated;
- Include **informed consent of the individual**; and
- Include **an assurance that interventions and supports will cause no harm** to the individual.

Supports and Services: Natural Supports

Need

The needs, outcomes, strategies and actions to be addressed by natural supports summarized in this section are reflected in the Action Steps above. Technology (e.g. smart phone apps) may also be a potential natural support and should not be overlooked.
Natural Support(s)
The name of the person or technology providing the natural support.
Relationship
The relationship of the person providing support to the individual.
Frequency
How often the support is provided.

Other Areas of Importance

Personal Focus

What's important to me and for me and what do others need to know to support me in the other areas of importance?

Based on discussion with the individual and his or her guardian, this section should include a description of what the individual thinks is important to have a good life in other areas of importance.

When reading the plan, it should be easy to distinguish the difference between what is important to the individual from what is important to others. An effective person-centered plan combines and balances the two.

- ***Important to*** the individual is usually related to joy, comfort, purpose, happiness, contentment, fulfilment and satisfaction.
- ***Important for*** generally includes what is necessary for maintain the individual's health and safety.

"What others need to know to support me" crosses all domains. The support information in the PCISP is a crucial component to ensure assessed needs are met consistently. This area identifies how supports need to be provided day to day.

What assessment tools were used in identifying these?

Assessment tools include, but are not limited to:

- Functional need assessments;
- Level of Care screening tool;
- Inventory for Client and Agency Planning (ICAP);
- Clinical Assessments;
- Medical Assessments;
- Vocational Assessments;
- Informal Conversation with the individual, guardian, family, friends, and providers; or
- Person-Centered Planning MAPs and/or LifeCourse Tools, including:
- My Preferences (What Works for Me; What Doesn't Work for Me);
    - My Gifts and Competencies;
    - Vision of My Future;
    - LifeCourse Trajectory;
    - LifeCourse Integrated Support Star; and
    - Tools for Developing a Vision.

Person-centered planning MAPs and/or LifeCourse tools may be attached to the PCISP for distribution using the link in the Appendix.

Vision of a Preferred Life

What is currently happening in this domain?

Within the area identified by the individual, guardian, and/or IST, what is currently happening?

What I prefer for this life domain

This section is to include information that will inform the reader about the individual's preferred vision for Other Areas of Importance. Based on the discussion with the individual, guardian, and IST what is preferred in this area?

What is the desired outcome? ("I Want to…..In Order to Move to My Vision")

The desired outcome is a functional statement that includes what an individual would like to LEARN, PARTICIPATE, IMPROVE UPON, MANTAIN or ACCOMPLISH toward their preferred vision. The individual with assistance as needed from the IST, develops their own outcomes. Outcomes represent a specifiable intermediate point in movement from what is currently happening in the individual's life to the individual's preferred vision. Outcomes:

- Reflect what is important to and important for a person;
- Are specific and measurable;
- Support progress toward the Vision of a Preferred Life; and
- Can be derived from what is working and not working in a person's life.

For other areas of importance, outcomes emphasize the importance of desired that were not identified in other life domains.

Strategies for implementation ("I Need…..to Support Me with the Outcome")

In situations where there are different people implementing the outcome, strategies can assist all supporters to know what is needed to consistently implement each outcome. Strategies shall focus on:

- How the individual learns best (if teaching is involved);
- Instructions to teach defines what it takes to reach the action;
- How to best document progress;
- Addressing barriers; and
- Building on what is working and overcoming what isn't working.

Strategies provide information needed to understand the individual's expectations, family / team expectations, staff / agency expectations, etc., to implement each action.

Action steps needed ("I Will…..to Achieve this Outcome")

Action steps are stepping stones toward outcome. They include tasks that needs to be carried out in order to support an individual in achieving an outcome. Action steps are SMART:

- SPECIFIC
- MEASURABLE
- ATTAINABLE
- REALISTIC
- TIMELY

How will progress be measured? ("I Did…..to Achieve this Outcome")

Identifying how progress will be measured helps the individual and their IST determine if progress is occurring, what needs to continue to occur, if more time is needed to achieve the action taken, if the means of measuring progress is working or not working and if the timeline makes sense.

Who/When?

Describes who is responsible for a specific action step and within what timeframe. Should include the individual and both natural and paid supports.

Team Discussion on Outcomes

The purpose of team meetings is to review and assess as a team whether or not the plan is working as written and if not to discuss what the team can do to make it work. As shared earlier, to accomplish this purposes, team meetings should include:

- Opportunity for the individual and/or guardian to address the team on the dreams, desires, and what they would like their future to be like;
- Review schedules to verify they accurately reflect the activities, timeframes, preferences, and needs of the individual;
- Meaningful discussion regarding implementation of the PCISP based on summaries of provider reports, incident reports, health and behavioral needs, and current services; and
- Celebrations towards progress on outcomes and strategies.

Following this discussion, the Case Manager will use this section to capture key discussion points and team decisions relative to modifying the plan and/or strategies to ensure outcomes and strategies stay on track or get back on track.

Actions/Activities for my Other Areas of Importance Safety

If not addressed elsewhere in this Action Plan, this section provides an opportunity for the team to required actions or activities within the domain of Other Areas of Importance needed for the individual's safety. This section:

- Identifies potential risks through assessments or as reflected as "Important For" in the Personal Focus section; and
- Specifies the actions needed to address, manage, or alleviate the risk, including the type, frequency, and location of supports and services needed. In specifying these actions, the IST should:
  - Identify the risk;
  - Clarify the problem they are trying to solve;
  - Describe what would happen if nothing was done; and
  - Identify the action the IST decided to take to manage this risk.

When a risk plan is needed for a risk in this domain, it is to be attached to the PCISP for distribution using the link in the Appendix.

Has informed consent and HRC approval been received and uploaded into the Document Library?

Restrictions require informed consent and Human Rights Committee approval. Case Managers will confirm the receipt of informed choice and Human Rights Committee (HRC) approval, or indicate it is not applicable in this life domain.

Supports and Services: Natural Supports

Need

The needs, outcomes, strategies and actions to be addressed by natural supports summarized in this section are reflected in the Action Steps above. Technology (e.g. smart phone apps) may also be a potential natural support and should not be overlooked.

Natural Support(s)

The name of the person or technology providing the natural support.

Relationship

The relationship of the person providing support to the individual.

Frequency

How often the support is provided.

Appendix

Historical Information

Historical information is included to provide a record of important events in the individual's life and their effect on the individual, as well as pertinent general information about the individual's past. Should criminal history or sexual offender status be part of an individual's life, it is to be included in this section.

Contact and Meetings

Case Manager Contact

At this time, face-to-face contact is required quarterly. Individuals and guardians may include their preference for more frequent contacts or what desired frequency should changes to the waiver and Indiana Administrative Code be made in the future. For individuals residing in a provider owned or controlled setting, at least one of the face-to-face contacts must be unannounced at the individual's home.

Individualized Support Team (IST) Meetings

Team meetings are required at least semi-annually and as needed or determined by the individual, guardian or other team members.

Next (IST) Meeting

Case Managers may include the date of the next IST for record keeping purposes, however including the date here does not eliminate the need to schedule the meeting at the time and location desired by the individual and/or guardian.

Frequency of Notification

Each provider is required to inform the individual of the following at least annually, but more frequently if requested:

- Medical condition;
- Developmental status;
- Behavior status;
- Risk of treatment; and
- Right to refuse treatment.

This requirement does not apply to providers of occupational therapy services, physical therapy services, music therapy services, and speech-language therapy services.

Personal File

Responsible Party

Include the name, address, and telephone number of the provider responsible for maintaining the individual's personal file.

Risk Plans and Other Documents

In the Appendix section of the entry system in the BDDS Portal , Case Managers will have the opportunity to select documents from the document library that will attach to the PCISP. Risk and behavior support plans should always be linked. It may also be desired by the individual, guardian, and IST for MAPs used in planning to be linked. All documents selected will be included in the final PCISP for distribution to all team members.

Final Review

Before finalizing the PCISP, Case Managers should preview the document to ensure all components of the PCISP are correct. Once a PCISP is finalized, information can only be changed or corrected by entering an Update PCISP.

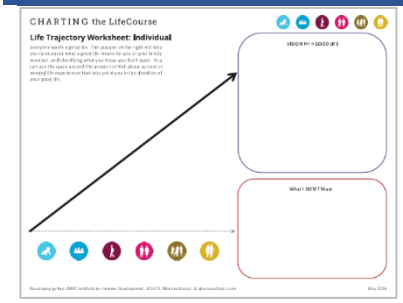
- Does the About Me section capture what the individual wants known?
- Is the individual's profile up to date? ***Inaccurate profile information cannot be changed once the PCISP has been finalized.***
- Is the life stage selected reflective of the IST's discussion?
- Are the sections of each domain completed as desired by the individual and IST?
    - Are the strategies developed for each outcome measurable?
    - Is the individual's routine outlined and include community activities and events?
- Are risks outlined in the Actions/Activities section of the appropriate life domain current and all risk plans linked to the PCISP?
- For individuals 16 or older, does the Daily Life and Employment section include the discussion on employment?
- Have service definitions been reviewed to ensure required components are include in the plan?
- Have HCBS questions been responded to appropriately and any remediation information included?
- Are natural supports included in life domains as appropriate?
- Are all sections of the Appendix complete and up-to-date?
- Have needs been entered for each service listed in the Service Plan?

Appendix B: Tool Box

The PCISP is based upon the LifeCourse Framework (LCF), however it is not required LCF tools be used in development of an individual's plan. A tool box has been created to provide individuals, families, and teams with resources that might be helpful in developing a vision for the future and plan to achieve the vision.

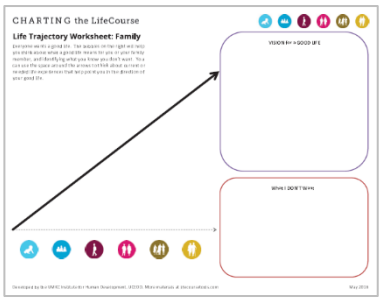
LifeCourse Tools

Tools for individuals, families and professionals



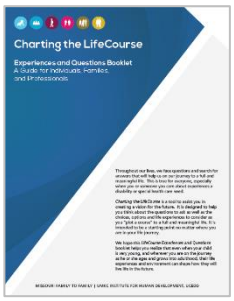
Life Trajectory Worksheet: Individual Version

Everyone wants a good life, and defines their good life in their own way. This tool can be used to help individuals and families think about what a good life means to them, and also identify what they know they don't want. The space around the arrows can be used to think about current or needed life experiences that help point the trajectory arrow in the direction of the good life vision.



Life Trajectory Worksheet: Family Version

Everyone wants a good life, and defines their good life in their own way. This tool can be used to help individuals and families think about what a good life means to them, and also identify what they know they don't want. The space around the arrows can be used to think about current or needed life experiences that help point the trajectory arrow in the direction of the good life vision.

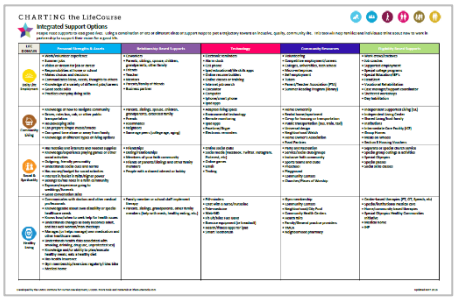


Charting the Life Course: Experiences and Questions Booklet

This booklet helps individuals and families know the questions to ask and things to think about throughout the life course, in order to have the experiences that help lead to the good life that they envision. Most of the questions and life experiences in this booklet could apply to anyone, whether they have a disability or not. *Intended as a supplement when using the Life Trajectory worksheets.*

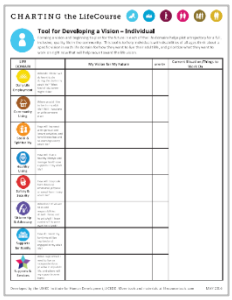
Integrated Supports Star

All people need support to lead good lives. Using a combination of many different kinds of support helps to plot a trajectory toward an inclusive, quality, community life. This tool will help individuals and families brainstorm the supports that they already have or might need in order to work in partnership to make their vision for a good life possible.



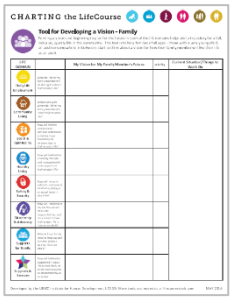
Integrated Supports Options

People often need support to lead good lives. Using a combination of many different kinds of support helps to plot a trajectory toward an inclusive, quality, community life. This tool will help families and individuals think about how to work in partnership to support their vision for a good life. *Intended as a supplement when using the Integrated Supports Star worksheets.*



Tool for Developing a Vision: Individual Version

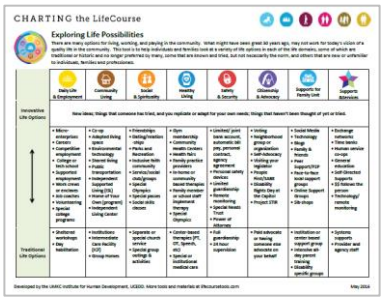
Forming a vision and beginning to plan for the future in each of the life domains helps plot a trajectory for a full, inclusive life in the community. This tool is to help individuals of start to think about a more specific vision for life as an adult. This tool also helps individuals narrow down what life domain(s) they are focusing on by rating what is most important to them at this point in time.



Tool for Developing a Vision: Family Version

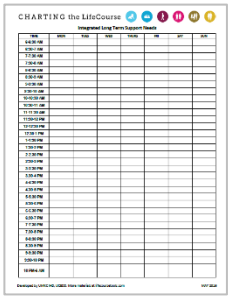
Forming a vision and beginning to plan for the future in each of the life domains helps plot a trajectory for a full, inclusive life in the community. This tool is to help individuals of all ages and/or their families – from the very young child, an adult or somewhere in between – start to think about a more specific vision for life as an adult. This tool also

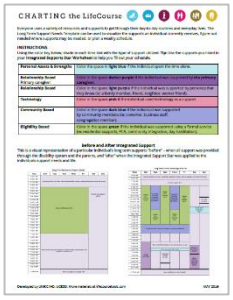
helps families narrow down what life domain(s) they are focusing on by rating what is most important to them at this point in time.



Exploring Life Possibilities

There are many options for living, working, and playing in the community. What might have been new and exciting 30 years ago may not work for today's vision of a quality life in the community. This tool is to help individuals and families explore a variety of options for where they might life or do during the day to earn money or have fun. Some may be more traditional or historic and no longer preferred by many, some that are known and tried but no necessarily the norm, and others that are new or unfamiliar to individuals, families, and professionals.



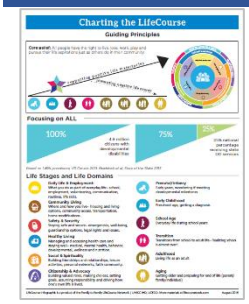


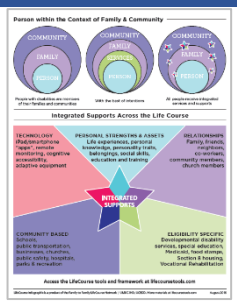
Integrated Long Term Support Needs

Once individuals and/or families have determined the types of supports needed and/or existing, this template is a way to apply the supports to a daily/weekly schedule. The worksheet include instructions and an example on the back.

Learning Materials

Educational Resources to help you learn about the LifeCourse framework, life stages, and life domains.



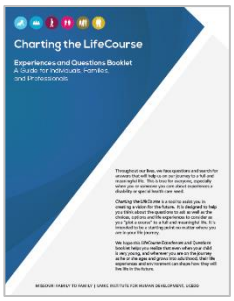


Charting the LifeCourse Infographic

This 2-page handout is a visual representation to help with understanding the LifeCourse framework guiding principles. It high lights the key areas of the framework and presents the information concisely. This handout pairs best with a presentation or professional who knows the framework well and is able to answer any questions.

Foundation of the LifeCourse Framework

This tool explains the main elements and core beliefs of the LifeCourse framework. It can be used to help someone who is unfamiliar with the LifeCourse framework or tools understand the basics and explain it to others.

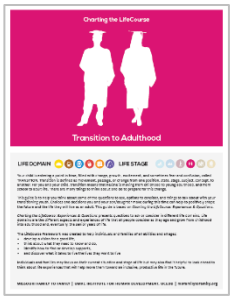


Charting the Life Course: Experiences and Questions Booklet

This booklet helps individuals and families know the questions to ask and things to think about throughout the life course, in order to have the experiences that help lead to the good life that they envision. Most of the questions and life experiences in this booklet could apply to anyone, whether they have a disability or not.

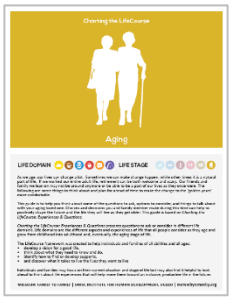
Charting the LifeCourse: Daily Life & Employment

This 20-page guide is meant to help transition age youth and families figure out what daily life is going to look like after high school ends. It includes activities and resources to begin to think about jobs, careers, or continuing education in adult life.



Charting the LifeCourse: Focus on Transition

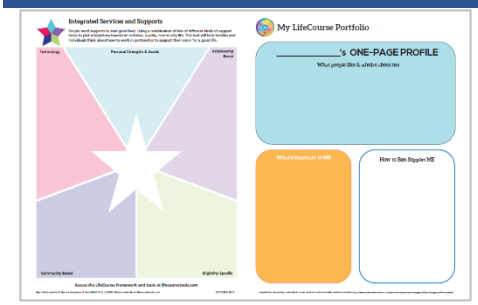
This short 4-page guide can be given to youth and parents of youth who are nearing or have reached transition age, to help them begin to think about things in each of the life domains that will be important in the transition from school to adult life. It includes questions to ask and options to consider and discuss with transitioning youth, to move toward a vision for a good life as an adult.



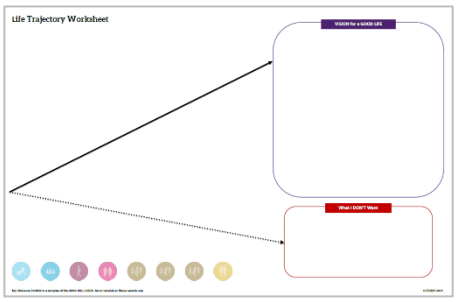
Charting the LifeCourse: Focus on Aging

This short 4-page guide can be given to aging individuals, caregivers, family members, and supporters to help them think about some of the questions to ask, options to consider, and conversations to have as they age. Choices and decisions you and family members make during this time can help to positively shape the future and the life they will live as they get older.

My Portfolio Tools



My LifeCourse Portfolio – Basic

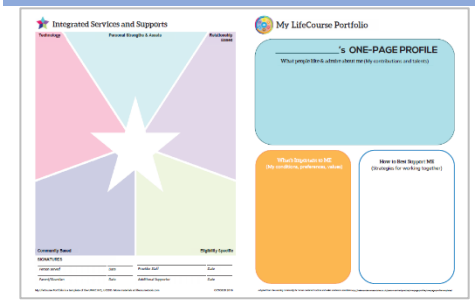


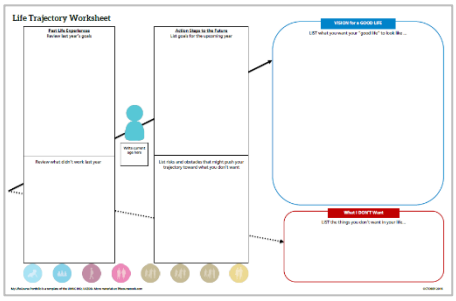
My LifeCourse Portfolio – Expanded

My LifeCourse Portfolios are Adobe Acrobat PDFs set up as 11” x 17” documents that fold. They are meant to be printed double-sided, flipping on the short edge. They Include:

- A one-page profile that provides a quick overview of the focus person or the focus life domain;
- Life Trajectory (customized for the purpose of the portfolio; and
- Integrated Supports Star Worksheet

My LifeCourse Planning Portfolio

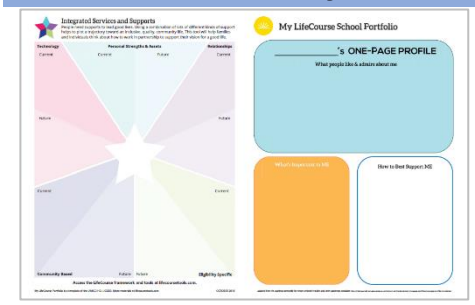


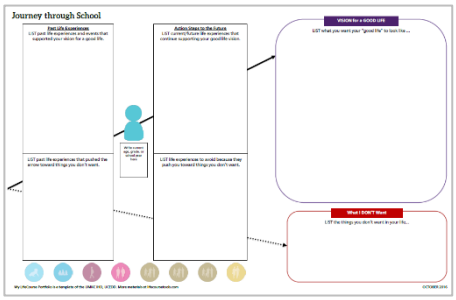


[My LifeCourse Planning Portfolio for Person-Centered Individualized Support Plans]

Developed in partnership with LOQW/County Connections, this portfolio was developed to help prepare the individuals, as well as staff, for the annual planning meeting in accordance with the CMS rules for person-centered planning.

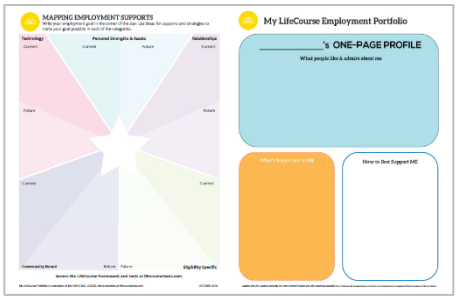
My LifeCourse Portfolios for Daily Life and Employment

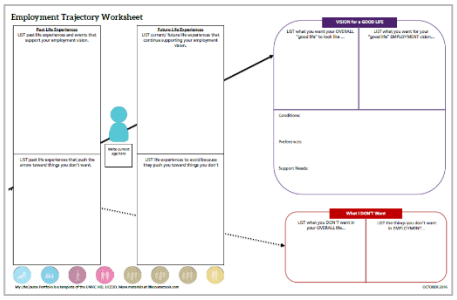




[My LifeCourse School Portfolio]

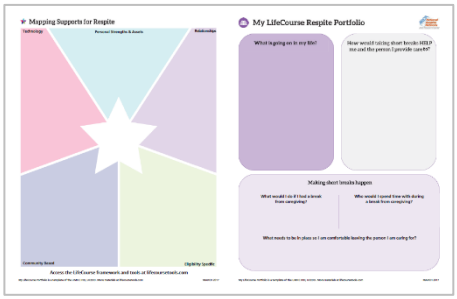
Piloted by Abilities First, this portfolio was developed specifically for school-age children and their families to help them work with school staff.

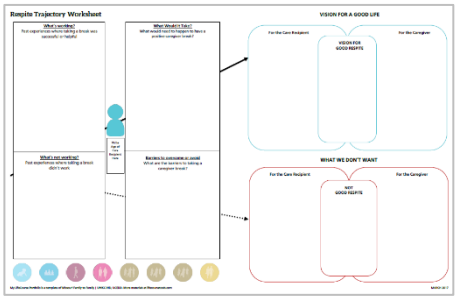




My LifeCourse Employment Portfolio

Developed in partnership with LOQW/County Connections, this portfolio was developed to help employment professionals help the individuals they support, al plan for employment goals.

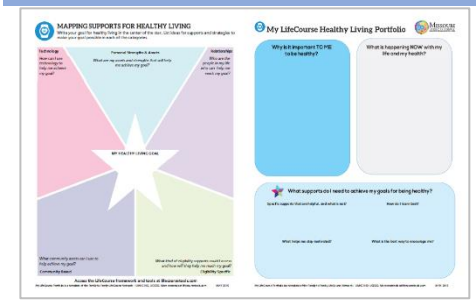


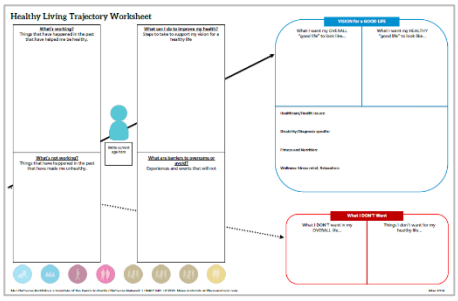


My LifeCourse Respite Portfolio

Developed in partnership with ARCH National Respite Network, this portfolio was developed to help family caregivers and those who support them to think through creating respite or short break opportunities.

My LifeCourse Portfolios for Healthy Living

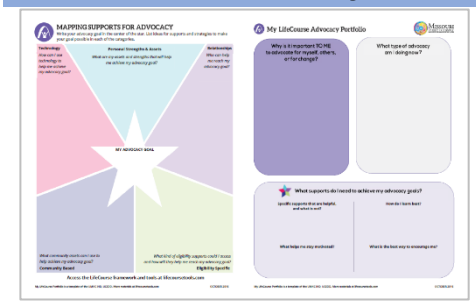


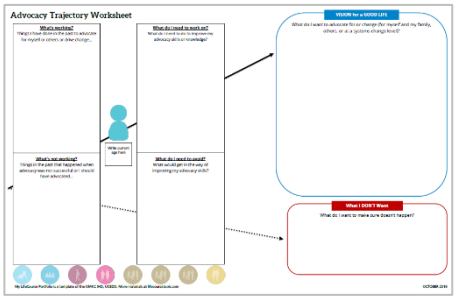


[My LifeCourse Healthy Living Portfolio]

Developed in partnership with Eitas, this portfolio was developed to help community health workers support individuals with I/DD to accomplish their goals for a healthy life.

My LifeCourse Portfolios for Citizenship & Advocacy





[My LifeCourse Advocacy Portfolio]

Developed in partnership with the LIFE Ability Center/Adair County SB40 board, to help self-advocates and family leaders think through the skills and experiences needed to advocate effectively for their good life, for other people/families, and for large scale change.