

# PCISP Requirements Checklist

## Overall System Requirements

- ① One life domain with all fields, including desired outcome, completed
- ② All fields identified with a red asterisk (\*)
- ③ Responses to all HCBS questions, including any required remediation, when the individual is identified as residing in a provider owned or controlled setting (POCOS)

## General Overview

- ☐ Edition Type
- ☐ CCB (*selection populates date range of PCISP and service plan*)
- ☐ Life Stage
- ☐ Living Arrangement (*auto-populates from Profile*)
- ☐ Provider Owned or Controlled Setting (*auto-populates from Profile*)
- ☐ Date of Team Meeting

## Individuals at My Team Meeting

- ☐ Case Manager, CMCO Name, Relationship (*If the Case Manager is deleted, the name, CMCO name, and relationship of the case management company representative in attendance must be added.*)
- ☐ Other Individualized Support Team members at team meeting
- ☐ Other meeting participants

## PCISP Edition Prepared By

- ☐ Facilitator Name, Relationship and Email Address
- ☐ Recorder Name, Relationship and Email Address

## About Me

- ☐ What people like and admire about me:
- ☐ My strengths and assets are:
- ☐ My good life includes:

## Life Domains

*Should the individual or guardian, if applicable, choose not to focus on a particular life domain at the present time, the case manager may enter a note within the first text field of that life domain including the plan for completing it in the future. However, at a minimum, at least one life domain must be complete.*

## Daily Life & Employment

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

## Community Living

- ☐ What's important to and for me and what do others need to know to support me in the area of community living?
- ☐ HCBS Question: Does the individual have privacy in their sleeping or living quarters?
- ☐ HCBS Question: Does the individual's living quarters have lockable entrance doors, with the individual and appropriate staff having keys to doors as needed?
- ☐ HCBS Question: If the individual shares living quarters, did the individual have a choice of roommates?
- ☐ HCBS Question: Does the individual have the freedom to furnish and decorate their sleeping or living quarters within the lease or other agreement?

## Safety & Security

- ☐ What's important to and for me and what do others need to know to support me in the area of safety and security?
- ☐ HCBS Question: Is the individual's dwelling/unit owned, rented, or occupied under a legally enforceable agreement?
- ☐ HCBS Question: 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?

## Healthy Living

- ☐ Medical Conditions: List chronic medical, behavioral, psychiatric, and other health conditions.
- ☐ Medication administration needs:
- ☐ What's important to and for me and what do others need to know to support me in the area of healthy living?
- ☐ What's important to me in regards to helping manage my health care?
- ☐ What assessment tools were used in identifying these?
- ☐ Person responsible for coordinating my healthcare:
- ☐ Allergies: List food, drug, and other allergies:
- ☐ Mealtime: List food likes and dislikes, special diets, dining issues, weight issues, etc.
- ☐ What's important for me to be healthy and safe at mealtime?
- ☐ HCBS Question: Is the setting physically accessible to the individual?
- ☐ HCBS Question: Does the individual have access to food at any time?

## Social & Spirituality

- ☐ What's important to and for me and what do others need to know to support me in the area of social and spirituality?
- ☐ HCBS Question: Is the individual allowed visitors at any time?

## Citizenship & Advocacy

- ☐ What's important to and for me and what do others need to know to support me in the area of citizenship and advocacy?
- ☐ Am I registered to vote?
- ☐ HCBS Question: Does the individual have the freedom and support to control their own schedule and activities?

## Other Areas of Importance

- ☐ What's important to and for me and what do others need to know to support me in other areas?

## Appendix

- ☐ Historical Information

## Contact & Meetings

- ☐ I would like my Case Manager to contact me:
- ☐ I choose to have team meetings:
- ☐ My next team meeting should be scheduled in:

## Indicate how often I am notified of the following:

- ☐ Medical Condition
- ☐ Developmental Status
- ☐ Behavioral Status
- ☐ Risk of Treatment
- ☐ Right to Refuse Treatment

## Person responsible for maintaining personal file:

- ☐ Name
- ☐ Company
- ☐ Phone number
- ☐ Email
- ☐ Photograph on File?

## Documents

- ☐ Risk plans as applicable
- ☐ LifeCourse tools, MAPS, or other assessments as desired

## Service Plan

- ☐ Need for each service listed

# Profile

## Basic Information

- |  |                                  |
|--|----------------------------------|
| <input type="checkbox"/> Legal Name  | Required                         |
| First and last name of individual; middle initial if used.   |                                  |
| <input type="checkbox"/> Preferred Name or Nickname  | If desired by waiver participant |
| Name the individual prefers to be addressed by, e.g. T.J. rather than Thomas Joseph.   |                                  |
| <input type="checkbox"/> RID Number  | Required                         |
| <input type="checkbox"/> Date of Birth   | Required                         |
| <input type="checkbox"/> Residential Address   | Required                         |
| Complete, USPS validated residential address (street address, cty, state, zip code, and county)  |                                  |
| <input type="checkbox"/> Home Phone Number   | Required                         |
| Home phone number of the individual, including area code.  |                                  |
| <input type="checkbox"/> Mobile Phone Number   | When applicable                  |
| Mobile phone number of the individual, including area code.  |                                  |
| <input type="checkbox"/> Email Address   | When applicable                  |
| <input type="checkbox"/> Gender  | Required                         |
| Gender recorded by Medicaid.   |                                  |
| <input type="checkbox"/> Marital Status  | Required                         |
| <input type="checkbox"/> Race  | Required                         |
| <input type="checkbox"/> Ethnicity   | Required                         |
| <input type="checkbox"/> Legal Status  | Required                         |
| Emancipated, minor, power of attorney, protected person, or ward of a court.   |                                  |
| <input type="checkbox"/> Guardian or Legal Representative Name   | Required, based on legal status  |
| First and last name of the Guardian. <i>The profile will allow more than one guardian entered, however, only the first entry will populate in the PCISP.</i> |                                  |
| <input type="checkbox"/> Guardian Relationship   | Required, based on legal status  |
| Parent, sibling, court appointed guardian, etc.  |                                  |
| <input type="checkbox"/> Guardian Address  | Required, based on legal status  |
| Complete, USPS validated mailing address (street address, cty, state, and zip code)  |                                  |
| <input type="checkbox"/> Guardian Phone Number   | Required, based on legal status  |
| Preferred phone number of the guardian, including area code.   |                                  |
| <input type="checkbox"/> Guardian Email Address  | When applicable                  |
| Complete email address of the guardian.  |                                  |
| <input type="checkbox"/> Language  | Required                         |
| Primary language or method of communication.   |                                  |

## Living Arrangement

- |   |          |
|---|----------|
| <input type="checkbox"/> Living Arrangement                   | Required |
| <input type="checkbox"/> Provider Owned or Controlled Setting | Required |

## Relationships

- |  |  |          |
|--|--|----------|
| <input type="checkbox"/>   | Individualized Support Team Member Contact Information | Required |
| Includes full name, relationship, and phone number. If available and applicable include company name, complete mailing address, and email address.                       |  |          |
| <input type="checkbox"/>   | Primary/Emergency Contact Information                  | Required |
| Includes full name, relationship, phone number.  |  |          |
| <input type="checkbox"/>   | Healthy Living Providers                               | Required |
| At a minimum, full name and phone number for the individual's primary care physician and dentist. Additional healthy living providers should be entered when applicable. |  |          |

## Diagnosis

- |   |                                      |                 |
|---|--------------------------------------|-----------------|
| <input type="checkbox"/>  | Qualifying I/DD Diagnosis            | Required        |
| The qualifying I/DD diagnosis is entered separately from other mental health or medical diagnoses. Limited to Primary, Secondary, and Tertiary fields. <i>Only a Primary Diagnosis is required.</i> |                                      |                 |
| <input type="checkbox"/>  | Diagnosis: Mental Health and Medical | When Applicable |
| Mental health and medical diagnoses must be entered separately from the qualifying I/DD diagnosis.  |                                      |                 |