A Guide to Individual Planning

Individual Plan

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Introduction

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The individual planning process results in the development of a comprehensive Individual Plan, which is the document to guide all supports and services provided to the individual. Individual planning, a form of person-centered planning, is a way to discover the kind of life a person desires, map out a plan for how it may be achieved, and ensure access to needed supports and services. Individual planning is an approach to planning driven by a respect for the individual, a belief in the capacities and gifts of all people, and the conviction that everyone deserves the right to create their own future.

Individual planning supports people to achieve the outcomes of the mission of the Department of Developmental Services, which states that all people should have opportunities to experience:

- Presence and participation in Connecticut town life.
- Opportunities to develop and exercise competence.
- Opportunities to make choices in the pursuit of a personal future.
- Good relationships with family members and friends.
- Respect and dignity.

The individual planning process promotes and encourages the person and those people who know and care about him or her to take the lead in directing this process and in planning, choosing, managing, and evaluating supports and services. Individual planning puts the person at the "center" of the plan. Individual planning offers people the opportunity to lead self-determined lifestyles and exercise greater control in their lives.

Individual planning is a way of listening to the person. During the process, the person is viewed holistically to develop a plan of supports and services that is meaningful to him or her. The resulting plan identifies services and supports to meet the person's unique desires and needs, regardless of funding source and may include Medicaid waiver services, state plan services, generic resources, and natural support networks. The plan is not the outcome. The life the person wants is the outcome. Through the implementation of ongoing action steps the planning and support team help the person move towards the life that he or she desires.

Case managers may share information with individuals about different types of person-centered planning processes and encourage them to choose the planning process that works best. However, any information obtained from other types of person-centered planning processes must be incorporated into the DDS Individual Plan form.

Individual Planning Policy

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Individual Planning

The Individual Planning Policy states that each individual served by the department shall have an Individual Plan or Individual Plan – Short Form commensurate with the supports and services received.

The following individuals shall have an Individual Plan:

- All individuals who receive DDS HCBS Waiver services
- All children in Behavior Supports Program
- All individuals who receive any DDS funded residential supports, including Individualized Home Supports
- All individuals in the Autism Spectrum Disorder division
- All clients of the department who pay directly for Residential Habilitation services.

Exceptions to an Individual Plan

Individuals served by the department are **not** required to have a comprehensive Individual Plan under the following circumstances:

- Individuals who are enrolling in a HCBS waiver will use the Individual Plan – Short Form, along with a Summary of Supports and Services, IP.6, for the first 90 days of receipt of new HCBS Waiver services, 45 days in licensed settings, after which time an Individual Plan must be in place. This process will also be used for any individuals in the MFP program.
- Individuals who live in private ICF/IID settings may plan using an Individual Plan – Short Form or the private agency's plan form.
- Individuals who live at home with their family or in their own homes and who do not receive DDS funded residential supports, including Individualized Home Supports or any Home and Community Based Services (HCBS) Waiver supports, including day support shall have an Individual Plan – Short Form.
- Individuals who are appropriately placed in Long Term Care facilities shall have an Individual Plan – Short Form.
- Individuals who pay directly for employment supports or day services shall have an Individual Plan – Short Form.

Individual Planning Timeframes

The Individual Plan is the document that guides the supports and services provided to the individual. The Individual Plan should accurately reflect the individual's current life situation and address their specific supports and services. At a minimum, Individual Plans will be reviewed and updated on a yearly basis for persons enrolled in a waiver. For HCBS Waiver recipients, the plan must be renewed within the same month of the prior year's plan date. If a plan cannot be completed within the required time frame the case manager must follow the procedure "To Extend an IP or IPS". For individuals newly determined eligible for DDS services, the case manager should ensure that an initial Individual Plan or Individual Plan – Short Form is developed within 60 days of the initial visit.

Roles and Responsibilities

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Role of the Individual

The individual is at the center of the planning process. Individuals and their family members should participate in the planning process to the greatest degree possible and effectively communicate their needs, desires and preferences to other team members. Individuals and their families have an important role in selecting participants to be invited to the planning meeting and helping to expand and enhance team membership. Ways that this can be done include identifying, recruiting and welcoming new team members and showing appreciation and support for the contributions of existing team members.

Before the meeting, the individual should begin to shape his or her vision for the future and choice of support options, including self-direction, vendor supports or the agency with choice option. Individuals and their families should provide information to the case manager to help him or her to update the information profile and complete the Level of Need Assessment and Screening Tool (LON). Along with the case manager, individuals and their families should review the assessments, reports, and evaluations and determine how information is to be presented.

During the meeting, the individual should share his or her vision for the future, objectives for the coming year, and preferences for activities to be pursued, types of supports to be provided, and support providers. He or she should identify which services will be provided by generic and informal sources. After the meeting, the individual and his or her family should review the completed plan for accuracy. The individual, parent, guardian or advocate, should contact the case manager within two weeks of receipt of the written plan if they do not agree with the plan as written.

Once the Individual Plan is developed and implemented, the individual should share information with the case manager and other team members about his or her satisfaction with the supports and services received. The individual should participate in ongoing monitoring and review of supports and services and in periodic reviews of the plan.

Role of the Case Manager

The role of the DDS case manager in individual planning is to support the person and other team members to develop and implement a plan that addresses the individual's needs and preferences. The case manager will support the individual to be actively involved in the planning process and to assume greater responsibility over time for directing and facilitating the meeting.

The case manager should assist the individual to identify members of his or her planning and support team and to invite them to the meeting. The case manager will support the individual and family to review assessments and reports before the meeting and to contribute information that will be used in the planning process. Prior to the meeting, the case manager will ensure that any individuals who express interest in self-directing supports are made aware of the opportunity to hire an independent support broker to assist with planning.

The case manager is responsible to ensure the individual planning meeting is scheduled at a time when the person, his or her family and other team members can attend. He or she is responsible to facilitate the annual individual planning meeting unless the individual requests another team member facilitate the meeting. The case manager should ensure the meeting is facilitated in line with the individual planning process and encompasses input across services settings.

At the time of the individual's planning meeting, the case manager is responsible for ensuring the individual, and his or her family, guardian, advocate or other legal representative, if applicable, is informed of the rights extended to them by DDS, including the right to appeal any decision that is made at the meeting through the Programmatic Administrative Review (PAR) process. The case manager should also notify the individual's family or guardian about the department's guidelines for reporting incidents to family members. Department guidelines require that the family will be notified of all critical incidents, injuries that require treatment by a physician regardless of location, restraint use that has not been approved for the individual by the Program Review Committee (PRC) and/or the parent has not been informed of the procedure, and emergency restraints. The case manager shall provide the family with the option to be notified more or less frequently if desired. At the time of the meeting, the case manager will also inform the individual of his or her human/civil rights, will share information about reporting suspected incidents of abuse or neglect, will inform individuals on the waiting list of their priority status, and will inform waiver participants and their families about Medicaid Fair Hearing rights. The case manager will also offer an opportunity for individuals who are age 17 or older to register to vote.

The case manager shall ensure the individual has been offered a choice of supports, service options, and providers and that the plan represents the individual's preferences. The case manager will transcribe and document the plan on the Individual Plan forms. In private Community Living Arrangements (CLAs) the plan will be transcribed by other team members. The case manager will review the documented plan for accuracy and share with the individual and his or her family or guardian for review. At the planning meeting, the case manager will document who participated in the planning process and obtain signatures of those present on the Signature Sheet. The case manager will ensure the plan is distributed to all team members within 30 days of plan development. In incidences where the IP is not written and/or distributed in the required time period, the case manager or provider will follow the "Procedure to ensure Timely documentation".

The case manager is responsible to monitor implementation of the plan to ensure supports and services are provided as outlined in the plan and that progress is being made that results in improvements in the individual's quality of life. He or she will ensure the plan is periodically reviewed and updated based on individual circumstances and regulatory requirements.

Support Provider Roles

The role of support providers is to ensure that quality, effective and timely supports are provided by qualified, trained staff. Providers should be active participants in the individual planning meeting and are responsible for developing specific plans including teaching strategies, programs, protocols, and guidelines that are in line with the individual plan and include how,

when, where, and what supports will be provided and how these supports will help the individual to achieve desired goals.

Providers will complete any assessments, evaluations, or reports for which they are responsible and will submit them to the case manager at least 14 days before the Individual Planning meeting or at other required deadlines. They shall provide information to the case manager to assist with the completion of the LON. Support providers will maintain documentation of progress on specific plans, including teaching strategies, programs, protocols, and guidelines and will provide six month reviews of progress to the case manager. Providers will notify the case manager at any time there are any significant changes in the individual's life that warrant a revision of the individual plan. Note that in some settings, more stringent review and reporting requirements may apply.

Individual Planning
Planning and Support Team Member Roles and Responsibilities

Individual Planning Activities	Individual	Case Manager	Support Providers (includes residential, day, & other providers)
Before the meeting select participants to be invited	✓	✓	
Schedule meeting at time and place convenient for individual/family, CM, and other team members and invite participants	✓	✓	
Submit current assessments to case manager 14 days prior to IP meeting			✓
Review Assessments, Reports, Evaluations with individual and family		✓	
Ensure copies of Assessments, Reports, Evaluations are shared with Support Providers		✓	
Complete LON with input from individual, family, and other team members		✓	
Update Information Profile	✓	✓	
Share LON and LON Summary Report with individual/family and provider(s)		✓	
Gather Personal Profile Information		✓	
Facilitate the meeting unless individual requests another facilitator		✓	
Transcribe the Plan within 2 weeks of IP meeting		✓	✓ (Private CLA only)
Review IP for accuracy and completeness	✓	✓	
Distribute the Plan Within 30 days of IP meeting		✓	
Notify CM within 2 weeks of receipt if do not agree with plan as written	✓		
Develop and Implement Specific Plans in line with the IP, including teaching strategies, protocols, guidelines, and program plans			✓
Document Progress on Goals and Specific Plans			✓
Provide 6 month Individual Progress Reviews to team members			✓
Convene team meeting if needed during the plan year.		✓	
Update CAMRIS information		✓	

Steps of the Individual Planning Process

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Following are the overall steps in the planning process:

Prepare to Plan

- Identify the individuals to be involved in the planning process
- Schedule the planning meeting
- Support the individual to prepare for the planning meeting
- Develop the Level of Need Assessment and Screening Tool

Gather a Good Understanding of the Individual

- Complete the Information Profile, Personal Profile, and the Future Vision
- Review recent assessments, screenings, evaluations and reports
- Review the LON and the LON Summary Report

Develop an Action Plan to Achieve Desired Outcomes

- Identify themes and outcomes
- Develop action steps that are specific and measurable

Summarize the Plan of Supports and Services

- Identify types and amounts of services and supports to address the Action Plan
- Document who will provide the support
- Specify which waiver services will be provided

Identify Additional Supports Needed to Assist the Individual

- Identify needed provider qualifications and training specific to the individual
- Develop a plan for emergency back up supports, if applicable
- Identify supports needed to assist the person to make choices and participate in planning
- Identify how progress on the individual's plan will be monitored
- Complete the Aquatic Activity Screening - Addendum to the plan

Address Medicaid and HCBS Waiver Eligibility

- Ensure the individual has maintained Medicaid eligibility
- Complete the HCBS Waiver re-determination form

Document the Plan and Obtain Agreements

- Document the Plan and disseminate to team members
- Individuals/families/team members notify case manager within 2 weeks if do not agree with written plan

Put the Plan Into Action

- Arrange for needed supports and implement the plan
- Providers implement specific plans including teaching strategies, programs, protocols, etc.

Monitor and Revise the Plan as Needed

- Monitor plan implementation
- Providers submit 6 month progress reviews to all team members

- The team convenes to make changes to the plan as needs and circumstances change.

Prepare to Plan

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Identify the Participants to be Involved in the Planning Process

The individual and his or her family members should be comfortable with the people who help to develop the Individual Plan and should consider inviting a balance of people who can contribute to planning, including friends, family, support providers, professional staff. The individual should be supported to include people in the planning and support team who:

- Care about the individual and see him or her in a positive light.
- Recognize the individual's strengths and take the time to listen to him or her
- Can make a commitment of time and energy to help the individual to develop, carry out, review and update the plan.

At the very minimum, all planning and support teams shall include the individual who is receiving supports, his or her guardian if applicable, his or her case manager, and persons whom the individual requests to be involved in the individual planning process. The case manager should contact the individual prior to scheduling the meeting to identify the people the individual requests to have present at his or her planning meeting.

Individuals who are interested in self-directing their supports shall be made aware of the opportunity to hire an independent support broker. If selected, the independent support broker would become a member of the person's planning and support team.

Planning and support teams for individuals who receive residential, employment,or day support should include support staff chosen by the individual and who know the person best. Depending upon the individual's specific needs, health providers, allied health providers, and professionals who provide supports and services to the individual should be involved in the individual planning process and may be in attendance at the individual planning meeting.

Individuals who are interested and would benefit from the support of additional members of their team should be encouraged to invite friends and interested community members to their planning meetings. These community members should be supported to participate in the planning process in a meaningful and constructive ways.

Schedule the Planning Meeting

Every effort will be made to schedule the planning meeting at times and locations that will facilitate participation by the individual and his or her family, guardian, advocate or other legal representative as applicable. The case manager will ensure that the individual and/or the person's family is contacted to schedule a meeting at their convenience.

If the person, family, or guardian refuses to participate in the Individual Plan meeting, the case manager will document his or her attempt(s) to invite participation and the responses to those

attempts in the electronic case note system and in the Summary of Representation, Participation, and Plan Monitoring, IP.9. In these situations, the case manager shall pursue other ways to involve the individual, family, or guardian in the planning process outside of the meeting.

Support the Individual to Prepare for the Planning Meeting

The case manager should assist the person and his or her family to be actively involved in the planning process. This includes inviting team members to participate in the planning process, determining the content of the meeting and deciding how the meeting will be run and organized. The case manager and other team members shall assemble as much information as possible before the meeting to assist the individual and his or her family to prepare for the meeting and helps the meeting to be shorter, more focused on decision making, and more efficient. Supporting the individual to prepare for the meeting offers an opportunity to express his or her desires or concerns to the case manager or another team member with whom he or she is comfortable and who can assist the individual to share these issues with the larger group.

If the person and his or her family are interested in self-directing their supports, the case manager shall explain the supports an independent support broker can provide and offer an opportunity to invite an independent support broker to be involved in the planning process.

Before the meeting, the case manager may assist the individual and his or her family to begin to update the Information Profile and develop the Personal Profile and Future Vision. The case manager will complete the Level of Need Assessment and Screening Tool (LON) with information from the individual, the family, providers and/or the master file prior to the planning meeting.

Providers of supports and services will share current assessments, reports and evaluations with the case manager at least 14 days prior to the scheduled meeting. The case manager will share the LON and LON Summary Report with team members prior to the planning meeting. The case manager shall provide an opportunity for the person and his or her family to review the information contained in current assessments, reports, and evaluations that will be discussed at the meeting.

The individual has the option of having the case manager facilitate the planning meeting or selecting another person to facilitate the meeting. If the person selects an independent support broker, he or she may also choose to have the broker facilitate the meeting.

Accommodations

The case manager shall ensure individuals have needed accommodations for the meeting. Individual plans should be developed and provided to individuals and families in their native language when requested. Should an individual or family member require a language or sign language interpreter to effectively participate in the planning process, case managers may submit requests for translation or interpreter services to their supervisor for approval. A list of competent, authorized translators and interpreters for persons with limited English proficiency, as well as sign language interpreters is posted on the "J" drive in the Case Managers folder.

Some individuals may have communication devices, adaptive equipment or technology, or other types of required accommodations that must be available in order to successfully participate in the planning meeting. The case manager will help to make sure that these devices, equipment, or accommodation supports are available and in good working order at the time of the meeting, so that there are no barriers to participation.

There may be circumstances when the individual does not want to discuss something in a meeting. This preference should be respected when possible, however, personal information that affects supports or impacts the individual's health or safety should be addressed. In these circumstances, the topic should be acknowledged and dealt with respectfully and privately outside of the meeting with the person and with others who need to know this information to provide appropriate supports.

Informed Choice

An important part of pre-meeting planning is helping the individual understand the choices that are available. The case manager will help the individual to understand the waiver service options and hiring options that DDS provides to all consumers and will explain the DDS portability process. A review of support options is especially important during periods of transition, such as during the transition from school-to-work, when funding resources become available to the individual, when major life changes occur, or when aging issues become apparent.

Develop the Level of Need Assessment and Screening Tool

Prior to developing the individual plan, the case manager will develop or update the Level of Need Assessment and Screening Tool (LON) with input from the individual, the family, and providers and with information from the master file. Support providers may have input into the LON and should share current information about the person, including their skills and abilities, behaviors, health care needs, and medications. The case manager is responsible to reviewing the information for accuracy and ensuring it aligns with his or her own knowledge of the individual, information from the family, and assessments and reports that are on file.

The LON will be completed before the initial plan and updated annually or more often as needed to reflect significant changes in the person's life or to identify and document concerns or issues that may pose a health and safety risk to the individual. The completed LON and the LON Summary Report, along with other assessments, will be shared with the individual's team members in preparation for the planning meeting.

For more detailed instructions for the completion of the LON, refer to the Connecticut Level of Need Assessment and Screening Tool Manual located on the "J" drive under the LON folder.

Gather a Good Understanding of the Individual

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During the planning meeting, the individual and his or her planning and support team complete the personal profile or assess the person's current life situation and future vision. The team should complete an analysis of the person's preferences, desired outcomes, and support needs. They also shall analyze the information profile, personal profile, future vision, current assessments, reports, and evaluations, including the Level of Need Assessment and Screening Tool (LON) and the LON Summary Report, to identify what is important to include in the plan and to identify any additional assessments needed. The sections of the plan completed and reviewed during this stage of plan development include the:

- Information Profile
- Personal Profile
- Future Vision
- Review of Level of Need Assessment and Screening Tool
- Review of the LON Summary Report
- Review of Assessments

Complete the Information Profile

The section of the plan completed during this stage of plan development includes the:

Information Profile, IP.1

The Information Profile, IP.1, is a form to update and document basic demographic information about the individual. Much of this information can be updated prior to the meeting. It should only take a few minutes for the team to provide a confirmation that the information contained in the Information Profile is accurate and complete. After the meeting, any updated information shall be entered into the department's automated data system, CAMRIS.

The Contact sections are a place to record updated information including addresses, phone numbers and providers. The Primary Language section should be completed with the language spoken or understood by the individual. The Communication Style section is a place to record the means of communication the individual uses such as verbal, sign language, or gestures. The Diagnosis section will indicate the ICD10 code for the person's diagnosis or genetic disorder. The list of ICD10 codes that would be documented is included at the end of this guide and in the Case Manager Table of Contents on the shared drive: Diagnoses with ICD10 Codes.

The Resource and Benefits Information section of the Information Profile shall be used to document financial and entitlement information. Within this section, the case manager will indicate whether a Medicaid Application or Re-determination has been submitted to maintain benefits for the individual. For earned income and monthly benefit amounts which change frequently, the information entered is for this point in time. Detailed information about financial

amounts entered into this section does not have to be replicated in the Finances section of the Personal Profile, IP.2.

The Notifications and Reviews section of the Information Profile should be completed after the Individual Planning meeting. This section enables the case manager to document information shared with the individual and his or her family or guardian during the meeting including the choice of service options, choice of support providers, notification of incidents, Medicaid hearing rights, human rights, reporting suspected abuse and neglect, the choice to register to vote, and the option to pursue a Programmatic Administrative Review (PAR). For those who self direct, there is a place to document that prior to the meeting the case manager offered the option to choose an independent support broker. The HIPAA and legally liable relative notifications sahll be done at the initial visit with the individual and family and do not have to be repeated each year. This section also includes a place to document if the necessary consent forms have been signed by the individual and family or guardian and are on file.

Complete the Personal Profile

The section of the plan completed during this stage of plan development includes the:

Personal Profile, IP.2

The Personal Profile, IP.2 should describe information that members of the planning and support team and other support providers need to know in order to assist the individual to achieve what is important to him or her and to stay healthy and safe. The Personal Profile includes information about the individual's significant life history; accomplishments and strengths; relationships; home life; work, day, retirement, or school ; leisure and community life; health and wellness; and finances. Refer to the document "Questions to Guide Individual Plan Development" for further information to complete this section of the plan. This section is an opportunity to give a snapshot of the individual and will contain important information to know what to and what not to incorporate into the action plan.

Complete the Future Vision

The section of the plan completed during this stage of plan development includes the:

Future Vision, IP.3

Within the Future Vision section of the Individual Plan, IP.3, the individual and his or her planning and support team will describe his or her hopes and dreams for one to three years into the future and for the coming year. It is essential that each person be encouraged to "dream" and aim high. The case manager will support the person so that a person's dreams are not limited or curtailed by team member's expectations of what is or is not "realistic". The practical, realistic component of the planning process will occur during the action step of the planning process. The future vision portion of the plan is designed to discover what is in the heart of the individual and what she or he hopes to achieve in the future. The action plan identifies the specific step by step actions that are taken to make these hopes become a reality.

There may be times when an individual is unable to identify his or her dream because limited experiences have been available to help the person to be aware of the possibilities of a future different from the life he or she is experiencing at present. In this case, the planning and support team can ensure the action plan provides the individual with enhanced opportunities to go new places and try new experiences so that he or she can make informed choices about how life will be lived in the future.

For many adults the vision of the future may include desired improvements or changes in some or all of the personal profile areas: health and safety, relationships, leisure and community life, home life, finances, and career outcomes. Assessments and actions plans that may be needed to assist in the attainment of each identified outcomes shall be included in the plan.

Review Recent Assessments, Screenings, Evaluations and Reports

The section of the plan completed during this stage of plan development includes the:

Assessments, Screenings, Evaluations, and Reports, IP.4

The individual and his or her planning and support team shall review all recent assessments, screenings, evaluations and reports to gather additional information about the individual that will inform the planning process.

The assessments section of the Individual Plan, IP.4, lists the current assessments, screenings, evaluations, and reports that are available or needed by the individual. Any assessments that are not relevant to the person should be marked as not applicable. For example, IP.4 includes three assessments that are required only for individuals who live in their own homes and receive Individualized Home Supports. The list also includes age-related assessments that may be applicable only to individuals who are experiencing difficulties related to their advancing age.

Any assessments or reviews identified as needed must be referenced in the Action Plan, IP.5, and as a rule, should be done within three months. However, any issue or concern that poses an immediate risk must be addressed immediately. During the year, providers will document any new assessments that are needed or were obtained on the six-month Individual Progress Review.

Once the assessments and reviews are completed, any recommended supports, guidelines or procedures identified must be implemented and also referenced in the action plan. The action plan may reference documents such as specific service plans, health care plans, guidelines, procedures, or protocols that describe the detailed supports to be provided. The planning and support team is responsible to ensure that recommended supports and procedures are in place, required staff training is completed and documented, and ongoing supervision provided.

Review the LON and the LON Summary Report

As part of the assessment review, the individual and his or her planning and support team will review the Level of Need Assessment and Screening Tool (LON) and the LON Summary Report to ensure they address all the areas of support needed by the individual.

The Assessment Summary section of the LON Summary Report will show the results in each area assessed by the tool. Those areas with higher results, relative to the maximum, are areas in which the person more likely requires an increasing level of support. Those support needs shallbe considered in the development of the Individual Plan.

When areas are identified as having the potential for risk in the LON Summary Report, they must be addressed in the person's Individual Plan. Potential risks may be addressed in a number of ways in the plan. Addressing the potential risk may include the identification of a needed assessment or evaluation and associated step in the action plan to obtain that assessment or evaluation; reference that current supports, guidelines, or a protocol are in place to address the need; specific notation of the team's review in the personal profile of the plan, or recommendations if any for additional supports, training, or sharing of information. The strategies listed on the LON Summary Report are potential ways identified risk areas may be addressed. The case manager and planning and support team are **not** required to complete the check boxes on this form, but should use it as a reference in developing the plan.

The Risk Summary section of the LON Summary Report does not include every area in which a person may need support to minimize risk. The Risk Summary only identifies common potential risk areas, so should not be considered all encompassing. The team must still refer to the completed LON Assessment for specific detail about the person's unique needs.

Develop an Action Plan to Achieve Desired Outcomes

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Action Plan Components

Once the team has gathered a good understanding of the individual's current life situation and future vision, they should begin to identify the action plan for the coming year. The action plan will include desired outcomes, needs or current status, the actions and steps that will be taken, the person's responsible person(s), and timeframes. While developing the action plan, the team should keep the individual's choices and preferences in the forefront. The case manager shall ensure the individual and his or her family or guardian have information to make informed decisions regarding the degree to which the individual may wish to self-direct services and supports. Individuals may self-direct their supports and services, may choose an agency with choice to hire the staff they prefer, may select to have services delivered by qualified vendors, or a combination of options.

The action plan must include:

1. The areas that are important to the person (issues or needs addressed),
2. What the person wants to accomplish (desired outcomes),
3. How the person will accomplish what they want to achieve including all the steps to get to their outcome (action and steps),
4. Who is going to assist the person or if they will be working on the step independently (responsible person(s)),
5. Timeframes that everyone agrees to work to accomplish the action steps developed (by when).

Identify Themes and Outcomes

To identify what the person wants to accomplish (desired outcomes) the members of the planning and support team should work together to identify ideas or themes that surfaced during a review of the information collected and shared about the individual. The themes may be recurring ideas about required support needs or about wants and desires on the part of the person. Themes shall be identified by reviewing the personal profile, discussing the person's preferences and choices, reviewing the future vision and short term desired accomplishments, and sharing the various assessments and progress reviews.

Develop Action Steps

The section of the plan completed during this stage of plan development includes the:

Action Plan, IP.5

Once themes are identified, the action plan is developed. The action plan will include information about specific actions that must be taken to help the individual attain identified outcomes that have been culled from the larger themes. The action plan becomes the guide to

support the individual in reaching their desired outcomes and provides the planning and support team members with a plan to measure progress towards assisting the person to accomplish his or her life goals. The Action Plan is the guide for the year so it is important to be specific, especially in the Action and Steps section.

The "issues or needs addressed" section describes the current status of the area(s) the person wants to improve or change, or why it is important to work towards the desired outcome. The desired outcome section describes the outcome the person hopes to accomplish as a result of the actions and supports and services to be provided.

The Action and Steps section must be specific and measurable and shall indicate all actions to be taken to address the need or reference a teaching strategy, specific service plan, guideline, procedure, protocol, health care plan, behavior plan, or other document that contains the step by step actions to take. As a guideline, any need the individual has which warrants a program, protocol, procedure, specific plan or staff guidelines must be included in the Action Plan. Action steps to be taken by the individual shall be included in the action plan. This will reflect the person's involvement in planned activities and may support the development of self-determination skills and assist the person to assume greater control and authority in his or her life.

The action plan shall include all supports needed to address the person's needs including HCBS waiver services, DDS state funded supports, Medicaid state plan services (ex. home health care), and generic (ex. a school program or other agency supports) or informal supports. The need for a waiver service that addresses specific outcomes included in the Action Plan must be clearly identified and supported by the Individual Plan. The Action Plan will include the needs that will be addressed by the supports the person will receive through planned waiver services.

In the "By When" section of the Action Plan, describe the timeframe by which the activity will be completed or the frequency of the supports. For example some action steps will be completed by a certain date and others will be provided daily, weekly, monthly, or quarterly. Use of the terms Ongoing or As Needed are not to be used since they do not provide a measurable/specific time frame for support providers to follow.

When an individual plan identifies the use of behavior modifying medication or aversive programming including restraints, PRC (Programmatic Review Committee) and/or HRC (Human Rights Committee) policies and procedures must be followed, unless there is a valid waiver from such review in accordance with applicable policies and procedures. Documentation of consent for psychotropic medication and/or restraint/aversive procedure must be renewed annually.

When a PRC exemption is in place, **t**he individual's case manager shall review the exemption annually, or sooner if indicated by changes in the individual's health or cognitive status. The case manager will document whether the exemption status remains appropriate during the individual's annual planning meeting. If exemption status remains appropriate, the case manager will document and date such on the original exempt approval form. If exemption status does not remain appropriate, the case manager shall notify the PRC Liaison and the PRC Exemption Committee chairperson in writing.

Summarize the Plan of Supports and Services

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The section of the plan completed during this stage of plan development includes the:

Summary of Supports and Services, IP.6

Once the individual and team have completed the action plan, they must identify the type of services and supports that will address and implement the action plan. The Summary of Supports and Services form, IP.6, will be completed to document services the individual will receive. Individuals shall be offered choices of qualified providers and be fully informed of their right to freely select among qualified providers. The case manager or support broker shall ensure that the individual and his or her family or guardian have sufficient information available to make informed selections of support providers. Case managers shall provide individuals and families information about self-directing, agency with choice, and qualified provider options. When individuals request supports and services from agencies, case managers will refer them to the directory of qualified providers within that region. The directory is located in the case manager Table of Contents and on the Intranet under Qualified Providers. Individuals interested in hiring their own staff should be referred to the Rewarding Work website: http://www.rewardingwork.org/.

Case managers or support brokers may accompany individuals to interviews, tours, and initial visits with providers. Case managers shall also assist individuals and their families or legal representatives to evaluate several different options and providers to ensure the best selection. If the person has chosen an independent support broker, the independent support broker will assist the person with this step in the process.

Once the individual has selected providers, the Summary of Supports and Services, IP.6, will identify specific agencies and/or individuals who will provide supports or services. This section must include DDS funded supports (waiver services and state funded), Medicaid state plan services, generic resources, and natural supports provided to address the needs identified in the action plan. The information documented in the plan must include the agency or individual who will provide support, the type of service or support, and the amount of service or support. Individual plans that include waiver services will specify which waiver service(s) are to be provided (ex. Personal Support, Individualized Home Support, Supported Employment - Individual, Health Care Coordination, Respite, Clinical Behavioral Support Services).

For Waiver services which are inclusive, such as Residential Habilitation (CLA), IP.6 does not have to list on separate lines each support included within that Waiver service, such as Occupational Therapy or Nursing Services. If the team wants to note services specific to the person that are part of a comprehensive service, these inclusive supports may be shown in parentheses following the Waiver service. For example, Residential Habilitation – CLA (includes occupational therapy and nursing supports) or shown in the comment section of the automated IP.6.

The Summary of Supports and Services must also include the type and frequency of contact the case manager will have with the person. For individuals who self-direct, the Summary of

Supports and Services does not have to include specific costs associated with hiring staff such as workers compensation or background checks.

If a provider of a particular support or service has not been identified at the time of the meeting, the plan may indicate that a provider will be selected and will be identified in the person's individual budget document. In these situations the team should indicate the type of provider to furnish the service and describe the activities to support that selection. Once a selection is made the case manager shall ensure the information is incorporated into the final Individual Plan.

Identify Additional Supports Needed to Assist the Individual

Identify Additional and Specific Provider Qualifications and Training

The section of the plan completed during this stage of plan development includes the:

Provider Qualifications and Training Form, IP.7

The Provider Qualifications and Training Form, IP.7 must be completed for all individuals who receive HCBS waiver services

Each waiver service identifies a set of *standard qualifications* that the employee(s) must meet prior to employment or prior to working alone/or within 30 days of working with an individual for whom the service is being provided. To complete this section of the plan, it is necessary for the planning and support team to identify any *additional and specific qualifications* (expertise, competence, and or training) required for the employee(s) to effectively support the individual to *achieve the personal outcomes* identified in his or her plan and to *maintain a healthy and safe lifestyle.* For example, an individual may require a special diet/food consistency and a specific plan or protocol to safely chew or swallow his or her food. The planning team would need to specify that employees who provide support to the individual have training in Dysphagia and training on the individualized diet/food consistency plan or protocol. This requirement would also apply in situations where individuals receive health, behavioral, supervision, age related support, personal care or other supports and services that require employees to have specialized expertise, competence or training.

The Provider Qualifications and Training Form, IP.7, is used to document the *additional and specific qualifications or training* that an employee must have to support the individual to achieve the specific outcomes and strategies outlined for that waiver service. It may be necessary to add or remove qualifications and training requirements from IP.7 if the person's situation changes or waiver services in the plan are modified.

Under the section of the IP.7 form labeled, "HCBS Waiver Services To Be Provided", the team will identify and check all of the waiver services the person will receive. Next, the team shall review the standard qualifications and training required for each of the waiver services to be provided. Please refer to the DDS HCBS Waivers Operations Manual where each service definition includes the minimum training requirements for that service. Based on the person's individual needs and preferences, the planning team must identify and document the following information for each waiver service.

- ❑ **No additional qualifications are required.** In checking this box, the team is stating that no special expertise, competence, and or training beyond the minimum standard requirements are needed to effectively support the individual to *achieve* ***personal outcomes*** and maintain a ***healthy and safe lifestyle.***

- ❑ **Yes, the following additional qualifications are required.** In checking this box, the team is stating that special expertise, competence, and or training is required to

effectively support the individual to *achieve* ***personal outcomes*** and maintain a ***healthy and safe lifestyle. The team will list the specific qualifications and training needed.*** For each specific qualification or training identified, the team will indicate the timeframe in which the qualification(s) must be met, either prior to working alone with the person or within 30 days of starting work.

The case manager or broker must ensure individuals or qualified providers who provide waiver services to the person are notified of the additional and specific requirements listed on IP.7. Qualified providers must ensure that all employees providing services to the individual meet the standard requirements as well as the additional and specific qualifications and training listed on IP.7. Qualified providers must maintain individual employee records that verify the qualifications and training requirements are met. Periodic audits of vendor documentation associated with IP.7 will be conducted.

Individuals who hire their own employees must also ensure that the staff hired are qualified and have the necessary training to complete their job. The Fiscal Intermediary (FI) will assist the individual or his or her family to ensure that all new employees meet the standard waiver qualifications and training requirements. The FI will ensure that each new employee fills out a standard employment application, Criminal History Background Check, DDS Registry Check, and DSS Provider Agreement. The FI will complete a drivers license check for employees who will be transporting a consumer as part of their duties. The FI will also provide employers with a packet of training materials for the following standard requirements: Abuse and Neglect, Human Rights, Incident Reporting requirements, Approved and Prohibited Physical Management Techniques, HIPAA notice of privacy practices for protected health information, Individual Planning, Fire and Other Emergencies, and False Claims Act Policy. The FI will provide a copy of the Provider Qualifications and Training Verification Record.

The case manager or support broker may provide information on training resources available to meet the additional and specific training identified in IP.7 which may include the College for Direct Support (CDS). The employer and case manager or support broker are responsible for documenting that the qualifications and training requirements are met on the *Provider Qualifications and Training Verification Record*. Each employee is responsible for acquiring the necessary qualifications and training and signing the verification record. The employer also signs the form to verify the employee has acquired the necessary qualifications and training. The employer is responsible for returning the signed verification form to the FI **prior to** the start of employment for each employee. Periodic audits of documentation associated with IP.7 and the Provider Qualifications and Training Verification Record will be conducted.

The Provider Qualifications and Training Verification Record and training materials are available on the Case Managers Table of Contents on the shared drive.

Develop A Plan for Emergency Back Up Supports

The section of the plan completed during this stage of plan development includes the:

Emergency Back Up Support Plan, IP.8

The Emergency Back Up Support Plan, IP.8, must be completed for all individuals who receive HCBS waiver services if the individual is receiving waiver services in their own or family home or other settings where staff might not be continuously available. The individual plan must include a backup plan to address contingencies such as emergencies, including the failure of an employee to appear when scheduled to provide necessary services when the absence of the service presents an immediate risk to the individuals health and welfare. The planning team must describe the specific protocols to follow in the event that these needed supports and services are not available.

For individuals who hire their own employees, the back-up plan shall include a list of staff, family, friends, and neighbors who have agreed to provide backup support, their contact information, and their availability. Qualified providers and Agency with Choice providers are responsible for providing back up support for the services they are provided.

If an individual receiving waiver services in their own or family home or in other setting s does not require an emergency Backup Plan the team must note that it was discussed in the Home section of the Persona1 Profile.

Identify Additional Supports Needed to Assist the Individual to Make Choices and Participate in Planning

The section of the plan completed during this stage of plan development includes the:

Summary of Representation, Participation & Plan Monitoring, IP.9

The Summary of Representation, Participation & Plan Monitoring, IP.9, summarizes four areas: the person's understanding and capacity to make important decisions/choices, accept assistance from others, and possible need for guardian/advocate/legal or personal representative; the team's efforts to involve the person in planning, the person's actual participation in the planning process, and planned efforts to enhance the person's future participation in planning; the team's efforts to involve the person's family, guardian, advocate, or legal or personal representative in the planning process; and the team's plans to ensure that the Individual Plan will be implemented and that progress is made toward achieving desired outcomes.

This is an important part of the plan, as the information in this section can be used by the team to determine if the individual's participation in the planning process has been enhanced over time. The case manager shall ensure that actions are include in the action plan to increase the individual's participation in the planning process, if this concern has been identified by the team.

At this point in the planning meeting the individual and his or her planning and support team will discuss any additional supports the individual may require to make good choices, important decisions. The team shall consider ways that greater involvement in self advocacy may be of benefit to the person and they can review whether the individual would like or could benefit from the assistance of a self advocate Individual Plan (IP) Buddy, guardian, advocate, or legal or personal representative. The individual and team will also discuss ways the person and his or her guardian, advocate, or legal or personal representative were involved in the planning process and

ways that involvement could be improved if needed. Any plans for assisting a person's participation in their planning must be documented in this section.

Identify How Progress on an Individual's Plan Will Be Monitored

*T*he section of the plan completed during this stage of plan development is:

Summary of Representation, Participation & Plan Monitoring, IP.9

During the planning meeting, the individual and his or her planning and support team should discuss plans to monitor progress and to evaluate whether the supports are helping the person to reach desired outcomes. The team shall review all areas of the individual plan when there are any changes in the individual's life situation, and at least annually, or more frequently as required by state or federal regulations.

Address Medicaid and HCBS Waiver Eligibility

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Maintaining Medicaid Eligibility

The individual and his or her family or legal representative shall maintain Medicaid eligibility and submit required documents to the Department of Social Services (DSS), which is the state Medicaid agency. During the planning meeting, the case manager will discuss the status of person's Medicaid eligibility and plans to maintain eligibility. The case manager is responsible for verifying a person's continuing eligibility for Medicaid. During the Case Manager Quality Service Review, the case manager will review documents to ensure the individual and his or her family or legal representative have submitted required information and may ask to view the person's Medicaid card. Medicaid information is also located in eCAMRIS on the "*Client Medicaid Operations*" screens.

HCBS Re-Determination

The section of the plan completed during this stage of plan development is:

HCBS Re-Determination, IP.10

On an annual basis, during the Individual Planning process, the case manager and the planning and support team complete an HCBS Level of Care Re-determination for continued waiver eligibility. This form will be maintained with the Individual Plan form in the master file/individual record and at the provider service location(s). The Level of Care Re-determination **must** be completed within the same month of the previous year's Level of Care determination and no earlier than 90 days prior to the IP.

The HCBS Re-determination form indicates whether there is a reasonable indication that the person, but for the provision of waiver services would need services in an ICF/IID. For individuals initially applying for enrollment in a HCBS Waiver, the case manager is responsible to ensure the HCBS waiver application has been completed during the Individual Planning process and the Level of Care Determination form (Form 219e) has been included in the Individual Plan and Budget package submitted for authorization.

In situations where the individual planning meeting is postponed and cannot be held within the same month as the previous plan, the case manager follow the process to extend an Individual Plan. The case manager should schedule a team meeting to update the individual plan no later than 60 days beyond the end of a full year since the last plan update. When the full plan is updated, the case manager will also update eCAMRIS with the date of the new plan and ensure a new IP.10 is completed. If the case manager review indicates the plan is no longer current or appropriate, the case manager shall convene the team as soon as possible to update the plan.

Complete the Addendum to the Individual Plan

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Completing the Aquatic Activity Screening

The Planning and Support Team shall complete the Aquatic Activity Screening form, (Aquatic Activity Screening form), as an addendum to the plan annually at the time of the Individual Plan meeting. The Aquatic Activity Screening is also to be completed at the time of the Individual Plan – Short Form for those individuals who do not have comprehensive plans. The purpose of the Aquatic Activity Screening form is to have accurate information about an individual's abilities and safety needs around water activities. Refer to the Aquatic Activity Code Guidelines for guidance on completing the Aquatic Activity Screening.

The information on the Aquatic Activity Screening promotes team member awareness of an individual's supervision needs during aquatic activities, including activities proximal to water. The completed Aquatic Activity Screening form shall be distributed to all team members along with the plan and filed as an addendum to the plan in the Master File. All staff whom provide supports to the individual shall refer to the individual's Aquatic Activity Screening before participation in activities that are in or proximal to water.

Document the Plan and Obtain Agreements and Approvals

Document the Plan

Once the plan is completed and the individual and planning and support team agrees with the plan, the case manager will transcribe and document the plan on the Individual Plan forms. In private Community Living Arrangements (CLAs) the plan will be transcribed by other team members. The Individual Plan shall be documented within two weeks of the planning meeting and shared with other team members within a month of the meeting. The case manager will review the documented plan for accuracy and share with the individual and his or her family or guardian.

The Individual Plan Forms are available on the DDS Intranet and on the Common "J" Drive under the "Case Managers" folder, within the "Table of Contents":

When completing the Individual Plan forms information that reflects the person's point of view and preferences shall be put in quotation marks and should use pronouns like "I" or "me". When the information represents the perspective of the planning and support team, that information should be written in the third person tense and use pronouns such as "he" or "she".

Obtain Agreement with the Individual Plan

The Signature Sheet, IP.11, includes the names of all who attended the meeting or received a copy of the plan for review. At the team planning meeting, those who participated in the planning shall sign the Individual Plan Signature Sheet, IP.11 and check that they were present at the meeting. The plan shall be distributed to the individual, parent, guardian or advocate and other team members within 30 days of the plan meeting. The individual, parent, guardian or advocate, should contact the case manager within two weeks of receipt of the written plan if they do not agree with the plan as written.

Submit the Individual Plan for Approval and Authorization

When the Individual Plan is completed, the case manager will ensure the IP.6 information is entered into the automated IP.6 database, as needed. The automated IP.6 database shall include the type and amount of DDS HCBS waiver and state funded services to be purchased based on the identified needs and desired outcomes in the Individual Plan. The automated IP.6 shall also include the provider, the type of support, the hours of support to be provided.

New individual plans with an IP6 budget that are within the amount allocated by the regional Planning and Resource Allocation Team (PRAT) will be forwarded by the case manager to the case management supervisor. The supervisor will review the plan and the automated IP.6 database, if applicable. Plans may be considered approved by the department once they are reviewed and approved by the case management supervisor. Services may not begin, however, until the individual budget authorization process is completed by Resource Management. The resource administrator or designee will change the status in the automated IP.6 database to

authorized after verification that the IP.6 guidelines have been met. This includes verification that the current and annual costs are within the PRAT authorized allocation. Once approved, the Resource Manager authorizes the release of funds to the fiscal intermediary or to the contractor.

Renewed individual plans that do not include a change in services and are within the amount allocated by the regional Planning and Resource Allocation Team (PRAT) may be considered approved by the department once they are reviewed and updated by the team.

An Individual Plan with service levels or amounts that exceed an allocated budget limit from PRAT or previously authorized overall Individual Budget is not considered approved by the department. If this is an initial plan for services, no supports and services of any kind may be initiated until the plan and individual budget has been authorized by the department. When the Individual Plan developed by the person and his or her team exceeds the allocated budget limit from PRAT or previously authorized Individual Budget, the case manager should follow procedures to submit a request for additional resources to PRAT.

To request additional resources for a new Individual Plan, the case manager should submit a Request for Services along with the LON Summary Report and the proposed Individual Plan to the case management supervisor. The Request for Services should detail the amount of services requested, the reasons for the requested services and indicate if supports are self-directed. The case manager supervisor will review the request, summary report and proposed new plan and will submit the LON Summary Report and the Request for Services to the PRAT. The PRAT will review increased service requests based on identified needs and may request additional information to assist with the decision.

Once PRAT notifies the case manager that resources have been assigned to the person, the resource manager authorizes the budget and vendor service authorization, if needed. New services may not be initiated until this authorization occurs.

When a person who is enrolled in or seeking enrollment in a DDS HCBS waiver has a request to exceed the allocated budget limit denied by PRAT or another department utilization review committee in whole or part, the case manager will be notified of the decision outcome on page 3 of the Request for Services. If the department does not approve an initial request for supports and services as described in the plan, the case manager shall notify the person of the decision and determine if the person wishes to accept the decision and reconvene a meeting with the case manager and other team members to revise the individual plan. If so, the team will develop a plan which first addresses all of the individual's basic health, safety, and supervision needs within the allocated budget amount and/or through other generic, community or natural support networks. Then the team can plan and arrange for any additional supports and services the person requests.

If the person wishes to discuss the decision in more detail and request an alternative plan, the case manager shall convene a meeting with the person and designated DDS manager for such a meeting. This may be considered mediation, and does not affect any rights to a Medicaid Fair Hearing. The person may instead request immediate review by the DDS Central Office Waiver Unit. In this case, the DDS Waiver Unit will notify the person of the final decision and provide associated Fair Hearing Rights if applicable.

Put the Plan into Action

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The individual's plan describes his or her services for the coming year. Every effort should be made to arrange for needed supports and to implement the plan as soon as possible after the meeting. Supports and services shall be implemented within 60 days of plan development, or within 30 days in licensed settings, and should be provided as described in the Individual Plan. Only approved supports and services identified in the Individual Plan may be purchased with DDS funding. If supports and services cannot be promptly implemented, the case manager, individual and planning and support team must consider the need to revise the Individual Plan to meet the person's needs.

The case manager has overall responsibility for ensuring that Waiver services are coordinated with other services, resources, and supports available to the person, including state plan, generic, and informal services and supports. Case managers shall assist individuals to coordinate the services identified in the individual plan and promote cooperative communication among support providers.

The Individual Plan is the individual's plan and he or she should be included in all aspects of implementation of the plan. Moving towards a person's desired outcomes will be accomplished with everybody on the team working together and communicating their progress.

The individual and his or her planning and support team, including his or her family or legal representative and support providers, also have roles in assuring that services are delivered as described in the plan to meet the person's needs. The individual and the planning and support team members will inform the case manager of any changes in the person's life situation or needs which require the planning and support team members to meet and modify the plan. The individual and team members shall provide access to locations and information that will enable the case manager to monitor supports and services.

Monitor and Review the Individual Plan as Needed *Table of Contents*

Monitoring Plan Implementation

The case manager has responsibility to ensure approved waiver services are delivered according to the Individual Plan, and to routinely review and monitor all aspects of service delivery. Case managers will engage in activities to evaluate whether supports and services are meeting the desired outcomes for the individual and will work with the individual and his or her family or legal representative to make adaptations to plans and service arrangements as needed.
The case manager shall monitor progress on plan goals on an ongoing basis through contacts, site visits, review of individual progress reviews, review of provider documentation, and Quality Service Reviews (QSRs).Through ongoing monitoring and review the case manager is able to:

- Determine that needed supports and services in the Individual Plan have been provided
- Review implementation of strategies, guidelines, and action plans to ensure specific needs, preferences and desired outcomes are being addressed.
- Review the individual's progress and accomplishments
- Review the individual's satisfaction with supports and with service providers
- Identify any changes in the individual's needs, preferences and desired outcomes
- Identify the need to change the amount or type of supports and services
- Identify the need to revise and update the individual's plan of services.

Case managers shall have contact with individuals on a frequency based on the services the individual receives. For specific minimum requirements for case management contact, case managers should refer to the Case Manager Tasks chart or the Frequency of Case Management Contact Procedure as references.

On an ongoing basis, service providers will review and document progress on the specific personal outcomes and actions for which they are responsible. Providers of residential and day services are required to submit a written six month Individual Progress Review to the case manager and other team members two weeks prior to the annual plan and six months thereafter. At a minimum, other team members who should receive the six month reviews are the individual's family and the residential or day providers. (i.e. the day provider shall submit their review to the case manager, family, and residential provider and the residential provider will submit their review to the case manager, family, and day provider).

Case managers will review all service provider Individual Progress Reviews, and file them in the Individual Plan section of the Master File. Case managers and support brokerswill also review regular reports from Fiscal Intermediaries (FIs) as applicable. Case managers shall document all their activities related to development, monitoring or review of the plan in the electronic case note system. At a minimum, case management running notes should include a description of the Case Management services provided. The electronic case note system will require date, location and author of any notes entered.

Case manager monitoring and review of supports and services includes implementation of Case Manager Quality Service Reviews (QSR). The case manager will visit the individual at locations

where the Waiver supports and services are provided to conduct the Case Manager Quality Service Reviews. The Quality Service Reviews include an interview with the individual, observation of support providers, and a review of provider documentation. Case managers must document their quality reviews and ensure the data is entered into the QSR data system.

When a case manager identifies or is notified that an individual may be in need of additional support, is at risk, or may be entering a crisis, the case manager shall take steps to notify appropriate parties, convene the planning and support team to make needed support changes, make referrals to the region's Planning and Resource Allocation Team (PRAT), implement appropriate practices or procedures, or manage the crisis as appropriate to respond to the situation. If the issue is related to the individual's program or plan the case manager will bring the issue to the planning and support team and may schedule a meeting to update the plan.

Team members will inform case managers at any time an individual's life circumstances or needs change resulting in a need to convene the planning and support team to change the plan of services. The case manager may convene a team meeting at any time to update the plan. The team shall be convened when:

- The individual, family or guardian requests a meeting, for example to plan a different outcome, new service, or different provider
- The person's needs change resulting in an increase or decrease in services
- One or more new service is added or discontinued
- There is a change in a service provider.

Periodic Review of the Plan – IP.12 need to check latest update in CCH

The section of the plan completed during this stage is the

Periodic Review of the Plan – IP.12

The periodic review form, Periodic Review of the Plan, IP.12, should be used to document reviews of the plan for individuals who live in Community Training Homes and may be used in other settings where more frequent reviews of the plan are required by state or federal regulations. The form is not required for other waiver services.

The following areas should be included in the periodic review of the plan:

- Overview of the person's current life situation
- Identification and documentation of any changes, progress, and accomplishments
- Determination that supports and services authorized in the Individual Plan have been provided
- Review of the individual's satisfaction with supports and providers
- Review of the individual's current needs, preferences and desired outcomes
- Review and/or development of strategies and action plans to ensure specific needs; preferences and desired outcomes are being addressed.

- Identification of any needed changes in supports and services
- Identification of the frequency of future individual plan reviews.

The Review Summary section of the Periodic Review form should indicate whether there are any changes, issues, or updates in each area of the plan. If the plan needs to be modified, include the rational for the change in the Plan Modifications section. The team should review progress on the Action Plan in the Summary of Progress section of the Periodic Review form. Team members should include a review of all action plans and steps and describe progress and/or modifications. If the Action Plan requires a change, the team should insert the changes, new actions and steps, responsible persons and timeframes. The Signature Sheet, IP.11, should be attached to the Periodic Review of the Plan to indicate attendance at the meeting and agreement with the review.

Monitoring Plans for Individuals Who Self-Direct

Support providers who are hired directly by the person or family to provide support will document progress on specific personal outcomes and goals for which they are responsible. The support broker or case manager will review documentation of progress on goals to assess if desired outcomes are being addressed by self-directed support staff.

For individuals who are hiring their own staff, the case manager will review the fiscal intermediary reports that indicate the supports that have been provided and billed as a method to monitor the actual delivery of services and supports as prescribed in the Individual Plan. Line items that are being overspent or under spent shall be reviewed and corresponding adjustments or amendments made to the budget, as needed.

Changes to the Individual Plan

The Individual Planning process is an ongoing process that should change as the needs and circumstances of the individual change. The individual or his or her legal representative may request a meeting to revise the Individual Plan at any time. The individual plan, (or most recent Periodic Review form, IP.12 for individuals in Community Training Homes or other settings as required), should accurately reflect the individual's current life situation and specific supports and services. The individual plan shall be updated and revised within 90 days when an individual receives new residential or day supports and services or experiences a major change in one or both of these services. Individuals who live in licensed settings must have their plans updated within 45 days of a change in services, and individuals in ICF/IID settings must have their individual plans updated within 30 days of a change.

The Individual Plan must be revised prior to the initiation of any new services or significant changes to services. If the planning and support team recommends changes to types of supports and services or providers within the authorized individual budget, the plan will be revised to show the changes in services including, at a minimum, a revised Action Plan, IP.5, and a revised Summary of Supports and Services, IP.6 and a Signature Sheet, IP.11. Other sections of the plan may updated, if needed. The revised plan will be shared with all team members.

For individuals enrolled in a DDS HCBS waiver, a change in services may occur prior to an update to the Individual Plan when it is a change in the amount or duration of an already approved service type. If the change constitutes a new waiver service not previously authorized in the Individual Plan, the new service may not be initiated until The service has been approved and authorized by DDS.

If a requested change in services will exceed the dollar limit in the approved service level or Individual Budget, the case manager must submit a Request for Services to the PRAT along with the current Summary of Supports and Services, IP.6, a new LON Summary Report if there are changes in the person's needs, a Priority Checklist, if applicable, and a description of the change in the person's circumstances. The Request for Services should detail the amount of services requested, the reasons for the requested services and indicate if supports are self-directed. The PRAT will review increased service requests based on identified needs. Once PRAT notifies the case manager that resources have been assigned to the person, the case manager shall contact the person and his or her family within 5 days to initiate the planning process and should complete a new Individual Plan within 30 to 60 days. A new Individual Budget should also be developed within 30 to 60 days based on the new plan.

If additional services are thought to be needed at the time of the annual plan, a new Individual Plan shall be developed that represents current service levels, describes the change in the person's circumstances, and includes steps within the action plan to request increased supports through PRAT. If PRAT approves the request, the team will update the plan to show the approved increase in services. At a minimum, the updated plan shall reflect the new action steps associated with the need for the new or additional services and include the revised IP.6 and a new Signature Sheet, IP.11. If PRAT denies the request there may still be a need to revise the plan if there is a need to reorganize the service array, develop new action steps to seek supports in a different manner, or otherwise update the plan.

If the PRAT responds to a Request for Services by indicating increased funding will be assigned within 12 months, the Individual Plan that describes current service levels remains in place until resources are assigned. If the PRAT denies the request for additional resources, the current Individual Plan remains in place. In these situations, the case manager will inform the individual and family of the decision and they may request a meeting with the designated regional manager to discuss alternative supports or options. Based on those discussions, additional information may be provided to PRAT sufficient to alter the decision. If the individual and the family do not accept partial or delayed funding the case manager notifies the PRAT. When this occurs or when PRAT recommends denial of the request PRAT will notify the DDS Central Office Waiver Policy unit. If the Waiver Policy unit agrees with the recommendation to deny the request, they will notify the individual or personal representative of the DSS Fair Hearing Rights.

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Transition Planning

For individuals who are moving to new residential settings, transition planning can help team members to ensure all the details of the move are addressed. The Transition Planning Checklist shall be completed for individuals moving between or into DDS-funded or operated residences and may be used for other individuals who change residences. For individuals moving between or into DDS funded, or operated residences, the sending case manager will ensure the individual has an updated Transition Plan, including a current IP.6 that describes the services to be received as a result of the move. Regions shall ensure that individuals receive notification of their rights to request a transfer hearing when a move is planned from one public or private DDS supported residence to another according to transfer hearing requirements.

When an individual lives with his or her family, is moving into a DDS-funded or operated residence, and is enrolling in a DDS waiver, the case manager must complete an Individual Plan - Short Form (IPT), along with a Summary of Supports and Services, IP.6, for the first 90 days of receipt of new HCBS Waiver services, 45 days in licensed settings, after which time an Individual Plan must be in place.

Case managers shall follow the Case Transfer Procedure, (I C 1 PR 001f: Case Transfer Procedure), when transitions result in a transfer between case managers. It is best practice, but not required, that case managers use the Transition Plan and Transition Planning Checklist for individuals who experience transitions or major changes in services or supports other than changes in residences.

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Where to File the Individual Plan Forms

The Individual Plan section of the master file or individual record maintained by the case manager should include the following sections of the plan:

- IP.1 Information Profile
- IP.2 Personal Profile
- IP.3 Future Vision
- IP.4 Assessments, Screenings, Evaluations and Reports
- IP.5 Action Plan
- IP.6 Summary of Supports and Services
- IP.7 Provider Qualifications and Training
- IP.8 Emergency Support Backup Plan
- IP.9 Summary of Representation, Participation and Plan Monitoring
- IP.10, HCBS Re-determination form
- IP.11 Individual Plan Signature Sheet
- IP Addendum: Aquatic Activity Screening
- IP.12 Periodic Review of Plan, as applicable

Individual Progress Reviews, self-directed supports progress summary documentation, and transition plans should also be filed in this section with the Individual Plan.

Forms that should be included in the Assessments and Clinical Services section of the master file include the:

- Any clinical assessments and reports completed for the Individual Plan meeting such as occupational therapy assessments, medical exams, nursing reports, behavioral assessments, etc.

Documents that should be filed in the Service and Support Provider Reports section of the master file include service provider's residential or vocational evaluations, specific service plans, teaching strategies, protocols, procedures, or guidelines referred to in the Individual Plan.

Agreements for Self Directed Supports or Individual Service Agreements (ISA's), when applicable, should be filed with individual budget information.

It should be noted that the appropriate file at service locations, at the individual's home and/or day program site should contain all of the applicable plan documents identified above, IP.1 – IP.11 and the IP Addendum: Aquatic Activity Screening, as well as the LON and LON Summary Report and IP.12, if applicable.

Individual Planning Reference Materials

Table of Contents

Questions to Guide Plan Development

IP.1 Information Profile
Questions to Prompt Discussion

Contact Information

1. Have there been any changes in addresses or contact information about you, your guardian, primary responsible person, or other contact people? What is the current information?
2. Have any of your support providers changed? What is their contact information?
3. Does my residence and employment/retirement/day or other support service providers know who my DDS case manager is?

Resource & Benefit Information

1. Have you submitted a Medicaid application or redetermination recently?
2. What are the current amounts of your wages, savings, checking, and entitlement income?
3. Have any of your insurance identification numbers changed?
4. Do you have a trust fund?

DDS Support Information

1. What are the supports you receive from DDS?
2. Do you self-direct your supports or use a qualified provider? Or are your supports paid by contract?

Notifications & Reviews

1. Has information about your rights been shared with you? For example, your right to a PAR and your Medicaid Due Process rights?
2. Has your family been notified if there are plans to change your residence? This applies if you live in a CLA, CTH, campus and plans are in place for you to move to another residence. Your family has the right to a transfer hearing if they do not agree with the move.
3. Did your family receive information about how they will be notified in the event there is an incident that occurs while you are being supported? Does your family want to be notified for more than the required incidents? In what instances?
4. Did you receive information about your rights and about self advocacy?
5. Have you received information about how to report suspected abuse or neglect?
6. Have you and/or your family been informed of your priority status if you are on the waiting list, if applicable?
7. Have you received information about your choices of service options to self-direct, use a qualified provider, or use an agency with choice? Do you have any questions about this information? Do you need any additional information?
8. Have you received information about your choice to use an independent support broker if you self-direct?

9. Did you receive information about your choice of qualified provider and support providers?
10. Did you receive information about your right to register to vote?
11. Did you and/or your family receive information about legal liability?
12. Did you and your family receive notification of HIPAA?
13. Has your family or guardian signed consent forms when needed?
14. Do you know the date of your next PRC review, if applicable?

IP.2 Personal Profile
Questions to Prompt Discussion

Important Things to Know about You

1. What is most important to know about you?
2. How would you describe yourself?
3. Is there anything about your history or any significant milestones that you would like your planning and support team members to know about you?
4. What past events have been important to you and helped to make you who you are?
5. What is most important to you?
6. What are your preferences and dislikes?
7. Is there anything you would like to change about your life right now?
8. What is important to you about your heritage and ethnic background?

Accomplishments, Strengths and Things You Are Most Proud Of

1. What are some things you have achieved?
2. What are you good at?
3. What are your strengths and talents?
4. What do you believe you do well?
5. What are your favorite things to do?
6. What have you done, been involved in, or accomplished that you are most proud of and want everyone to know?

Relationships

1. Who are the most important people in your life?
2. How do you communicate best with other people?
3. With whom do you like to spend your time?
4. How do you meet new people?
5. Do you have friends you like to talk to and do things with?
6. Would you like to make or have more friends? If yes, what are ways you can meet new people?
7. Are there other people you would like to invite to be on your support team?

Home Life

1. Where do you live and with whom do you live?
2. Are you happy with your home situation and daily routine?
3. Who decides your daily routine? Are there any changes you would like to make?
4. What is most important to you or do you like most about your home?
5. Do you have any family traditions or cultural preferences?

6. What skills do you have at home? Which ones do you want to develop?
7. What supports do you need to live in your home? In what areas do you need help? How are your support needs being met in your home?
8. What issues did you identify in your assessments, screenings, or Level of Need tool for which you need supports in your home? Are you getting those supports?
9. Did you choose the people who help you at home?
10. Do you feel you're getting the help you need from your support staff?
11. What are your responsibilities at home? Would you like more responsibility?
12. Do you have privacy? Can you be alone if you want to?
13. Do you open your own mail?
14. Can you use the phone when you want to?
15. What do you find most challenging in your home?
16. Are you concerned about your safety in your home or community? Would you like to build in some safeguards?
17. Do you have transportation to get where you need to go?

Employment, Retirement, School or Other

1. Where do spend your day – school, work, retirement etc?
2. Do you like your job, retirement, school or other activities that you do during the day? What activities do you like best?
3. If you are an adult, do you have a job that is a good fit and pays well? (i.e. real work for real pay)
4. If not, how can you gain experience that could lead to a different job?
5. What is most important to you at work, at school, in your retirement or other activities?
6. What do you find most challenging in your job, at school, or retirement or other day activities?
7. What support do you need at your job, at school, during your retirement or other day activities?
8. Do you receive any natural supports at your job?
9. Did you choose the people who help you at work or during other day activities?
10. Do you feel you're getting the help you need from your support staff?
11. How do you get to work, school, and activities each day? Are you satisfied with your transportation supports? Are their other transportation options you would like to try?
12. As an older adult, are you thinking about retirement and what you would like to do when you retire?
13. Have you reviewed your benefits and/or talked with a Benefits Counselor at BRS?

Leisure Interests and Community Life

1. How do you like to spend your free time?
2. What do you consider fun?
3. What activities are you involved in?
4. How are you involved in your community? How do you, or would you like to, contribute to your community?
5. Do you belong to, or wish to belong to, any groups or clubs?
6. Have you ever participated in a self advocacy group? Would you want to?
7. What interests do you have that you would like to explore/expand?
8. Would you like to take classes or learn/increase your skills?
9. What transportation do you use to when participate in activities?

10. What supports do you need to do the things you like to do in your community?
11. Do you have any spiritual interests?
12. What supports do you need to participate in your spiritual community?

Health and Wellness

General

1. How would you describe your health?
2. Have you had a physical exam in the last year?
3. Have you seen the dentist in the last six months?
4. Were there specific concerns your doctor wants you to pay attention to?
5. Have you had any incidents this past year related to your health?
6. What supports do you need to maintain good health? Are you getting them?
7. Do you or others who care about you have any concerns about your health?
8. What health issues were identified in your physical exam, health assessments, screenings or Level of Need tool?
9. What supports do you and your support team members need to take care of your health issues?
10. Do you need someone to help you to make medical decisions?
11. Have you had any falls this year?
12. Have you had medical follow-up as a result of any recent falls or new condition?
13. Have you designated some one as a health care representative?
14. Do you want more information about this?
15. Do you require hospice care or have a DNR?
16. Is there any additional information regarding your health you would like to learn about?
17. Would you like information about living wills?

Medications

1. What current medications are you taking? For what conditions do you take them?
2. Are there any important things to know about this medication?

Adaptive Equipment

1. Are you in need of any adaptive equipment or accommodations?
2. Is it available to you when you need it?
3. Are your support staff trained to help you to use your adaptive equipment?
4. Is there an adaptive equipment plan that describes when and how to use your adaptive equipment?
5. Is it properly maintained?
6. Are there any other accommodations that you would like to receive at home, work or while in the community?

Finances

1. What are your sources of income? (**Note**: Include the amounts of income in the Information Profile, IP.1, Resource and Benefit Information section.)
2. Do you need support to manage your money and other benefits?
3. Are there areas of managing your funds that you would like to develop or strengthen?
4. If you need assistance, who helps you or would you like to help you manage your finances?
5. Do you have sufficient money to support your needs?

6. Do your resources meet your needs?
7. Do you choose what you buy with your spending money?
8. In what ways could you increase your skills in making purchases or paying your bills?
9. Have you applied for all the entitlements for which you may be eligible?
10. Have you kept current with Medicaid and other entitlements and benefits?
11. If you want to make a major purchase, do you have a plan to save money?
12. Have you looked at a special needs trust for yourself? Asset planning?
13. Have you thought about a retirement fund?
14. Have you thought about funeral plans or a burial fund? Who would be the best person to talk to you about funeral plans?
15. Do you have any concerns about your benefits? Do you need a benefits check-up completed?
16. Should you consider contacting a benefits specialist to help understand the impact of employment on your benefits as part of your overall financial management planning strategy?

IP.3 Future Vision
Questions to Prompt Discussion

What are your hopes and dreams for the future?

1. What would you like your life to look like in three years?
2. Where would you like to live, work, spend your day, spend your free time?
3. What supports do you believe you need?
4. Who would you have in your life?

What do you hope to accomplish in the coming year?

1. Where do you see yourself in one year?
2. What do you hope to accomplish:
    a. At home?
    b. At work or at school, during retirement or during any other times during the day?
    c. For fun or leisure?
    d. In your community?
    e. With relationships?
    f. With your money?

3. Do you have any personal goals around your health and safety? career outcomes? self-advocacy?
4. What additional supports do you believe you will need this coming year?

IP.4 Assessments, Screenings, Evaluations & Reports
Questions to Prompt Discussion

1. What current assessments are available?
2. What important information do these assessments tell about you?
3. What should planning and support team members know about these assessments?
4. What important support needs are identified in these assessments?
5. What are the risk areas identified on the LON Summary Report?
6. Are there supports that must be available to keep you healthy and safe?
7. Are the needed supports in place and adequate?
8. What additional information would be important to know about you?
9. What additional assessments, screenings, evaluations, or reports are needed to gather this information? Be sure to include any that are needed in the Action Plan, IP.5.
10. Are there any age related assessments in areas such as Falls, or Dementia that are needed?

IP.5 Action Plan
Questions to Prompt Discussion

1. Based on all the information you reviewed in the Personal Profile, Level of Need Assessment and Screening Tool, LON Summary Report, Assessments, and the Future Vision sections of the plan, what are the most important priorities for you to address in the Action Plan?
2. What are the themes that surface about the things you want to accomplish and the supports you will need?
3. What are the most important outcomes you would like to accomplish this year?
4. What issue or need does each outcome address? Why are they important to you?
5. What actions or steps will need to occur in order for you to accomplish these outcomes?
6. How will you know if you have accomplished this outcome?
7. How will you measure progress toward reaching this outcome (method, frequency)?
8. Who would you like to support you to reach your goals or accomplish the things you want?
9. Who will be responsible for making sure the action plan is implemented?
10. When will the outcome be achieved or the action step completed? What are the timeframes?

IP.6 Summary of Supports and Services
Questions to Prompt Discussion

1. What are the waiver, state funded, generic, and informal supports and services that will be provided to you?
2. Who are the agency vendors or individuals who will provide the supports?
3. What types of support or service will they provide? If these are supports funded by one of the DDS HCBS waivers, please be sure to include the name of the waiver service.

4. What is the amount of supports and services that will be provided and how often will they be provided? For instance, how many hours per week or times per month will you receive the supports?

IP.7 Provider Qualifications & Training
Questions to Prompt Discussion

1. Each Waiver service identifies standard qualifications that employee(s) who support you must have. What are the basic requirements for staff who provide your supports?
2. Are there any additional or specific qualifications (expertise, competence, and or training) that staff should possess to effectively support you?

IP.8 Emergency Back Up Plan
Questions to Guide Discussion

1. Do you live in your own or family home?
2. Do you receive personal care or other supports that must be available as described in the Individual Plan or it would lead to an immediate risk to your health or safety?
3. What are the specific back up plans that should be followed in the event that needed supports are not available?

IP.9 Summary of Representation and Participation
Questions to Prompt Discussion

Choice and Decision-Making

1. What support and assistance do you need or rely upon to make informed choices and decisions?
2. On whom do you rely for support and assistance in decision-making?
3. Do you have, need, or want a guardian for assistance and support?
4. What information, support, and assistance do you need to make informed choices and decisions in your best interest?

Individual's Participation in Planning Process

1. How were you involved in preparing for and participating in your planning meeting?
2. Were there any ground rules you established for your meeting? Any there ground rules you want to be sure are followed in the future?
3. Were you prepared to say what you wanted to say at your meeting? How could you be better prepared for the next meeting?
4. What supports did you receive to effectively communicate your thoughts?
5. What supports will help you to successfully advocate for yourself in the future if others do not agree with you?
6. Is there anything else that is needed to help you prepare for your next planning meeting?

Representative's Participation in Planning Process

1. How were your representatives including family, guardian or advocate involved in preparing for and participating in your planning meeting?
2. Are there any supports your representatives need to participate more effectively in the future?

Summary Of Monitoring and Evaluation of The Plan

1. At a minimum, your plan should be reviewed according to the schedule required for your support arrangement. Your plan may be reviewed sooner if you have a major life change or if you request that it be reviewed.
2. How will you make sure that your plan gets reviewed as often as needed?
3. Who should be involved in this review process?

IP.10 HCBS Waiver Redetermination
Questions to Prompt Discussion

1. Do you have needs that can be met through waiver services so you do not have to live in an institution (ICF/IID) or in a Nursing Home to have your support needs met?
2. Do you and you team feel that but for the provision of waiver services you would need services in an ICF/IID or Nursing Home?
3. Do you require supports and help to perform and learn self care and daily activities?
4. Was the Waiver Redetermination done within 365 days of the last one?

IP.11 Signature Sheet
Questions to Prompt Discussion

1. Who attended your planning meeting?
2. Who participated in the planning process?
3. After a review of the completed plan, do you agree with it? If not, please notify your case manager within 2 weeks of receipt of the plan.
4. After a review of the completed plan, does your family or guardian agree with it? If not, they should notify your case manager within 2 weeks of receipt of the plan.

ICD10 Codes

ICD9	ICD10	ICD9_Description	ICD10_Description
317	F70	Mild mental retardation	Mild intellectual disabilities
318.0	F71	Moderate mental retardation	Moderate intellectual disabilities
318.1	F72	Severe mental retardation	Severe intellectual disabilities
318.2	F73	Profound mental retardation	Profound intellectual disabilities
	F78		Other intellectual disabilities
319	F79	Unspecified mental retardation	Unspecified intellectual disabilities
270.3	E710	Disturbances of branched-chain amino-acid metabolism	Maple-syrup-urine disease
270.3	E71110	Disturbances of branched-chain amino-acid metabolism	Isovaleric acidemia
270.3	E71111	Disturbances of branched-chain amino-acid metabolism	3-methylglutaconic aciduria
270.3	E71118	Disturbances of branched-chain amino-acid metabolism	Other branched-chain organic acidurias
270.3	E71120	Disturbances of branched-chain amino-acid metabolism	Methylmalonic acidemia
270.3	E71121	Disturbances of branched-chain amino-acid metabolism	Propionic acidemia
270.3	E71128	Disturbances of branched-chain amino-acid metabolism	Other disorders of propionate metabolism
270.3	E7119	Disturbances of branched-chain amino-acid metabolism	Other disorders of branched-chain amino-acid metabolism
270.3	E712	Disturbances of branched-chain amino-acid metabolism	Disorder of branched-chain amino-acid metabolism, unspecified
270.9	E729	Unspecified disorder of amino-acid metabolism	Disorder of amino-acid metabolism, unspecified
299.00	F840	Autistic disorder, current or active state	Autistic disorder
299.	Invalid	Pervasive developmental disorders	
299.0	Invalid	Pervasive developmental disorders; Autistic disorder	
299.01	F840	Autistic disorder, residual state	Autistic disorder
299.1	Invalid	Pervasive developmental disorders; Childhood disintegrative disorder	
330.9	G94	Unspecified cerebral degeneration in childhood	Other disorders of brain in diseases classified elsewhere
742.2	Q040	Congenital reduction deformities of brain	Congenital malformations of corpus callosum
742.2	Q041	Congenital reduction deformities of brain	Arhinencephaly
742.2	Q042	Congenital reduction deformities of brain	Holoprosencephaly
742.2	Q043	Congenital reduction deformities of brain	Other reduction deformities of brain
755.55	Q870	Acrocephalosyndactyly	Congenital malformation syndromes predominantly affecting facial appearance
756.4	Q770	Chondrodystrophy	Achondrogenesis
756.4	Q771	Chondrodystrophy	Thanatophoric short stature
756.4	Q774	Chondrodystrophy	Achondroplasia

756.4	Q775	Chondrodystrophy	Diastrophic dysplasia
756.4	Q777	Chondrodystrophy	Spondyloepiphyseal dysplasia
756.4	Q778	Chondrodystrophy	Other osteochondrodysplasia with defects of growth of tubular bones and spine
756.4	Q779	Chondrodystrophy	Osteochondrodysplasia with defects of growth of tubular bones and spine, unspecified
756.4	Q784	Chondrodystrophy	Enchondromatosis
756.51	Q780	Osteogenesis imperfecta	Osteogenesis imperfecta
758.0	Q900	Down's syndrome	Trisomy 21, nonmosaicism (meiotic nondisjunction)
758.0	Q901	Down's syndrome	Trisomy 21, mosaicism (mitotic nondisjunction)
758.0	Q902	Down's syndrome	Trisomy 21, translocation
758.0	Q909	Down's syndrome	Down syndrome, unspecified
758.1	Q914	Patau's syndrome	Trisomy 13, nonmosaicism (meiotic nondisjunction)
758.1	Q915	Patau's syndrome	Trisomy 13, mosaicism (mitotic nondisjunction)
758.1	Q916	Patau's syndrome	Trisomy 13, translocation
758.1	Q917	Patau's syndrome	Trisomy 13, unspecified
758.2	Q910	Edwards' syndrome	Trisomy 18, nonmosaicism (meiotic nondisjunction)
758.2	Q911	Edwards' syndrome	Trisomy 18, mosaicism (mitotic nondisjunction)
758.2	Q912	Edwards' syndrome	Trisomy 18, translocation
758.2	Q913	Edwards' syndrome	Trisomy 18, unspecified
758.5	Q920	Other conditions due to autosomal anomalies	Whole chromosome trisomy, nonmosaicism (meiotic nondisjunction)
758.5	Q921	Other conditions due to autosomal anomalies	Whole chromosome trisomy, mosaicism (mitotic nondisjunction)
758.5	Q922	Other conditions due to autosomal anomalies	Partial trisomy
758.5	Q925	Other conditions due to autosomal anomalies	Duplications with other complex rearrangements
758.5	Q9261	Other conditions due to autosomal anomalies	Marker chromosomes in normal individual
758.5	Q9262	Other conditions due to autosomal anomalies	Marker chromosomes in abnormal individual
758.5	Q927	Other conditions due to autosomal anomalies	Triploidy and polyploidy
758.5	Q928	Other conditions due to autosomal anomalies	Other specified trisomies and partial trisomies of autosomes
758.5	Q929	Other conditions due to autosomal anomalies	Trisomy and partial trisomy of autosomes, unspecified
758.5	Q930	Other conditions due to autosomal anomalies	Whole chromosome monosomy, nonmosaicism (meiotic nondisjunction)
758.5	Q931	Other conditions due to autosomal anomalies	Whole chromosome monosomy, mosaicism (mitotic nondisjunction)
758.5	Q932	Other conditions due to autosomal anomalies	Chromosome replaced with ring, dicentric or isochromosome
758.5	Q952	Other conditions due to autosomal anomalies	Balanced autosomal rearrangement in abnormal individual
758.5	Q953	Other conditions due to autosomal anomalies	Balanced sex/autosomal rearrangement in abnormal individual
758.7	Q980	Klinefelter's syndrome	Klinefelter syndrome karyotype 47, XXY
758.7	Q981	Klinefelter's syndrome	Klinefelter syndrome, male with more than two X

			chromosomes
758.7	Q983	Klinefelter's syndrome	Other male with 46, XX karyotype
758.7	Q984	Klinefelter's syndrome	Klinefelter syndrome, unspecified
759.5	Q851	Tuberous sclerosis	Tuberous sclerosis
759.8	Invalid	Other and unspecified congenital anomalies; Other specified anomalies	
759.81	Q87.1	PRADER-WILLI SYNDROME	Congenital malformation syndromes predominantly associated with short stature
759.81	Q871	Prader-Willi syndrome	Congenital malformation syndromes predominantly associated with short stature
759.89	E7871	Other specified congenital anomalies	Barth syndrome
759.89	E7872	Other specified congenital anomalies	Smith-Lemli-Opitz syndrome
759.89	Q872	Other specified congenital anomalies	Congenital malformation syndromes predominantly involving limbs
759.89	Q873	Other specified congenital anomalies	Congenital malformation syndromes involving early overgrowth
759.89	Q875	Other specified congenital anomalies	Other congenital malformation syndromes with other skeletal changes
759.89	Q8781	Other specified congenital anomalies	Alport syndrome
759.89	Q8789	Other specified congenital anomalies	Other specified congenital malformation syndromes, not elsewhere classified
759.89	Q898	Other specified congenital anomalies	Other specified congenital malformations
760.71	P043	Alcohol affecting fetus or newborn via placenta or breast milk	Newborn (suspected to be) affected by maternal use of alcohol
760.71	Q860	Alcohol affecting fetus or newborn via placenta or breast milk	Fetal alcohol syndrome (dysmorphic)
760.79	P042	Other noxious influences affecting fetus or newborn via placenta or breast milk	Newborn (suspected to be) affected by maternal use of tobacco
760.79	P045	Other noxious influences affecting fetus or newborn via placenta or breast milk	Newborn (suspected to be) affected by maternal use of nutritional chemical substances
760.79	P046	Other noxious influences affecting fetus or newborn via placenta or breast milk	Newborn (suspected to be) affected by maternal exposure to environmental chemical substances
760.79	P048	Other noxious influences affecting fetus or newborn via placenta or breast milk	Newborn (suspected to be) affected by other maternal noxious substances
760.79	P049	Other noxious influences affecting fetus or newborn via placenta or breast milk	Newborn (suspected to be) affected by maternal noxious substance, unspecified
760.79	Q862	Other noxious influences affecting fetus or newborn via placenta or breast milk	Dysmorphism due to warfarin
760.79	Q868	Other noxious influences affecting fetus or newborn via placenta or breast milk	Other congenital malformation syndromes due to known exogenous causes
771.0	P350	Congenital rubella	Congenital rubella syndrome
771.2	P352	Other congenital infections specific to the perinatal period	Congenital herpesviral [herpes simplex] infection
771.2	P353	Other congenital infections specific to the perinatal period	Congenital viral hepatitis
771.2	P358	Other congenital infections specific to the perinatal period	Other congenital viral diseases
771.2	P359	Other congenital infections specific to the perinatal	Congenital viral disease, unspecified period

771.2	P370	Other congenital infections specific to the perinatal period	Congenital tuberculosis
771.2	P371	Other congenital infections specific to the perinatal period	Congenital toxoplasmosis
771.2	P372	Other congenital infections specific to the perinatal period	Neonatal (disseminated) listeriosis
771.2	P373	Other congenital infections specific to the perinatal period	Congenital falciparum malaria
771.2	P374	Other congenital infections specific to the perinatal period	Other congenital malaria
771.2	P378	Other congenital infections specific to the perinatal period	Other specified congenital infectious and parasitic diseases
771.2	P379	Other congenital infections specific to the perinatal period	Congenital infectious or parasitic disease, unspecified

Additional References

For additional information about Individual Planning, please refer to the respective DDS policy, procedures in the DDS Manual, and reference documents located in the

Case Manager Table of Contents