

Policy Name:	Intellectual and Developmental Disability Person-Centered Service Plan	Policy Number:	M2018-042
Commission:	Community Services and Programs	Date Established:	4.9.2018
Applicability:	HCBS IDD Waiver	Date Last Revised:	
Contact:	IDD Program Manager	Date Effective:	7.9.2018
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Purpose

The purpose of this policy is to explain the Person-Centered Service Plan requirements found in 42 CFR § 441.301, K.A.R. 30-63-1 through 32, and the 1915 (c) HCBS IDD waiver and to detail the process for creation of the Person-Centered Service Plan.

Summary

This policy provides requirements for the implementation of a person-centered planning process, and aims to describe for 1915 (c) IDD waiver participants, what to expect through the development and implementation of a person-centered plan. This policy also provides information regarding applicable Person-Centered Service Plan forms and documents, elements for the 1915(c) HCBS IDD waiver plan of care quality assurance compliance requirements, and the procedures, timelines and responsible parties governing the Person-Centered Service Plan and implementation activities.

Entities/Individuals Impacted

- HCBS 1915 (c) IDD waiver participants and participant designated legal representatives
- HCBS 1915 (c) IDD waiver service providers
- Managed Care Organizations (MCOs)
- KanCare contracted Targeted Case Managers (TCMs)
- Kansas Community Developmental Disability Organizations (CDDOs)
- Kansas Department of Aging and Disability Services (KDADS)
- Kansas Department of Health and Environment (KDHE)

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I. Policy

A. Person-Centered Service Plan

1. The Person-Centered Service Plan and all associated processes conducted to establish a participant's finalized plan shall meet all requirements set forth in 42 CFR § 441.301, the requirements found within the 1915 (c) Home and Community Based (HCBS) waivers, and in K.A.R. 30-63-21 through 29, and K.A.R. 30-63.32.
2. The Person-Centered Service Plan and associated process shall be the document of record demonstrating compliance with 42 CFR § 441.301, the requirements found within the 1915 (c) HCBS waivers, and when applicable, K.A.R. 30-63-1 through 32.
3. No Person-Centered Service Plan shall be amended or otherwise changed without the participation of the individual/designated legal representative and in compliance with 42 CFR § 441.301, the 1915 (c) HCBS waivers, and K.A.R. 30-63-1 through 32.
4. All participants of a 1915 (c) HCBS waiver shall have a Person-Centered Service Plan completed by their Managed Care Organization (MCO).
5. MCOs may use contracted entities to assist in the development and monitoring of the plan, but will have primary responsibility for Person-Centered Service Plan development and accountability to deliver all Medicaid covered services, including HCBS, included in a member's Person-Centered Service Plan.
6. The development of the Person-Centered Service Plan shall be conflict free, as defined by 42 CFR § 441.301 (c) (1) (vi).
7. MCOs shall follow the timeframes established in their current contract relating to Person-Centered Service Plans, meetings, signatures etc.
8. All Person-Centered Service Plan templates and forms developed by MCOs must be submitted to the HCBS Policy and Program Oversight Manager for annual approval (every 365 calendar days), and prior to use. This requirement applies to any proposed changes to approved templates or forms. KDADS will have thirty (30) calendar days to approve or request changes to any templates or forms included in the Person-Centered Service Plan planning process.

B. Person-Centered Service Plan Meeting

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1. The Person-Centered Service Plan meeting refers to, at a minimum, the annual (once every 365 calendar days or less), face-to-face meeting where a participant develops their Person-Centered Service Plan with the support of any designated legal representatives, guardians, informal supports, or service providers requested by the participant.
 - a) The MCO shall document the meeting time and date in the individual's file as proof of then meeting and review of Person-Centered Service Plan if no changes are identified to the Person-Centered Service Plan.

2. Unless otherwise specified by the participant, the meeting will always include the participant's assigned MCO Care Coordinator, as well as the participant's TCM.

3. Additional Person-Centered Service Plan meetings may be necessary due to changes in condition or circumstance that require updates to the participant's plan, which would impact the scope, amount or duration of services included in the Person-Centered Service Plan. The following changes in condition or circumstance necessitate a Person-Centered Service Plan meeting to ensure the plan meets the participant's wishes and needs:
 - a) Change in functional ability to perform two or more Activities of Daily Living (ADLs) or three or more Instrumental Activities of Daily Living (IADLs) compared to the most recently assessed functional ability.
 - b) Change in behaviors that may lead to loss of foster placement or removal from the home.
 - c) Significant change in informal support availability, including death or long-term absence of a primary caregiver, and/or any participant identified changes in informal caregiver availability that results in persistent unmet needs that are not addressed in the most recently developed Person-Centered Service Plan.
 - d) Post-transition from any alternate setting of care (i.e.: state hospital, nursing home, etc.), when the participant was not residing in a community-based setting for thirty days or greater.
 - e) Upon the request of any waiver participant, guardian or legal representative.
 - f) Upon circumstances as defined in Article 30-63-21.8.c.1-3.

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- g) Any health and/or safety concern;
 - h) Any change in needs for an HCBS recipient not listed above.
4. A Person-Centered Service Plan meeting shall be held, subject to the convenience of the individual, and within the contractual timeframe of MCO notification or awareness of necessitating circumstances.
 5. MCOs shall conduct one face-to-face or telephonic visit with the participant after a transition from any alternate setting of care, after which the MCO must follow up with quarterly telephone calls, for the first-year post-transition, and face-to-face visits every six months.
 - a) Face-to-face is the preferred method of contact for this visit.

II. Procedures

A. In the event an IDD participant does not have a TCM, the MCO Care Coordinator shall complete the TCM responsibilities.

B. Person-Centered Service Plan Meeting Participant Selection

1. The participant, participant's designated legal representative, and MCO Care Coordinator shall participate in the Person-Centered Service Plan Meeting.
2. The MCO Care Coordinator shall ask the participant if they wish for their chosen TCM to participate. If the participant authorizes the TCM's attendance, the MCO Care Coordinator shall consider the TCM as a required participant.
 - i. The MCO shall honor and document any specific participant requests to exclude a TCM from participating in the Person-Centered Service Plan meeting.
3. MCO Care Coordinators shall participate in Person-Centered Service Plan meetings in-person.
4. The participant or participant's designated legal representative shall identify who shall attend the Person-Centered Service Plan meeting, in addition to the required participants.

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5. The MCO Care Coordinator shall invite known Person-Centered Service Plan providers to attend in-person, telephonically or through video conference modalities, unless otherwise directed by the participant.
 - a) The MCO shall honor and document any specific participant requests to exclude a provider from participating in the Person-Centered Service Plan meeting.

C. Person-Centered Service Plan Meeting Coordination

1. The MCO Care Coordinator shall schedule a face-to-face Person-Centered Service Plan meeting at a date and time that is convenient for the individual pursuant to CFR 441.301(c)(1)(111).
 - a) MCOs shall make at least three attempts to schedule the in-person Person-Centered Service Plan meeting and shall document in writing if they receive no participant response after three attempts.
 - i. Acceptable attempts to contact the individual include:
 1. live telephonic contact with the participant or participant’s legal representative
 - a) voicemails left with no response are not considered as “live contact”
 2. in-person contact, conducted at either the participant’s home, a provider location, or at a site selected by the participant
2. MCO Care Coordinators shall work with the participant and Person-Centered Service Plan participants to establish a meeting strategy that will allow remote participation without risk of improper disclosure of protected health information.
 - a) MCO Care Coordinators shall ensure, to the best of their ability, that Person-Centered Service Plan meeting participants who attend via telephone or video conference, are participating from a location that does not risk violation of privacy standards, such as the Health Insurance Privacy and Portability Act (HIPPA), including the improper sharing of protected health information about participants.

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D. Direction of the Person-Centered Service Plan Meeting

1. The Person-Centered Service Plan meeting shall be directed by the participant or designate legal representative as delegated by the participant.
2. The MCO Care Coordinator and TCM shall support the participant/ designated legal representative in leading the meeting, effectively coordinating the planning process and ensure that all the required components are completed.

E. Participant Choice, Rights and Responsibilities and Person-Centered Support Plan forms

1. The Person-Centered Service Plan meeting shall include a review of the Participant Choice, Right and Responsibilities and Person-Centered Support Plan forms.
2. The TCM shall review and obtain participant signature for the relevant pieces of the Participant Choice forms and Rights and Responsibilities Forms, and shall submit completed documents to the MCO Care Coordinator within five (5) business days of completing the form(s) or at the Person-Centered Service Plan meeting.
3. Participant Choice Forms
 - a) The CDDO shall provide choice for service providers and community-based vs. institutional alternatives.
 - b) The MCO Care Coordinator shall provide choice for agency versus self-direction and the participant's preferred format for the provision of all documents provided during the Person-Centered Service Plan.
 - c) All choice forms shall be signed by the participant or participant's legal representative.
 - d) MCOs, or their designee, shall provide the forms to participants or their legal representatives prior to the Person-Centered Service Plan meeting.
 - e) The CDDO or their designee shall provide a signed copy of the applicable forms to the MCOs during the Person-Centered Service Plan meeting.

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f) If a participant chooses services outside of their current CDDO area, the participant's current CDDO and MCO shall coordinate with the desired CDDO area to communicate the participant's choice.

- i. The CDDO serving the selected service area shall offer the participant choice forms.

4. Rights and Responsibilities Form

- a) The rights and responsibilities form will be furnished by the MCO, or their designee, to all participants to provide current information on their rights as KanCare participants.
- b) TCMs shall review, with the individual/ legal guardian, the rights and responsibilities of participants and those individuals who self-direct their person-centered care pursuant to KAR 30-63-22.
- c) Providers shall uphold rights and responsibilities activities, specific to service delivery, as defined in state regulation.
- d) The MCO Care Coordinator shall document verification that information was received and understood regarding the reporting of abuse, neglect, and exploitation; rights & responsibilities, and process for appeals and grievances, signed by the participant or participant's legal representative.

5. Person-Centered Support Plan (Support Plan)

- a) The Support Plan shall be compliant with the requirements in Article 63, 30-63-21.
- b) The Support Plan is a Person-Centered Service Plan related document that allows the participant to self-assess personal preferences, strengths, weaknesses, and goals prior to completing the Person-Centered Service Plan meeting.
- c) Impacted entities, including MCO Care Coordinators and TCMs shall use a standard Support Plan format, approved by KDADS.
- d) The TCM shall assist the participant with completing the Person-Centered Support Plan prior to holding the Person-Centered Service Plan meeting, and shall

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ensure that the MCO Care Coordinator receives the document to include in Person-Centered Service Plan documentation.

- e) For initial Person-Centered Service Plan meetings, the MCO shall notify the TCM as soon as the meeting is scheduled and no later than three (3) days in advance of the meeting of the need for the Support Plan to allow the TCM sufficient time to assist participant with completing the document.
- f) For annual redetermination meetings, MCOs shall notify the TCM of the need for a completed Support Plan no later than 30 days prior to the anticipated meeting date.
- g) For any additional Person-Centered Service Plan meetings due to change in condition, MCOs shall notify the TCM of a need for an updated Support Plan no later than 24 hours before the anticipated meeting.
 - i. In this case, the TCM shall do due diligence in facilitating an updated Support Plan, but is not required to update the Support Plan prior to the Person-Centered Service Plan meeting.
- h) The TCM shall document participant refusal to complete the Support Plan prior to the Person-Centered Service Plan meeting, and notify the MCO Care Coordinator, if applicable.
- i) While the MCO Care Coordinator has primary responsibility for development and delivery of the Person-Centered Service Plan, the TCM shall support development of the Support Plan and the referral process.
- j) As part of the Support Plan process, the TCM shall provide education and explore the following:
 - i. service options that will assist the participant in progress toward established goals,
 - ii. identified care gaps, including assessing the participant's understanding of risks and consequences if gaps remain.
 - iii. The TCM shall, in instances where a participant's preferences may put him or her at health or safety risk, verify, to the best of their ability, that the

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participant demonstrates understanding of risk, strategies to mitigate risks, consequences, and shall make appropriate referrals to address risks.

- iv. restrictions to the participant’s preferences as stated in the Support Plan or verbally.
- v. additional community and social supports available to the participant, that may not be furnished directly by the MCO.
- vi. Participants may use the assistance of non-paid supports, and shall be encouraged to engage with non-paid supports when completing the Support Plan.

F. Behavior Support Plan

1. The behavior support plan shall meet all requirements as identified per KAR 30-63-23.
2. In accordance with KAR 30-63-23, plans shall be reviewed by a provider-established behavior management committee comprised of parties defined by regulation.
3. The participant’s chosen TCM or applicable provider, shall complete the Behavior Support Plan in conjunction with impacted providers or external entities included by the provider.
4. The TCM shall assist with identification of any restrictions to the participant’s preferred lifestyle and will gather and provide information to the MCO and team regarding the following:
 - i. Informed consent;
 - ii. A specific and individualized need;
 - iii. Documentation of the positive interventions and supports used prior to restrictions;
 - iv. Less restrictive alternatives tried;
 - v. The reason for the restriction (other than disability);
 - vi. Frequency of use;
 - vii. How often the behavior plan is reviewed and by whom;
 - viii. Who collects the data;
 - ix. Assurances that the interventions used will cause no harm to the individual;
 - x. Additional community and social supports available to the participant, that may not be furnished directly by the MCO to align the contents of the Support Plan with the contents of the behavioral support plan to ensure coordination and avoid duplication.

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5. The completed behavior support plan shall be shared with the MCO Care Coordinator within 5 business days of approval by the behavior management committee, at which time the MCO Care Coordinator must update Person-Centered Service Plan accordingly. This standard is applicable to all instances when the behavior support plan is changed or updated.

G. Coordination with the Individual Educational Plan (IEP)

1. If the participant has an Individual Educational Plan (IEP), the MCO Care Coordinator shall request a copy.
2. If a copy is available the MCO shall coordinate with the TCM, where applicable, to ensure that both plans have coordinated goals and objectives

H. Development of the Back-Up Plan

1. The back-up plan shall be the responsibility of MCOs to complete as part of the Person-Centered Service Plan process. MCOs shall submit the back-up plan template to the State for approval prior to its use in the Person-Centered Service Plan process.
2. The participant's MCO Care Coordinator shall coordinate with the TCM to ensure the participant's back-up plan is updated during the annual Person-Centered Service Plan meeting.
3. The MCO shall monitor the implementation of the established back-up plan, including performing any necessary updates to the back-up plan and ensure updated documentation is forwarded to the TCM for inclusion in the participant's records.
4. It shall be clearly indicated if the participant has a "disaster red flag designation" within the back-up plan.
5. Back-Up plans for HCBS participants with a disaster red flag designation shall addresses how participant's care, health and safety needs will be met in the event of natural or other disasters regardless of the setting they reside in.

I. Documenting Participant Understanding of the Person-Centered Service Plan

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1. The MCO Care Coordinator shall obtain a signature of understanding from the participant or participant’s designated legal representative prior to implementation of the Person-Centered Service Plan.
2. The plan’s contents shall be clearly documented, including the scope, amount and duration of services established based on participant assessment when a signature is obtained.
3. MCOs retain the flexibility to design a participant-friendly signature page, but the template shall be subject to the review and approval of the State.
4. The MCO Care Coordinator shall clearly educate the participant, or participant’s designated legal representative that signing the Person-Centered Service Plan may not imply full agreement with the content of the plan.
5. A participant or participant’s legal representative shall sign to acknowledge understanding and agreement or disagreement with the Person-Centered Service Plan whenever content adjustments are made that change the scope, amount or duration of services within the plan, including interim changes.
6. MCO Care Coordinators shall document that they provided education for the participant explaining that participant signature does not waive a participant’s right to file a grievance or appeal.

J. Declining Signature of the Person-Centered Service Plan

1. If the participant or participant representative declines signing the Person-Centered Service Plan, the MCO Care Coordinator shall document the refusal in writing.
2. If the MCO Care Coordinator cannot obtain a signature within the 30-day window due to failure of the individual/legal representative to respond, the MCO Care Coordinator shall notify the HCBS Program Manager of the refusal, and demonstrate at least three (3) documented attempts, which include:
 - a) live telephonic contact with the participant or participant’s legal representative
 - i. voicemails left with no response are not considered as “live contact”
 - b) in-person contact, conducted at either the participant’s home, a provider location, or at a site selected by the participant

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3. The MCO shall send a NOA to the participant advising that services on the Person-Centered Service Plan will be closed due to no signature by the participant/ legal representative on the plan.
 - a) For initial Person-Centered Service Plans, a Notice of Action (NOA) shall be sent by the MCO to the participant advising that services on the Person-Centered Service Plan cannot be provided until the plan is signed by the participant/legal representative.

K. Documenting Provider Understanding of the Person-Centered Service Plan

1. Each service provider who will participate in the delivery of services shall sign a statement of understanding and consent to deliver the applicable services included in the Person-Centered Service Plan.
 - a) The MCO shall coordinate obtaining provider signatures.
 - b) Provider signature does not constitute approval or denial of Person-Centered Service Plan. Provider signatures indicate an understanding of Person-Centered Service Plan contents, and denotes a willingness and ability to deliver services within the scope, amount and duration established.
2. The participant may request that their primary or specialty care providers sign their plan. If this request is made, the MCO Care Coordinator shall obtain signatures from these providers.
3. In the event the only willing provider of HCBS services refuses to sign a statement of understanding and consent:
 - a) the MCO Care Coordinator shall provide education to the participant that services on the plan cannot be provided by a HCBS provider who is unwilling to sign the plan/ statement of understanding and consent.
 - i. The CDDO shall obtain another HCBS provider choice from the individual.
 - ii. The MCO Care Coordinator shall obtain signed documentation from the party that they refuse to sign the plan and the MCO Care Coordinator shall notify the applicable HCBS Program Manager, in writing, of this refusal. MCOs

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shall proceed with authorized services for providers who have signed the Person-Centered Service Plan.

4. When interim changes are made to a participant's Person-Centered Service Plan that change the scope, amount or duration of services within the plan, the MCO Care Coordinator shall obtain a signature from the impacted HCBS service providers.
5. HCBS providers who fail to sign a statement of agreement shall not be paid for services provided prior to receipt of a signed statement from the provider.

L. Obtaining I/DD Waiver-Specific Physician's Statements

1. The MCO Care Coordinator shall identify the need for a physician's statement for Health Maintenance Activities (HMA) or in-home I/DD Day Services, if those services are included in the participant's Person-Centered Service Plan.
 - a) The statement shall include documentation of the health maintenance activities and the identified responsible party for overseeing each of the identified Health Maintenance Activities.
2. The TCM shall coordinate with the MCO Care Coordinator to ensure completed documentation is forwarded to the MCO for inclusion in Person-Centered Service Plan documentation.

M. Confirming Appointed Designated Representatives and Paid Guardians

1. The Person-Centered Service Plan shall indicate if the participant has a designated legal representative and/or guardian.
 - a) MCOs shall maintain documentation from the court for court-appointed legal guardians when applicable.
 - b) MCOs shall maintain Activated DPOA documentation when applicable.
2. The TCM shall to coordinate with the MCO Care Coordinator to ensure the participant record includes designated representative and guardian details, including name and whether the individual is paid or unpaid to act as a guardian.

N. Providing a Finalized Person-Centered Service Plan

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1. The finalized Person-Centered Service Plan shall be completed within the contractual timeframe.
2. The MCO Care Coordinator shall supply the participant or participant's designated legal representative with a final Person-Centered Service Plan, once all parties have signed the agreement.
3. The MCO Care Coordinator shall sign the Person-Centered Service Plan as documentation of their participation in the process.
4. The final Person-Centered Service Plan shall be provided to the participant according to the method selected in the participant's completed choice form, within the established timeframe of the Person-Centered Service Plan meeting.
5. The MCO Care Coordinator shall document participant confirmation of receipt of a finalized plan with date, time and method of confirmation.
 - a) MCO Care Coordinators may accept written confirmation from a TCM that the final plan has been received by the participant with the date and time noted.
6. The MCO Care Coordinator shall supply each of the participant's applicable providers with a copy of the Person-Centered Service Plan within the established timeframe of the Person-Centered Service Plan meeting.
7. The MCO Care Coordinator shall supply the participant's TCM with a copy of the finalized Person-Centered Service Plan within the timeframe established within the KanCare MCO Contract.

O. Monitoring Implementation of the Person-Centered Service Plan

1. The participant's chosen TCM shall provide ongoing monitoring of progress toward Person-Centered Service Plan goals. In addition, the TCM shall make referrals for additional resources as needed, for participants on the I/DD waiver and individuals on the I/DD waiting list.
2. The TCM shall coordinate with the MCO Care Coordinator in the event there is a change in Person-Centered Service Plan goals.

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3. The MCO Care Coordinator shall monitor delivery of the Person-Centered Service Plan, including completion of a six-month face-to-face visit with the participant.
 - a) The participant’s designated legal/ legal representative may attend in person or telephonically.

P. Required Timelines

1. Each MCO shall meet all required timelines regarding the Person-Centered Service Plan found in the 1915 (c) HCBS IDD Waiver and the current KanCare MCO Contracts.
2. To be considered compliant on timeliness, the Person-Centered service plan must be signed within 365 days of the previous plan’s signature date.
3. The MCO Care Coordinator shall hold a face-to-face meeting with the participant at least every 6 months.

Q. Assignment and Changing MCO Care Coordinators

1. A participant shall have the right to request a new MCO Care Coordinator.
2. MCOs shall document requests for re-assignment to a new Care Coordinator, and re-assign MCO Care Coordinators within 14 business days.
3. For new MCO Care Coordinator assignments and any MCO Care Coordinator re-assignments, the participant or participant’s legal representative shall be notified in writing, within 30 calendar days of the change.
 - a) Notification shall include:
 - i. instructions for contacting the newly assigned Care Coordinator through the MCO’s established contract process and toll-free
 - ii. instructions for a toll-free line that provides direct contact with a live person in the event the Care Coordinator is unavailable to answer participant questions
4. In the event an individual requests a new Care Coordinator more than 3 times, the MCOs shall follow their internal policies and procedures to address the issue.

Policy Name:	Intellectual and Developmental Disability Person-Centered Service Plan	Policy Number:	M2018-042
Commission:	Community Services and Programs	Date Established:	4.9.2018
Applicability:	HCBS IDD Waiver	Date Last Revised:	
Contact:	IDD Program Manager	Date Effective:	7.9.2018
Policy Location:	http://www.kdads.ks.gov/commissions/home-community-based-services-(hcbs)/hcbs-policies	Date Posted:	4.16.2018
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- a) The MCOs internal policy must include an appeal and grievance process.

R. Conflict Resolution

1. Participants and their designated legal representatives shall retain the right to disagree with the process and/or outcome of the Person-Centered Service Plan contents and can invoke their grievance and appeals rights at any point in the following process.
2. Following the referral and use of the MCO's grievance process if the MCO is unable to resolve a Person-Centered Service Plan related conflict with the participant, the MCO shall facilitate a "warm transfer" to the KanCare Ombudsman, who will then assist with the following actions:
 - a. Engaging the MCO in informal conflict resolution activities, the outcome of which shall be documented by both the MCO Care Coordinator, as well as the KanCare Ombudsman.
 - b. Referring unresolvable conflict to state officials within KDADS or KDHE as necessary to ensure the safety and wellbeing of participants.
 - c. Assist participants to understand the State's Medicaid fair hearing process, grievance and appeal rights, and assist participants in navigating those processes and/or accessing community legal resources, if needed/requested.

III. Quality Assurance and Documentation

- A. The waiver participant or designated legal representative's signature, shall be required to meet all waiver Plan of Care performance measures provided in the HCBS 1915 (c) waivers.
- B. The choice of providers offered to individuals shall be consistent with the time and distance or other standards outlined in the KanCare MCO Contracts. A choice of state-wide providers shall not be required unless specifically requested by the waiver participant.

III. Definitions

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Activities of Daily Living (ADL)- routine activities that people tend to do every day without needing assistance. There are six basic ADLs: eating, bathing, dressing, toileting, transferring (walking) and continence.

Agency-directed- the traditional service delivery model. A qualified agency hires, fires, pays and trains direct service workers to provide services to individuals.

Alternate Setting of Care- includes Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID), Psychiatric Residential Treatment Facilities (PRTF), Nursing Facilities, State Hospitals and settings of incarceration.

Appeal- refers to an MCO’s internal grievance and appeal process leading up to a State Fair Hearing.

Back-Up Plan-The back-up plan is a component of the Person-Centered Service Plan that documents how a participant’s needs will be met when there are disruptions in the plan(s) established in the participant’s Person-Centered Service Plan. The plan shall address identified health and safety risks, staffing and disaster red flag designations.

Behavior Support Plan- a component of the Person-Centered Service Plan that documents the plan for addressing and supporting behavior management of participants with behavior treatment needs or mental illness. The purpose of this plan is to include methods that ensure appropriate, effective, and informed use of medications and other restrictive interventions to manage behavior or to treat diagnosed mental illness.

Disaster Red Flag Designation- An indication an individual has increased risk of harm during emergency or other disaster events. This is typically attributed to dependence on electricity for life sustaining equipment, dependence upon life sustaining medication, etc.

Health Maintenance Activities: include monitoring vital signs, supervision and/or training of nursing procedures, ostomy care, catheter care, enteral nutrition, wound care, range of motion, reporting changes in functions or condition, and medication administration and assistance.

Instrumental activities of daily living (IADL)- activities often performed by a person who is living independently in a community setting during the course of a normal day. IADLs include managing money, shopping, telephone use, travel in the community, housekeeping, preparing meals and taking medications correctly.

Individual Educational Plan (IEP)- defined by the Kansas Special Education Services Process Handbook as “as a written statement for each student with an exceptionality which describes that child’s educational program and is developed, reviewed, and revised in accordance with special education laws and regulations.”

Legal Representative – refers to any durable power of attorney or legal representative assigned by court or selected by the participant, and/or legal guardian.

Person-Centered Service Plan - a written service plan developed jointly with an individual (and/or the individual’s authorized representative) that reflects the services and supports that are important for the individual to meet the needs identified through a needs assessment, what is important to the individual

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regarding preferences for the delivery of such services and supports and the providers of the services and supports. (42 CFR § 441.725(a) and (b)).

Person Centered Support Plan- a written plan that contains a description of the person’s preferred lifestyle, the activities, training materials, equipment, assistive technology and services that are necessary to assist the person in achieving their preferred lifestyle. (K.A.R. 30-63-21)

Self-Direction- participants or their representatives have decision-making authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports.

Warm Transfer- the individual is connected to a new staff member such that the individual does not need to repeat their story to different workers.

Authority

1915(c) HCBS Waiver
KS.0224.R05.01 (IDD)

Federal Authority 42 CFR 441.301 Contents of request for a waiver

State Authority
K.A.R. 30-63-1 through 32. Person-centered support planning; implementation

Related Information

KDADS Provider Qualification Policy
Public Comment Period: