Louisiana Department of Health
Office for Citizens with Developmental Disabilities

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Children's Choice Waiver (CCW)

Instructions for the Plan of Care (POC) Form

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Louisiana Department of Health

Office for Citizens with Developmental Disabilities
Children's Choice Waiver (CCW)
Plan of Care (POC) Instructions

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PLAN OF CARE (POC) GENERAL PURPOSE

The Plan of Care (POC) establishes direction for all persons involved in providing supports and services for the individual being assessed for home and community-based waiver services, or for those already receiving services. The POC reflects information shared by the individual requesting/receiving services, as well as by those who know him/her best. The primary goal of the POC process is to learn as much as possible directly from the individual and those who support him/her. This personal perspective assists those who provide supports and services to identify the individual's expectations, desired outcomes and guide service activities.

An individual support plan should be a statement of the individual's vision for the future and the supports and services designed to assist him/her to move toward that future. The POC is a tool used to document specific information about individualized supports and services for each individual. It also communicates priorities to all support personnel and provides a point of reference for reviewing progress and change.

The POC is developed through a flexible, **on-going collaborative** process involving the individual, family, friends or other support systems, the support coordinator and appropriate service providers. Plans are based on information from the individual, the individual's primary support network and other service personnel who know and interact with the individual. It reflects discussion and decisions about services and supports during planning sessions. The plan provides a road map for the achievement of personal outcomes.

Learning about the individual does not stop when the planning session is completed. Interacting with people as they experience new opportunities and situations provides new information that can be used to initiate, and/or enhance the effectiveness of supports and services (both formal and informal) that can be combined to enable people to live the lifestyle they want to live.

The information contained in this instruction manual identifies and explains how to complete various sections/components of the Children's Choice Waiver (CCW) POC. This manual is not to be considered a stand-alone document in the development of an individual's plan of care, but rather used as a guide in the collection, planning, execution, evaluation and on-going documentation of valuable, key information. Significant movement toward the lifestyle an individual prefers and is satisfied with can only happen through the development of a network of people (paid and unpaid) who are committed, willing and able to listen to the individual's desired outcomes, and then build supports to achieve those outcomes.

Most importantly, keep in mind the purpose of the planning session. The planning session should create a shared understanding of the individual's priorities and a sense of excitement and possibility for the individual's future.

DEMOGRAPHIC INFORMATION

IMPORTANT NOTE: The individual's full name (last name first) should appear at the bottom of every page of the POC.

Purpose

This initial section of the Plan of Care (POC) contains basic identifying and descriptive information regarding the individual.

POC Type: Indicate the reason for completing the POC. If this is the first time a POC is being completed for an individual, check the box marked "INITIAL." Check the box marked "ANNUAL" for all subsequent POCs (i.e., submitted after the individual's initial approved POC).

Individual's Name: Indicate the individual's full **legal** name (last name, first name).

Date of Birth (DOB): Indicate the individual's date of birth.

Social Security Number: Indicate the individual's social security number.

Medicaid ID Number: Indicate the individual's 13 digit **Medicaid** number. Do not use the control card number (i.e., 7770000….).

Physical Address/ Mailing Address: List the individual's physical address (place of residence), **including zip code**. If the individual's mailing address is different from his/her physical address, note that information under "Mailing Address (if different)" section.

Parish/Region Indicate parish/region in which the individual resides.

Day Phone Number(s)/ Night Phone Number(s): List phone number(s) where the individual can be reached during daytime and nighttime hours.

Legal Guardian: List the name of the person (if any) who has a written, legal right to act on the individual's behalf. Attach a copy of the legal document indicating guardianship to the POC. Indicate if person listed is Legal Guardian or Authorized Representative by circling appropriate designation.

Authorized Representative:	List the name of the person (if any) who has written authorization from the individual to act on his/her behalf. An OCDD "Consent for Authorized Representation" Form must be completed in the event an individual has designated someone to act on his or her behalf.
Relationship:	Indicate what relationship the Legal Guardian or Authorized Representative has to the individual (i.e., parent, brother, sister, aunt, uncle, friend, etc.).
Legal Relationship:	Answer question regarding legal relationship noted above.
Address:	Indicate the Legal Guardian/Authorized Representative's address (physical and/or mailing address) if different from the individual's address.
Day Phone Number/ Night Phone Number:	Indicate the phone number(s) (including area code) where the Legal Guardian or Authorized Representative can be reached during daytime and nighttime hours.
Support Coordination Agency:	Indicate the name of the Support Coordination Agency that will be working with the individual/family. Indicate the Support Coordination Agency's full name (Do not use acronyms.).
Support Coordination Agency Address:	Indicate the Support Coordination Agency's physical and mailing address.
Provider Number:	Indicate the Support Coordination Agency's Medicaid provider number.
Support Coordinator:	Indicate the assigned support coordinator's full name.
SC Supervisor:	Indicate the support coordinator's supervisor's name.
Telephone Number:	Indicate the Support Coordination Agency's telephone number (including area code).
Sex:	Indicate the individual's gender/sex.

Race: Indicate the individual's race.

Education: Indicate if the individual attends school or if she/he receives homebound services.

Legal Status: Indicate the individual's **"**legal status" as far as his/her "legal" ability to make his/her own decisions regarding medical, financial and other areas of care. For an individual whose legal status is identified as "Interdicted," "Power of Attorney," or "Minor," attach a copy of the legal document denoting that status. Legal document must be submitted with initial POC or upon change in legal status. Continuing tutorship should also be noted (attach legal documentation).

Primary Diagnosis Code: Indicate the individual's primary diagnosis and the date of onset.

Secondary Diagnosis Code: Indicate the individual's secondary diagnosis and date of onset.

Level of IDD: Indicate the individual's level of Intellectual/ Developmental Disability (IDD) as identified on the individual's psychological evaluation or 1508 school evaluation form.

Adaptive Functioning: Indicate the individual's level of adaptive functioning as identified on the individual's psychological evaluation or 1508-school evaluation form.

90L: Indicate the date the physician signed the 90L and the date the Support Coordination Agency received the 90L.

Ambulation: Indicate if the individual is able to walk and specify specific ability in space provided using one of the following terms:

Independent: Individual is able to walk independently without personal assistance, and/or the use of assistive devices.

With Personal Assistance: Individual is able to walk with personal assistance, such as assistance to stand before he/she begins walking, assistance to

steady gait, and/or guided maneuvering once walking begins.

With Assistive Device(s): Individual is able to walk with the use of an assistive device(s), such as a walker, crutches, cane, etc.

Does not Ambulate: Individual is unable to walk independently, with assistance, and/or with assistive devices.

Emergency Self-Evacuate: Indicate if the individual is able to self-evacuate in the event of an emergency. (**NOTE: Attach a copy of the individual's emergency evacuation/response plan to the POC.)**

Emergency Response: Indicate the individual's emergency response level as defined below by checking the appropriate box:

Level 1: The individual requires **total assistance with life sustaining equipment** (i.e., Equipment is required to sustain the individual's life; generally, equipment is powered by electricity, and/or electricity is required as a backup.).

Level 2: The individual requires **total assistance** to respond to an emergency situation.

Level 3: The individual can **respond independently to an emergency but needs transportation** to complete this process.

Level 4: The individual can **respond independently** (i.e., The individual has available supports to meet all his/her needs in an emergency situation, including transportation.).

Will Residence Change with Waiver Participation: Indicate if the individual will be moving to another place of residence upon participation in a home and community-based waiver program. **If yes:** indicate proposed date and address, including house number/apartment number, street, city, state and zip code.

Are there Multiple Individuals with Wavers in the Home: Indicate if there are multiple individuals of any type of home and community-based waiver services residing in the individual's home. **If "Yes,"** how many?

Are there Multiple Individuals with Disabilities (Non-Waiver Individuals) Residing in the Home: Indicate if there are individuals with disabilities who reside in the home who do not receive waiver services. **If "Yes," how many?**

Does this POC include Plans for Restraints: No / Yes. If yes, explain in health section of POC.

Are Paid Caregivers Related to the Individual: **If yes, Relationship and Service Provided:** Indicate if any of the paid caregivers are related to the individual.

Do Paid Caregivers Live with the Individual: Indicate if paid caregiver(s) live with the individual. If yes, indicate name and service(s) provided.

Present Housing Arrangement: Indicate Housing Arrangement by checking appropriate box.

FOR LGE USE ONLY: LGE staff will complete this section.

SECTION I - EMERGENCY INFORMATION

Purpose

There are several possible situations that necessitate having current, easily accessible personal and medical information and workable evacuation plans in place. Medical emergencies, fire, hurricanes, hazardous materials release, tropical storms, flash flooding, ice storms, and other emergency situations should all be considered when planning for the safety and well-being of individuals we support.

Not knowing what to do or whom to call in an emergency is unacceptable. Reduced response/escape time may mean the difference between life and death.

Pre-emergency assessment and thoughtful planning and practice, which consider the specific needs of individuals with physical, mental, and/or memory impairments, foster independence and empower individuals and those who support them to respond quickly and efficiently at the onset of an emergency.

Information noted in this section, among other uses, will provide a quick reference regarding an individual's ability to evacuate in the event of an emergency. Circle of support contact information, doctor(s) name(s) and phone number(s), as well as other essential information are also included in this section.

INDIVIDUALIZED EMERGENCY EVACUATION/ RESPONSE PLAN ATTACHED:	**Individualized Emergency Evacuation/ Response Plan must be attached to the Plan of Care.**
INDIVIDUAL'S NAME, AGE, ADDRESS AND DIRECTION TO HOME:	Indicate the individual's full name, age, physical address, and directions to his/her home. Directions to the individual's home should be clear, concise and if at all possible, refer to a landmark as a starting point of reference.
PERSON RESPONSIBLE FOR EVACUATING OR BRINGING SUPPLIES TO THE INDIVIDUAL'S HOME:	List the person(s), who will be responsible for assisting the individual in the event of an emergency/ evacuation, in this section. **(NOTE: AGENCY NAME IS NOT SUFFICIENT - LIST DESIGNATED PERSON/STAFF.)**

FAMILY MEMBERS/OTHERS TO CONTACT IN CASE OF AN EMERGENCY (INCLUDING PROVIDERS): List the persons who are to be contacted in the event of an emergency in this section.

EMERGENCY EQUIPMENT IN THE HOME: Indicate if the individual has the following emergency equipment (in working order) in the home, including the location of equipment: 1) Fire Extinguisher, 2) Home Evacuation Plan, 3) First Aid Supplies, 4) Specialized Medical Equipment (e.g., ventilator, suction machine, nebulizer, etc.), 5) Smoke Detector, 6) other emergency equipment (Note: List "other" equipment.).

> ***IMPORTANT NOTE:*** *The safety and well-being of an individual should always be considered prime importance. Each individual situation should be thoroughly assessed to assure that circumstances specific to that individual are taken in to consideration when planning for the safety and well-being of that individual****. If emergency equipment, well thought out plans for evacuation, and the individual's understanding of how/when to evacuate are not found to be present, an Outcomes goal in Section V should reflect how this situation will be remedied.*** *A specific target date for initial review of the Outcomes goal in this section should be set as soon as possible, but no later than the first quarterly review****. Safety issues that pose an immediate threat should be dealt with immediately****.*

The support coordinator is responsible for assuring that the necessary steps to correct the situation are taken and documented as such. The support coordinator should explore all paid and unpaid resources to assist an individual, and/or his/her circle of support to obtain the necessary equipment/supplies to correct this situation. It is important to remember that the main focus in an emergency should always be making sure the individual is out of harm's way as soon as possible. For example, an individual that we are supporting should not attempt to use a fire extinguisher to put out a fire. Instead, he/she should be assisted or taught how to quickly and safely exit an unsafe area/situation.

Special Considerations/Necessities (Detailed Information Required): assistive technology, ventilator dependent, medications, etc. (See Individual Emergency Evacuation /Response Plan): List individual-specific considerations which have been identified and addressed in the individual's attached emergency evacuation/response plan.

Agencies involved with the individual:
(e.g., Service Providers, Office of Children Services, Louisiana Rehabilitation Services, churches, etc.):

Include agency name, phone number, and contact person.

Individual's Doctor(s): List the individual's primary physician (full name), his/her specialty (area of practice), and a phone number where he/she may be reached. Include the name(s), specialty and phone number(s) of other doctors the individual may see for routine, and/or specialized care.

SECTION II - CURRENT STATUS/ PERSONAL OUTCOMES AND SUPPORTS

Purpose

This section provides specific information on the current situations in the individual's life. Explore the current situation in the individual's life through a personal interview with the people who know him/her best (i.e., the individual, his/her family and the people who provide support to the individual). Also, reference psychological assessment, social summary, Personal Outcomes Assessment, and Person-Centered Plan (if available).

Outcome(s): Describe outcomes as defined by the individual and his or her preference and personal context. Outcomes spotlight what is most important for the individual and services and supports are based on what makes the most sense to and for him/her.

Support(s): Describe which individualized supports are present that are working toward the individual attaining his/her desired outcomes.

SECTION III - HEALTH PROFILE*

**Be especially aware of any information in this section that the individual may deem "Sensitive Information" and follow appropriate guidelines.*

Purpose

An individual's health profile is a collection of health and medical information obtained from the individual himself/herself, persons who know the individual best, other sources such as the individual's physicians, other health care providers, and medical and/or psychological records. Individuals with disabilities that interfere with cognition or communication may not be able to either recognize or tell anyone about significant changes in their health status. In these cases, people who know the individual best can provide an invaluable source of information.

A thorough collection of information concerning an individual's health profile and current health status can be an invaluable tool in early identification and monitoring of potential health and welfare concerns when working with populations of individuals with intellectual / developmental disabilities, especially those individuals who may have a history of unstable health conditions.

Information documented in this section will guide the individual's support team in assuring that appropriate, adequate and person-centered supports are addressed in the support planning process.

This section summarizes important aspects of the individual's physical and mental health status, medication needs, adaptive functioning capabilities/needs, frequency and reason for doctor visits, preventive medical/dental checkup schedules, and/or specialized medical follow-up, such as monitoring of medications, blood pressure, lab values, and other needs.

A. Health Status

1. **Physical:** This section describes the individual's functional and sensory abilities in the areas of vision, hearing, physical mobility, use of arms/hands, need for assistive devices, and overall health status.

2. **Medical Diagnoses/Concerns/Significant Medical History:** This section describes the individual's medical diagnosis as stated in the Physician's Medical Authorization for Long Term Care placement (90L) and other medical documentation. Medical concerns and significant medical history should be listed in this section. If an individual has a diagnosis of seizure disorder (epilepsy), a seizure protocol must be attached.

3. **Psychiatric/Behavioral Concerns:** This section provides a description of the individual's psychiatric status, diagnoses and behavioral problems which may impact his/her health status and/or ability to function. Significant social, affective, cognitive, and/or environmental factors that may trigger an inappropriate response (e.g., threat or injury to self and/or others, etc.) should be noted. Behavioral issues and concerns should be documented and successful interventions described accordingly. History regarding skills training in dealing with: suicidal or homicidal ideation, intent or attempts, history of elopement, aggression, and inappropriate sexual behavior should also be detailed in accompanying documentation. If restraints (physical and/or chemical) are used, provide explanation.

4. **Behavioral Support Plan:** This section describes the extent of staff and other support system required specifically for behavioral intervention as outlined in an individual's behavioral support plan. The intensity and frequency of such interventions are also described in this section.

5. **Incident Reports (For past 6 months – list number of times each incident occurred):**
    a. Critical Incidents (as defined by OCDD Critical Incident Policy)
    b. Non-Critical Incidents (as defined by OCDD Critical Incident Policy)
    c. Hospital Admissions: Frequency and reason(s) for hospital admissions.
    d. Emergency Room Visits: Frequency and reason(s) for emergency room visits.
    e. Psychiatric Hospital Admissions: Frequency and reason(s) for psychiatric hospital admissions.
    f. Other: Frequency and reason(s) for the critical incidents. (Example of "Other" would be law enforcement involvement, or other items not already listed.)

6. **Additional Information Summary Box:** Additional information for items listed under Incident Reports should be noted in this area.

B. List of Treatments (Examples: Catheterizations, Tube Feeding, Dressing Changes, Suctioning, Oxygen, Therapy, Splints, Braces, etc.): A complete list of the individual's treatments/procedures, including purpose of treatment/procedure, dosage/frequency, how prescribed and administered, prescribing physician, and person(s) administering the treatment should be listed in this section. Nurse Delegation/training should

be noted and attached to Plan of Care (POC) when required. DSW training documentation of Patient Specific Non-Complex Skill/Treatment should be included.

C. Allergies to medication/food/airborne: ("What does it look like?): The type and severity of allergy, whether individual requires medical intervention as a result of allergic reaction, need for special anti-allergy/emergency treatments, if under doctor's care for allergies, etc. should be included in this section.

D. List of Medications/Medical Procedures: (Including over the counter medications): Prescription and over-the-counter medications are listed in this area. Medication name, what it is prescribed/used for, dosage/ frequency, how taken (i.e., oral, patch, liquid, etc.), the name of prescribing physician, and who will be administering (i.e., self, family member, CMA, etc.) should be listed in this area. Nurse Delegation/ training should be noted and attached to POC when required.

> ***Important Note:*** *Awareness and proper management of an individual's medications, especially those used to stabilize, keep a medical condition from worsening, and/or avoid hospitalization should be of prime importance when discussing an individual's use of medications. Medication use should also be discussed when looking at emergency preparedness issues.*

SECTION IV – PARTICIPANT PROFILE

**Be especially aware of any information in this section that the individual may deem as "Sensitive Information" and follow appropriate guidelines.*

Purpose

The purpose of this section is to gather information to gain a better understanding of the life experiences of an individual and his or her family. The approach needs to be relaxed with questions that provide an opportunity for the individual and/or the people who know him/her best to share life stories. An understanding and appreciation of positive and negative events in an individual's life will provide beneficial insight to the individual and circle of support work necessary to develop a person-centered Plan of Care (POC) support plan.

Information should to be written in a manner that supports the values and philosophy of a person-centered approach. The use of **People First language** is critical throughout the plan of care. Language has the power to shape ideas and change perspectives. The language we use in our reports and plans is important because of the cumulative effect it has on the attitudes of caregivers, family members and community supports. It is important to use language that honestly paints a complete picture of the individual. Emphasize **the individual rather than the disability**. Remember that most individuals with a disability want to be thought of as ordinary people. State an individual's need in the context of performance or describe what is needed for success. Written information needs to be accurate and not judgmental. Describe an individual's personality traits, capabilities and interests and other qualities that make the individual who he or she is, emphasizing abilities, not perceived limitations.

Some individuals have difficulty letting us know their preferences, priorities, and perspectives. Some individuals communicate with gestures and some do not communicate verbally. The information gathering process may require extra attention to non-verbal means of communication. When gathering information from and about individuals, we need to spend time with them in different settings to develop rapport and to observe how they interact (or don't interact) in various surroundings. Gathering information from different people who know the individual best is very important in learning about individuals who have difficulty with language and verbal expression due to physical and cognitive limitations. People who are most familiar with the individual may be able to assist the interviewer in understanding the individual's own communication method and style. They may also offer suggestions and guidance to enhance interactions and thus a better understanding of that individual's wants and needs. When asking questions of those who know the individual best, be sure to ask how they know what they are telling you is so. (For example, "How do you know Mary likes to spend time outdoors?" or "What makes you think that John dislikes carrots?") It may be necessary to include plans for ways to discover and learn more about that individual so that we can provide him/her with truly meaningful supports and services.

Ask probing and open-ended questions in a conversational manner to gather information. This will promote detailed and descriptive life stories about experiences. Repeat what has been said to ensure that the information you are recording is accurate.

A. Pertinent Historical Information: Include date, age at time of onset, and cause of disability. If not known, enter "unknown." Also include placement history; recurring situations that impact care; response to interventions in the past; and summary of events leading to request for service at this time.

B. Current Living Situation: Describe current family situation including level of education attainment, family's understanding of the individual's situation/ condition, knowledge of the disability, and consequences of non-compliance with POC, economic status, relevant social environment and health factors that impact individual (i.e., health of care givers, home in rural/urban area, accessibly to resources), and residential status (i.e., own home/rental/living with relatives/ extended family or single family dwelling). Is the home environmentally safe? Does the home environment adequately meet the needs of individual or will environmental modifications be required?

C. **Natural Supports:** Include list of family members (names and ages); how they are involved/not involved. Who is the primary care giver (PCG)? Is the PCG employed? Are any of the care givers paid for supports? If there are no natural supports, has guardianship been considered? Description of complete social support network including list friends and other community resources involved in supporting the individual on a daily basis.

D. Current Community Supports or Other Agency Supports: Include the individual's significant life events, which may include family issues, issues with social/law enforcement agencies. Does the individual have social services caseworker or Probation Officer assigned? Will you have to interact with that agency/individual?

E. Daily Living Skills: Describe activities of daily living that must be completed by others. What skills can the individual complete independently? With assistance? Require total assistance?

SECTION V – PERSONAL PREFERENCES

Purpose

The purpose of this section is to get to know the individual, his or her personality traits, interests, capabilities, preferences and support needs to gain a better understanding of how to support him or her. Information is to be obtained in a ***positive*** and ***respectful*** manner that allows you to paint a full picture of the individual. Through this approach, the circle of support will strive to build services and supports that are individualized and responsive to the individual's personal preferences, interests and choices. This section of the Plan of Care will guide and direct how people, such as direct support professionals, teachers, provider agency staff, family members, and others, can play significant roles in the individual's life and assist him/her in planning individualized support and service delivery.

A. Gifts and talents:

In this section, you will ask open-ended questions to find out who the individual is. You will ask questions to determine the things people like about the individual, the things he or she likes about himself/herself and the things he or she is known for… gifts, talents and strengths. It is important to remember that some gifts, talents and strengths could be both positive and negative making it critical to keep the circle of support's focus constructive.

B. Things that work:

In this section, you will identify what works for the individual. This will include people, places, things and activities that create motivation, enjoyment, excitement, happiness and engagement. You may discover that you have learned some of the things that work in previous sections. This information should be recorded again in this section to provide a comprehensive list of "what works." Information will provide insight to the individual's personality and help support staff and significant others really know the individual. This is a very powerful tool in the development of individualized supports.

C. Things that don't work:

In this section, you will identify what doesn't work for the individual. This will include people, places, things and situations that create frustration, anger, upset, worry, boredom or depression. You may discover that you have learned some of the things that don't work in previous sections. This information should be recorded again in this section to provide a comprehensive list of "what doesn't work." Information will provide insight to the individual's personality and help support staff and significant others really get to know the individual, such as understanding what to avoid or when not possible, what support will be needed. This is a very powerful tool in the development of individualized supports.

SECTION VI - PERSONAL OUTCOMES

Purpose

Personal outcomes are what individuals expect from the services and supports they receive. Personal outcomes refer to the major expectations that individuals have in their lives. **The meaning for each of the Personal Outcome Measures is defined by the individual**. Using the outcome measures in the planning process requires that we discover how each individual defines the outcomes for him/herself.

First Column – My Personal Outcomes

What the individual wants for him/herself in the future. Such "goals" can be formal statements of what an individual wants to do or accomplish, or his/her informal expectations and hopes for the future.

Second Column – Support Strategy Needed

(What? Who? How?): **"What"** is needed for the individual to achieve his/her personal outcome? This section identifies the type of concrete action or support needed. This may reflect training needed, supports and/or skill acquisitions, or may be a statement regarding the individual's maintenance in the home and community with provided supports. **"Who and How"** the individual can be supported to achieve his/her personal outcome. This section identifies whether paid staff will be utilized or what natural supports (friends/family) are in place to support the strategy.

Third Column – How Often for Supports and Services

In this column, describe the frequency of service delivery the provider will use to meet the individual's needs and wants. (For example, "Assist with bathing once daily; Hair washing three times weekly to be performed by family and paid staff.") This section should be as specific as necessary to ensure adequacy of support.

Fourth Column – Review/Accomplishment Date

In this column, identify the frequency of when the Plan of Care (POC) will be reviewed. (Note: The POC must be reviewed at least quarterly and updated yearly.) The review will determine whether the individual's needs have been adequately met and whether the services continue to be wanted or needed in order to achieve, or move the individual closer to his/her defined personal outcomes. Identify when the goal/outcome is accomplished. This section identifies the minimum requirements for review of the plan. It should be at least annually or sooner if the individual's situation significantly changes.

(Additional copies of this section can be made as needed.)

SECTION VII - TYPICAL WEEKLY SCHEDULE

Purpose

The intent of this schedule is to assist individuals and their families in assessing and planning for services and supports that will help them move closer to their desired personal outcomes. Utilization of this section and subsequent planning will help assure continuity of care and unnecessary service delivery. Services should be provided in accordance with what is requested and needed by the individual, no more, no less. Simply list the source of service provision when applicable. In addition, for waiver support, simply mark the time the individual typically receives supports by using the "Pw" coding.

This section is for planning purposes only**. It is understood that this schedule is flexible and an individual's daily routine may change based on need or preference. The waiver supports that are initially requested will be based on this planning document.** Children's Choice Waiver services cannot be provided on the same day at the same time as any other waiver or state plan services. All available Medicaid State Plan and services provided through a program funded under the Individual with Disabilities Education Act (IDEA; 20 U.S.C. 1401 et seq.) must be utilized before accessing this service. All services must be outlined on the Plan of Care to prevent duplication of services.

Subsequent changes must to be requested by the individual, and/or his/her Authorized Representative, and processed through the support coordinator utilizing the appropriate Revision Request forms.

Typical Weekly Schedule

The top of this section lists the individual's desired/needed supports. For each hour indicate how the individual will typically spend his/her time using the codes listed below.

CODES:
F = Family
F = Friends
S = Self
Sc = School
C = Companion
Pw = Paid Waiver Support
P = Paid Support*

*Note: Paid Support is support provided by another funding source besides waiver funding [e.g., Early and Periodic Screening, Diagnosis, & Treatment (EPSDT) - Family Supports, Louisiana Rehabilitation Services (LRS), private pay funds, etc.].

When listing Paid Waiver Support (PW), identify the waiver support (e.g., PW - Family Supports, etc.).

An example of a typical weekly schedule is:

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SAT	SUN
12pm	PW – Family Supports (PCA)	PW – Family Supports (PCA)	Friend (Fr)	EPSDT – Family Supports	Family (F)	Family (F)	Fr

After completing the Typical Weekly Schedule, tally the hours by codes (e.g., PW) and enter the number of hours next to the appropriate code in the box located on the bottom left-hand corner of the page. The total number of hours in a week is 168.

SECTION VIII - POC REQUESTED WAIVER SERVICES (BUDGET SHEET)

Purpose

The purpose of this section is to document all services an individual and/or his Authorized Representative/Guardian have requested in accordance with information gathered and documented during the Plan of Care (POC) planning process. In addition, this section identifies whom the individual and/or his Authorized Representative/ Guardian have chosen to provide the specified service(s), the frequency, amount (units of service) and duration of each requested service for that particular POC year.

Signatures of the individual and/or his or her Authorized Representative, the chosen provider and support coordinator appear on this page documenting review and approval of services as reflected on Budget Sheets as written during the POC planning meeting.

The Local Governing Entity (LGE) is responsible for assuring that all information on the Budget Sheets is accurate before signing his/her approval of the POC as written.

The POC is a **legal document** and must be treated as such. The POC Budget Sheets must be completed in blue or black ink**. ALL** corrections must be made by **marking through an error only once and initialing each correction as such.**

Provider's Full Name:	List provider agency to provide CCW service (Full Name - no acronyms)
Provider Number:	List provider agency number to provide CCW services
Service Type:	List the type of CCW service provided (e.g., Family Supports, etc.)
Procedure Code(s):	List the CCW procedure code(s) for each requested service(s) (See attached CCW PROCEDURE CODES AND SERVICE RATES chart)
Total Monthly Cost:	List total cost of monthly service (e.g., Support Coordination)
Total # of Units:	List the total number of units of service for each CCW Procedure Code listed
Cost per Unit:	List cost per unit of CCW service
Yearly Cost:	List yearly cost per CCW services

Administrative Fees: List total cost per year of administrative fee. The total amount will be taken from annual budget cap for 12-month period. If the participant wishes to discontinue services, administrative fees will be discontinued on the first (1st) date of the following month.

Grand Total: Add all totals of services. Total cost of all combined services[1] and administrative fees[2] cannot exceed waiver POC year.

Provider Rep. Signature/ Provider Name/Dates: Signature(s) of provider agency representative(s) must be obtained upon completion of the POC Service Budget Sheets (Section VIII - IX). Service Provider signatures will indicate that the providers have reviewed the budget sheet and are in agreement with services as outlined, and that they are able to provide the services as requested by the individual, and/or his Authorized Representative/Guardian.

Support Coordinator Signature: The Support Coordinator signs indicating he/she has reviewed all CCW services with the individual, and/or with his Authorized Representative/Guardian, and agrees that services as outlined on the POC Budget Sheet are indeed what the individual is requesting for that POC year.

Individual/Guardian Signature: The participant/ Guardian signature will indicate that the Support Coordinator and Services Providers have reviewed the budget sheet and are in agreement with services as outlined.

LGE APPROVAL SIGNATURE/INITIALS: LGE is responsible for assuring that all information on the Budget Sheets is accurate before signing his/her approval of the POC as written.

Date: Date LGE signs indicating approval of budget sheet.

NAME: Individual's Name (last name, first name)

SECTION VIII (A) – ANNUAL BUDGET SHEET

Purpose

The purpose of this section is to document all services that an individual and/or his Authorized Representative/Guardian have identified to be authorized for Plan of Care (POC) year. No limits on the amount/ frequency of services other than approved POC budget limit. All request services are to be completed in the current approved POC year. **Exhausting available funds through the use of therapies does not qualify as justification for crisis designation.**

Signatures of the individual and/or his or her Authorized Representative/Guardian, the chosen provider, and support coordinator appear on this page documenting review and approval of services as reflected on Budget Sheets as written during the POC planning meeting.

The Local Governing Entity (LGE) is responsible for assuring that all information on the Budget Sheets is accurate before signing his/her approval of the POC as written.

The POC is a **legal document** and must be treated as such. The POC Budget Sheets must be completed in blue or black ink**. ALL** corrections must be made by **marking through an error only once and initialing each correction as such.**

SECTION VIII (B) - IDENTIFIED SERVICES, NEEDS AND SUPPORTS

Purpose

The section will provide an overview of supports and services needed for the individual to promote independence. The chart will ensure that all supports and services have been assessed, discussed and reviewed with the individual. The individual and his/her support system are provided with thorough information regarding home and community-based waiver services, other Medicaid funded programs, non-paid community supports and services so that he/she can make informed choices about services and supports he/she need and/or want in his/her life.

In this section, identify the supports the individual has requested and/or is receiving. If an individual is receiving non-waiver support, write in the type of support under the sections marked, “Medicaid Funded Services” and/or “Non-Waiver Support.”

The Support Coordinator is required to initial the bottom section of this page under “Note: Informed individual of all state plan services” indicating that he/she has indeed done so.

SECTION IX - POC PARTICIPANTS SIGNATURE PAGE

Purpose

This section should contain the signatures of all those who participated in the Plan of Care (POC) planning meeting. The signature(s) identify the individual's Circle of Support, and their signatures indicate participation in the POC planning meeting.

The Support Coordinator's signature and the Support Coordinator Supervisor's signature (indicating they have reviewed the POC) are required.

The next section outlines the individual's rights and responsibilities and indicates his/her understanding of waiver supports as presented in the POC. The individual (or his/her Authorized Representative) initials and signs if he/she is in agreement with statements. A witness signature is **ALWAYS** required.

The Support Coordinator has limited authority to approve annual plans of care as per policy. The Support Coordinator's Supervisor's signature indicates he/she has reviewed and approved the POC.

CARE PLAN ACTION (FOR LGE STAFF USE ONLY)