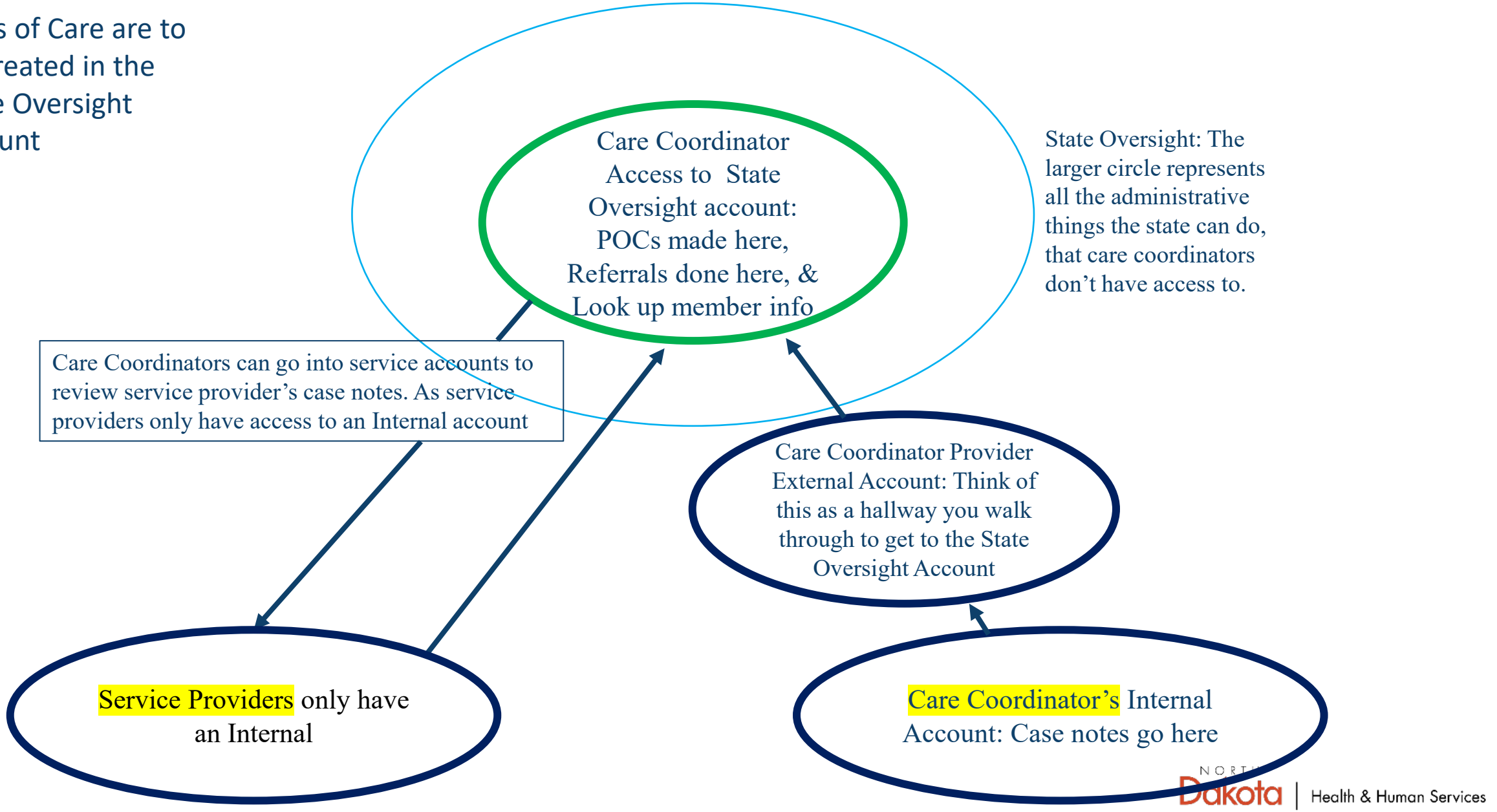
1915(i) Behavioral Health Services & Supports

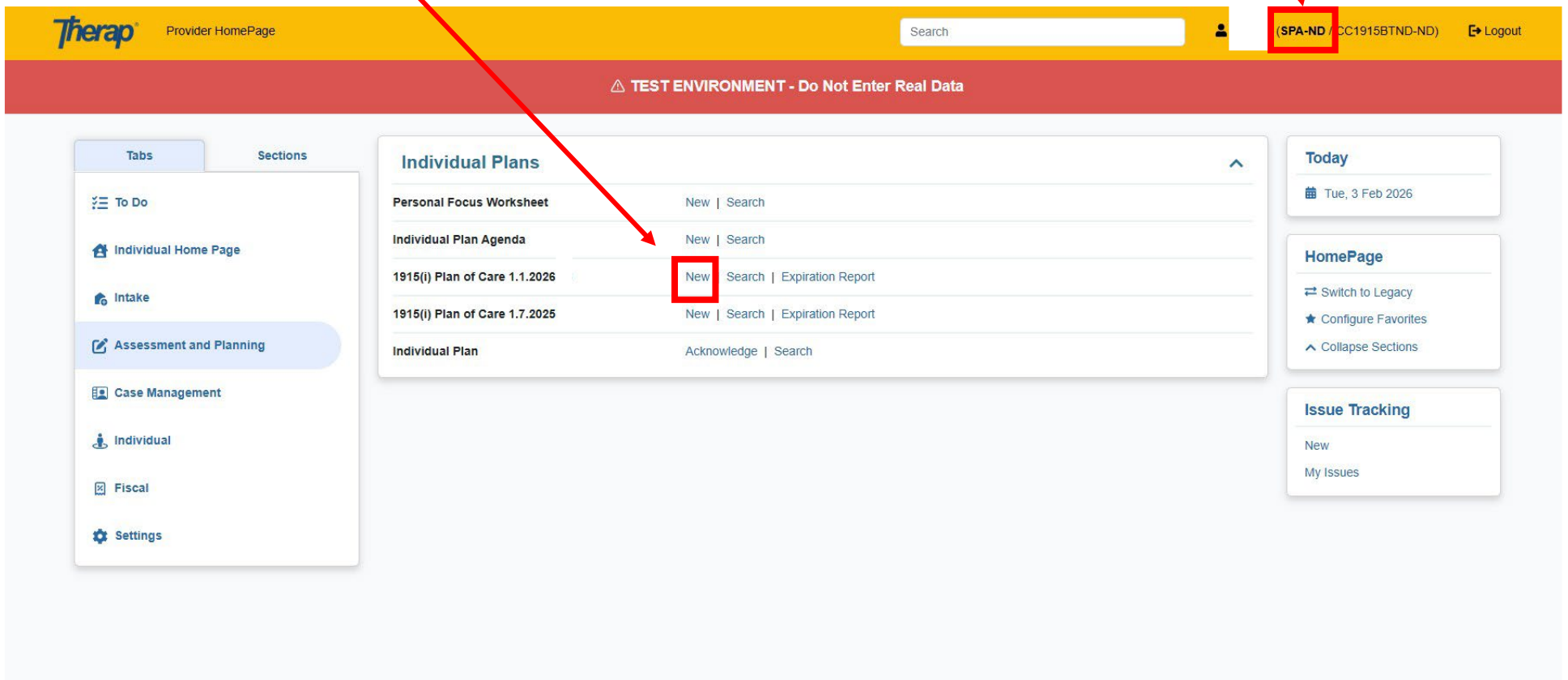
1915(i) Plan of Care 1.1.2026
Plan of Care Creation Guide

Plans of Care are to be created in the State Oversight account



Click on New in the 1915(i) Plan of Care 1.1.2026 line. You will then search for the member whom you want to make the plan of care for.

Make sure you are in the Oversight account



Release Notes for 2025.10.0 go over the new Therap Home page **help.therapservices.net/s/article/8320**

Legacy Dashboard/FirstPage to HomePage Mapping lays out the new homepage when compared to the Legacy Dashboard **help.therapservices.net/s/article/8327**

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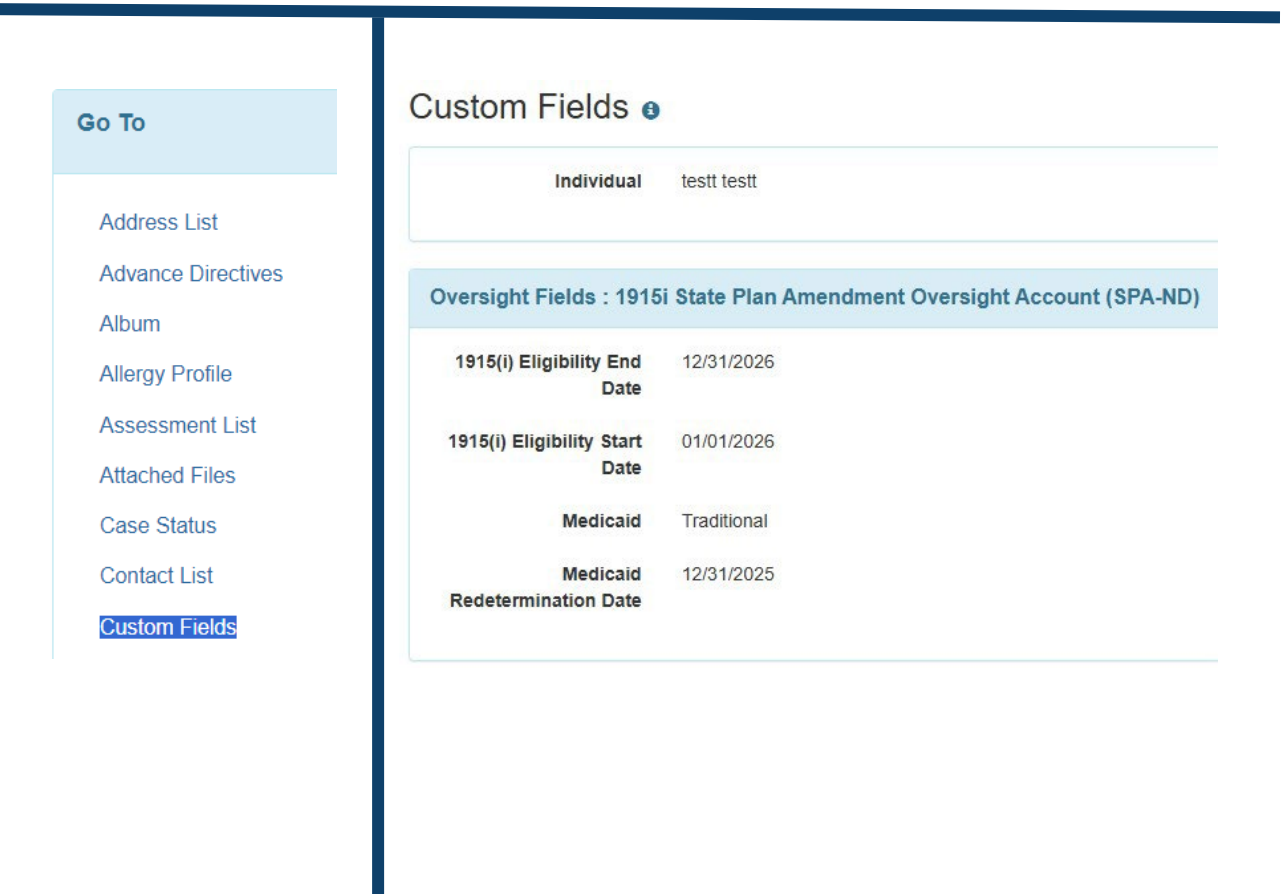
Filling in the Plan



Meeting date equals the date of your POC meeting.

Start date is the member's 1915(I) eligibility start date, unless the member is a transfer to your agency. See next slide for transfer start dates.

End date is the 1915(i) eligibility end date.

You will find the member's 1915i Eligibility start and end dates in the Custom Fields section, under the Go To tab, in the member's Individual Home Page, in the State Oversight Account.

See the How to Look up Member Information guide on the 1915(i) Provider Guidance and Policies webpage, in the Therap section.

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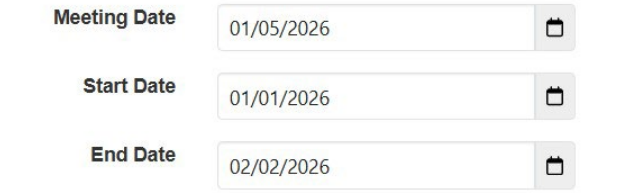
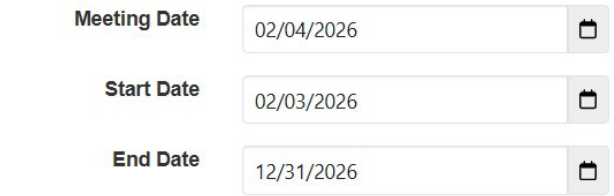
For transfers of Care Coordination, the Start Date will be different from the 1915i Eligibility Start Date.

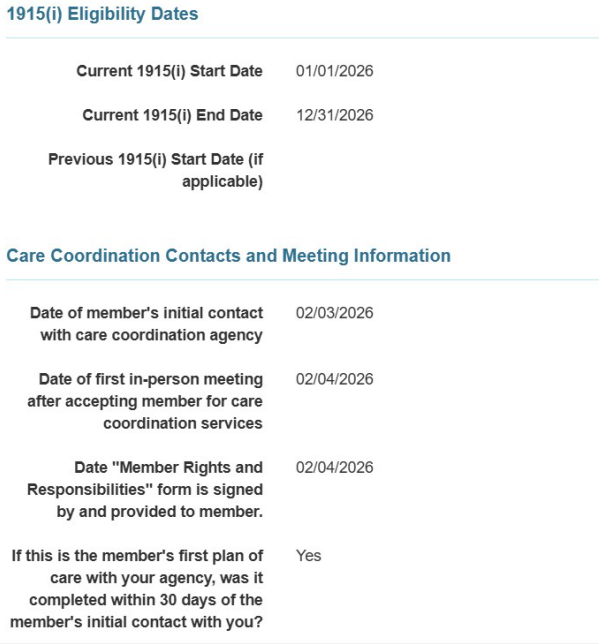
If this does not apply to what you are working on, skip ahead to the About Me slide.



1915i admins will change the dates on the previous POC to match the dates the member was with the prior agency.



Member started with the new agency on 2/3/2026. The dates on the new POC, with the new agency, will reflect this.



Member's 1915i Eligibility goes from 1/1/2026 to 12/31/2026. These dates stay the same on both POCs in the questionnaire sections.

Initial Contact is the date the member transfers to your agency, 2/3/2026

For transfers and discharges, the 1915i admins will change the Service Date To, in the pre-auths in the old POC to match the end date of the old POC.

For existing support services, the pre-auths in the new POC will have a Service Date from that matches the Start Date on the new POC. The Service Date To will be the end date of the POC.

For any services added to a POC that do not continue from the previous POC, the Service Date From on the pre-auth is the Anticipated Admission Date on the referral.

It is still the responsibility of the care coordinator to create the pre-auths on the new POC.

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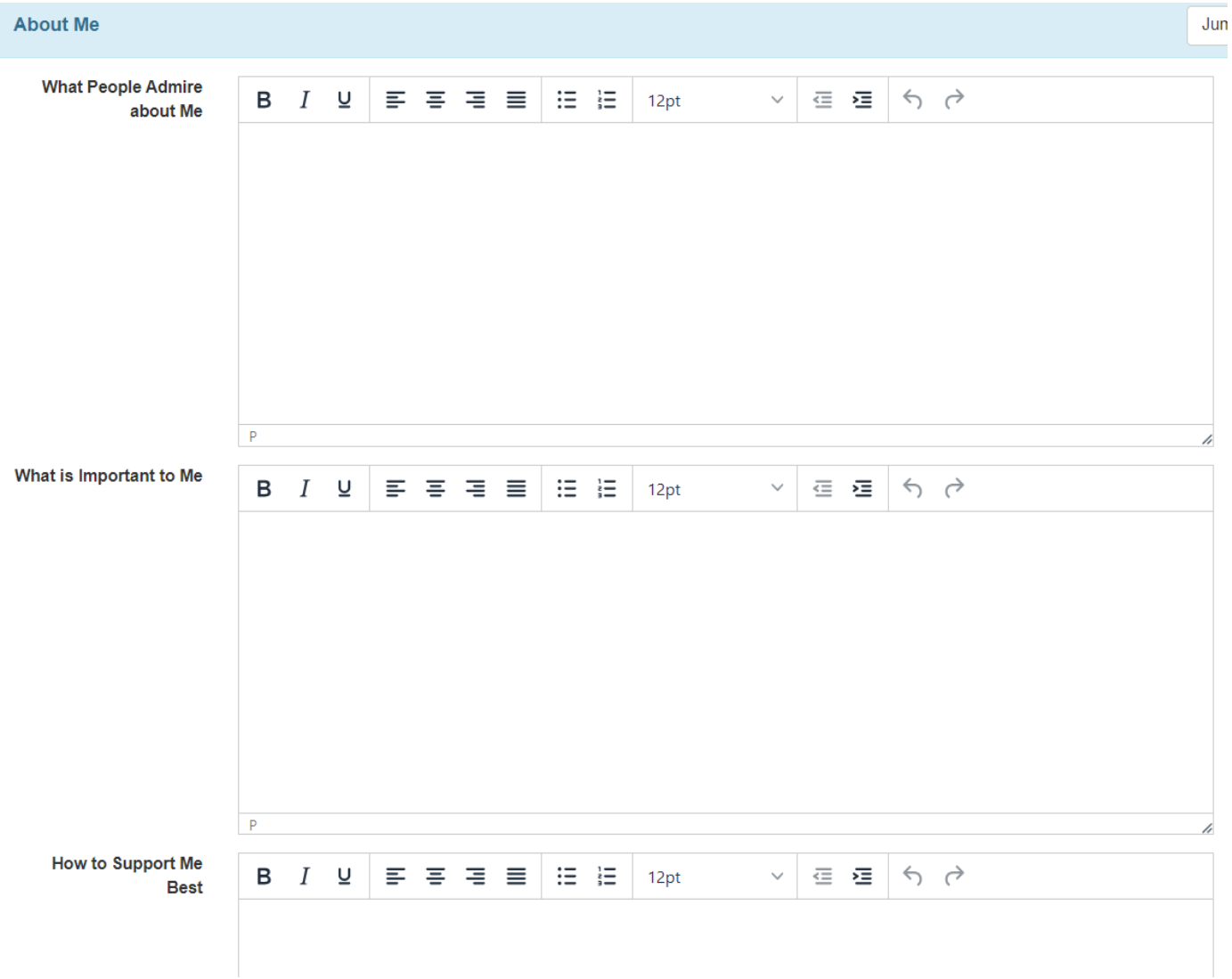

About Me

Ask and fill in the answers to these three questions. These are good questions to get to know the member, and for them to express their needs and wants. With 1915(i) Care Coordination a holistic perspective of the member is the goal.

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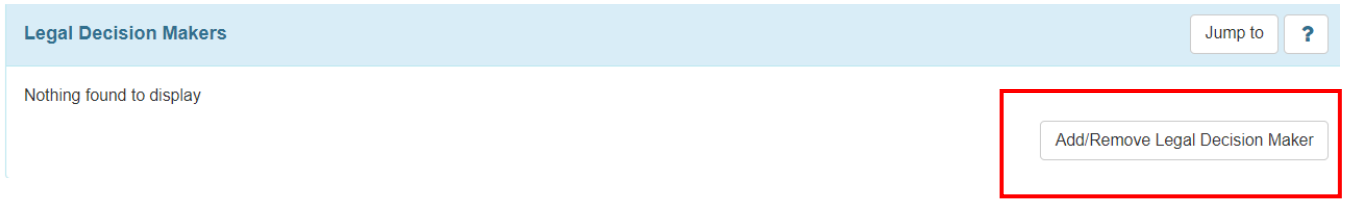
Legal Decision Makers



If the member has a parental guardian/legal guardian, you will select **Add/Remove Legal Decision Maker** to add their listed guardian.

You can also list the guardian under the Participants section of the POC.

If you need to check if the member has a guardian, it will be on their 1915(i) application, found in their Document Storage.

Questionnaire Section

This is the longest section of the Plan of Care.

Complete all questions unless directed otherwise. Read questions carefully, some do not need to be answered.

Scroll down the POC and click “Open” to access the questionnaire. It will appear in a pop-up window, and you can begin answering the questions. If you close the pop-up at any point, be sure to save your work first. After that, make sure you also save the Plan of Care itself. When everything is complete, click “Submit” to send it to the state for review. If you close Therap without saving or submitting the Plan of Care, you will lose any work you have done since your last save.

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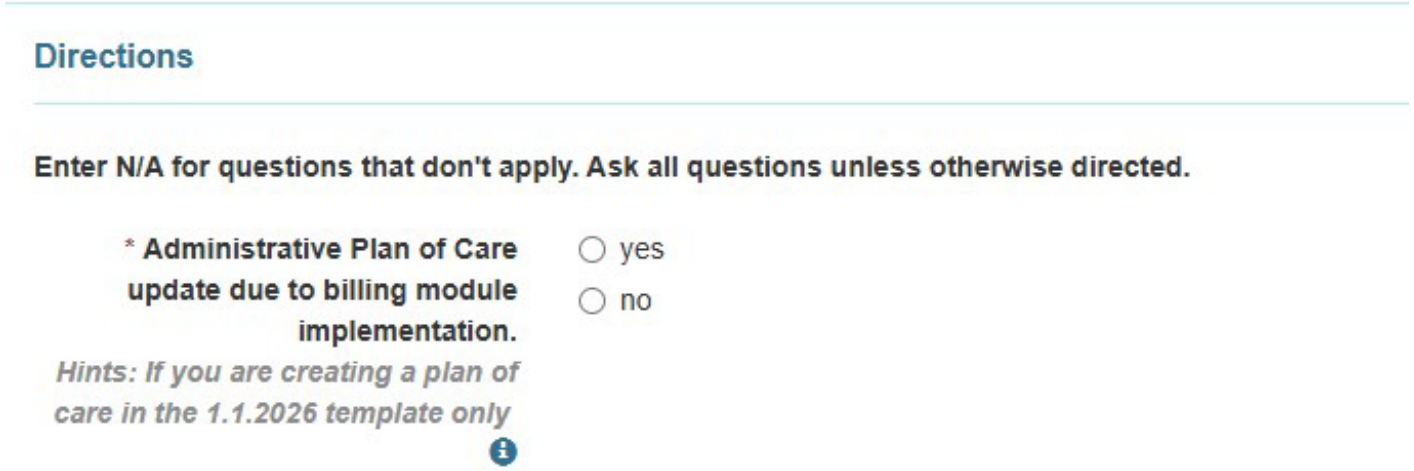
Administrative POC Update Question



For the first question, select “Yes” only if this Plan of Care is being created to replace an older Plan of Care that did not include billing. If you select “No,” you must meet with the member to review this new POC, and you will need to attach all required signed documents to it.

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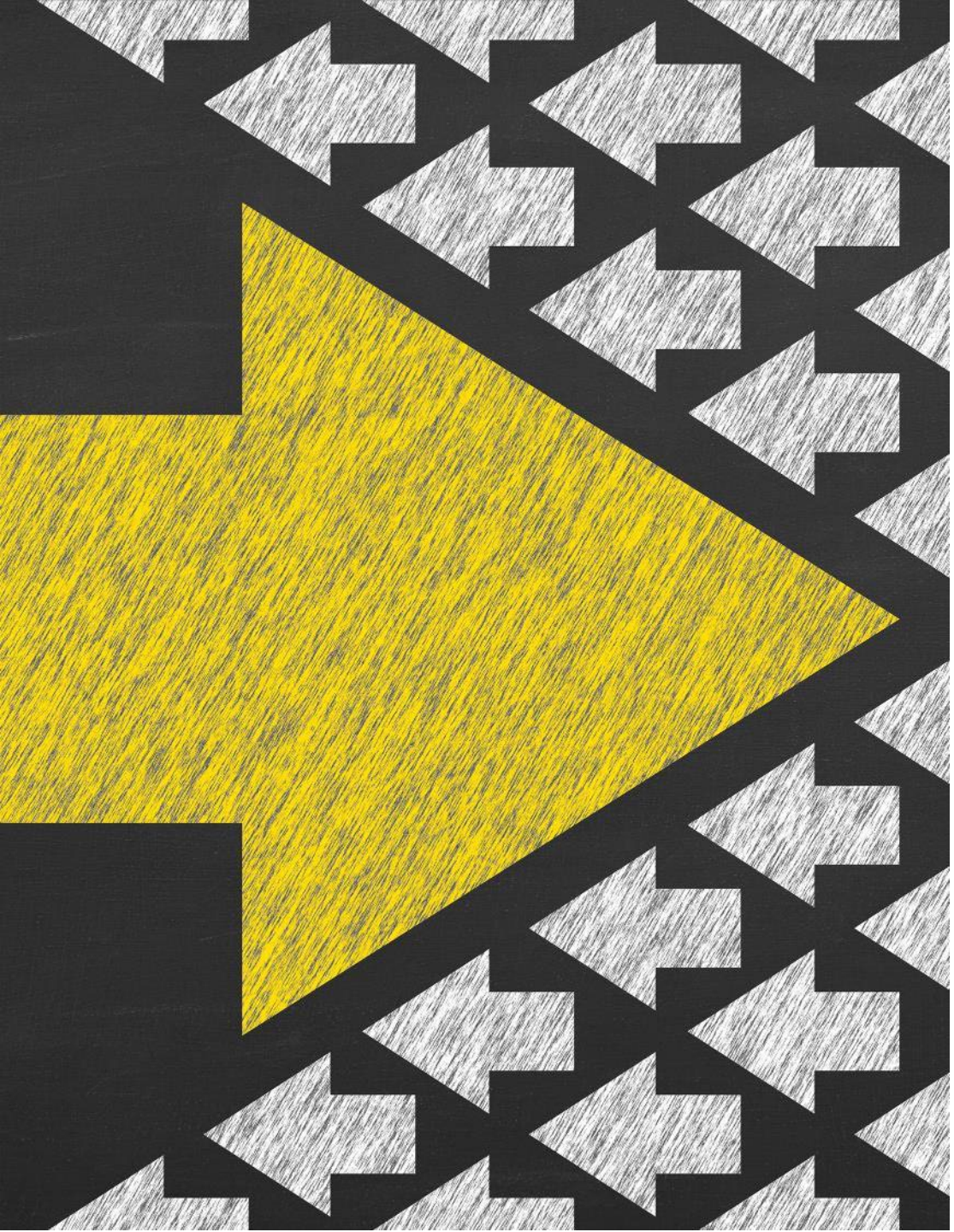
Strength and Preferences Assessment

The Strength and Preference Assessment section consists of a series of questions that are person-centered. These are designed to help care coordinators work with members to identify plan of care goals and steps/resources needed to achieve the goals. These questions are broken into subject matter sections.

Conflict of Interest Exemptions

This section is to determine whether a provider is exempted from the federal requirement that members receive care coordination and supportive services from separate provider agencies.



Conflict of Interest Exemptions Continued…

Answer the first question in this section to determine whether you need to answer the following questions. If you answered No, you do not need to answer any more questions in this section.

* **Is your agency wanting to provide both care coordination and supportive services (i.e. peer support, housing support, etc.) to this member?**	○ Yes ◉ No

If you answered yes to the previous question, is your agency the only willing and qualified provider in the member's county of residence?
Hints: You can be the only willing and qualified provider for the follow

- ○ Yes. Requires documentation showing you are the only willing and qualified provider. Please attach to this plan of care.
- ○ No. You cannot provide both care coordination and supportive services to this member.

If you are the only willing and qualified provider, which of the following shows you are the only willing and qualified provider?

- ☐ There are no other providers offering the service in the member's county of residence as documented by a dated screenshot of the 1915(i) Supportive Services Provider List uploaded along with this plan of care.
- ☐ There are no other providers offering culturally specific services to meet this member's specific service requirements as documented by this plan of care, a dated screenshot of the 1915(i) provider list uploaded to this plan of care and/or service denials or proof of no response from other service providers.
- ☐ All other supportive service providers in this member's county of residence have denied or not responded to service referrals. Documentation required (if referrals are sent in Therap there is documentation of no response or denials which suffices).
- ☐ Other. If you answer other, please explain in the next question.

If you answered "Other" please explain why your agency is the only willing and qualified provider to do both care coordination and supportive services for this member.

About 3000 characters left

If your agency is the only willing and qualified provider of both care coordination and supportive services to this member, please list all staff members who will be providing 1915(i) services to this member and what services they provide.

About 3000 characters left

Conflict of Interest Exemptions Continued...

You must answer all the questions in the conflict-of-interest section, if you are applying for one.

If you do not answer, in detail, all the questions the POC will be returned to you for more information.

You will not have a conflict-of-interest exemption granted until 1915(i) admins approve it.

Eligibility & Initiation

This section is where you'll enter information about eligibility, POC meetings and important dates, the member's qualifying assessment score as well as duplication of services.

You will refer to the information in the **Custom Fields**, **Assessment Lists** and **Document Storage** tabs in the member's individual home page for any information you need to fill out this section.

All of these are to be accessed from the State Oversight Account. Here is a guide on how to access these.

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Member Goals & Services

Elements of SMART goals have been broken into separate questions so it's easier to write the member's goals as SMART goals.

Tip: Write the member's goal as something they want to achieve versus the service that will help them achieve it. You will identify the service(s) in this section. For SMART goal trainings, review the available resources on the 1915(i) Provider Trainings & Information Sessions webpage.

NMT pairs with other supportive services

NMT is generally not a standalone goal. Transportation will be the goal and NMT may be used to support achievement of the goal.

- NMT is used to support a member in achieving POC goals.
- You can now select two services in support of one plan goal – i.e. peer support or housing support and NMT to support a member's transportation needs in relation to the goal.

Will non-medical transportation help me achieve this goal?

If you answered yes above, what kinds of activities or events do you need non-medical transportation (NMT) for to achieve this goal?

Total NMT Units Requested

NMT Frequency Requested

NMT Duration Requested

NMT Service provider name

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Risk Management/Crisis Plan

Here is where you will enter information about the member's qualifying diagnosis(es), other health information, as well as risk management and crisis planning information.

The member's diagnosis is found in the **Diagnosis List** tab in the individual home page.

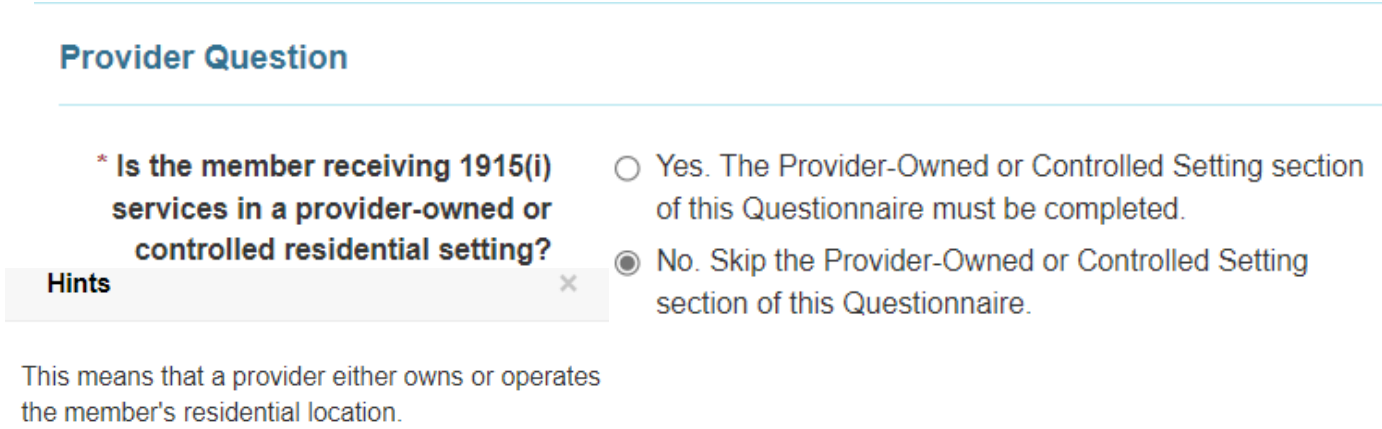
HCBS Setting Assessment Questions

Here is where you will verify the member is receiving services in a qualifying home and community-based setting.

Depending on the answer to the first question, you may be able to skip the remaining questions.

HCBS Setting Assessment Questions Continued….

If you answer Yes to the first question, you must complete the Provider-Owned or Controlled Setting section. If you answered no, skip the rest of the questions in this section



→ **Provider-Owned or Controlled Setting**

If you answer Yes to any questions in the Provider-Owned or Controlled Setting section, you must answer the questions in the Setting Modifications section.

→ **Setting Modifications**

Plan of Care Reviews – Quarterly and Interim

You won't fill out this section for initial plans of care.

This section is for the member's Quarterly Reviews and any Interim (between Quarterly Reviews) plan updates.

When you are completing a Quarterly or Interim Review, use the steps in the Quarterly/Interim Reviews & Individual Plan Agendas guide. If you need to make a change that does not require a Quarterly or Interim Review, use the steps in the Change Form guide instead.

Care Coordinator Contact Information

Here is where you enter your information as the care coordinator. This is important because the member and other planning team members receive this plan of care and may use this plan's information listed here to contact you.

Document Checklist

When creating a plan of care for the first time you will need to have the care coordinator and the member (and guardian if they have one) sign these three forms.

The rights and responsibilities only needs to be signed on an annual basis. The Signatures & Acknowledgment form must be signed anytime you change the plan of care. And the Meeting Attendee Signature page must be signed when you have a quarterly or interim review of the plan of care.

1. Meeting Attendee Signature Page

2. 1915(i) Plane of Care Member and Care Coordinator Signatures & Acknowledgements

3. Member's Rights and Responsibilities (for members on Traditional Medicaid)

OR

3. Member's Rights and Responsibilities (for members on Medicaid Expansion)

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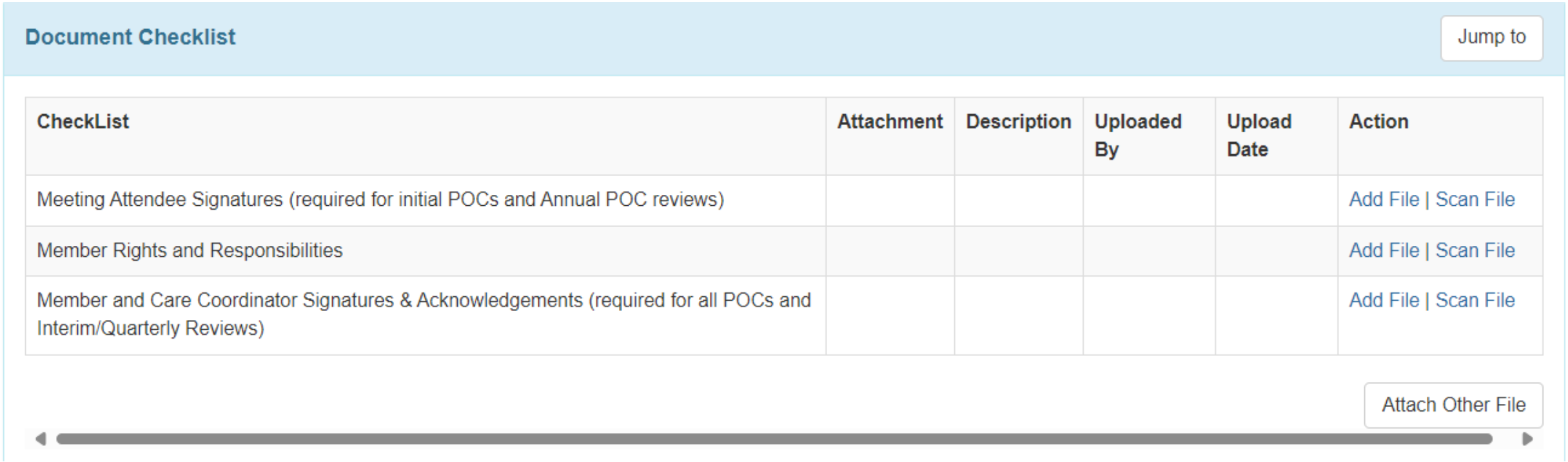
Document Checklist

Here is where you will upload the Meeting Attendee Signatures Pge, Member and Care Coordinator Signatures & Acknowledgements and Member Rights and Responsibilities.



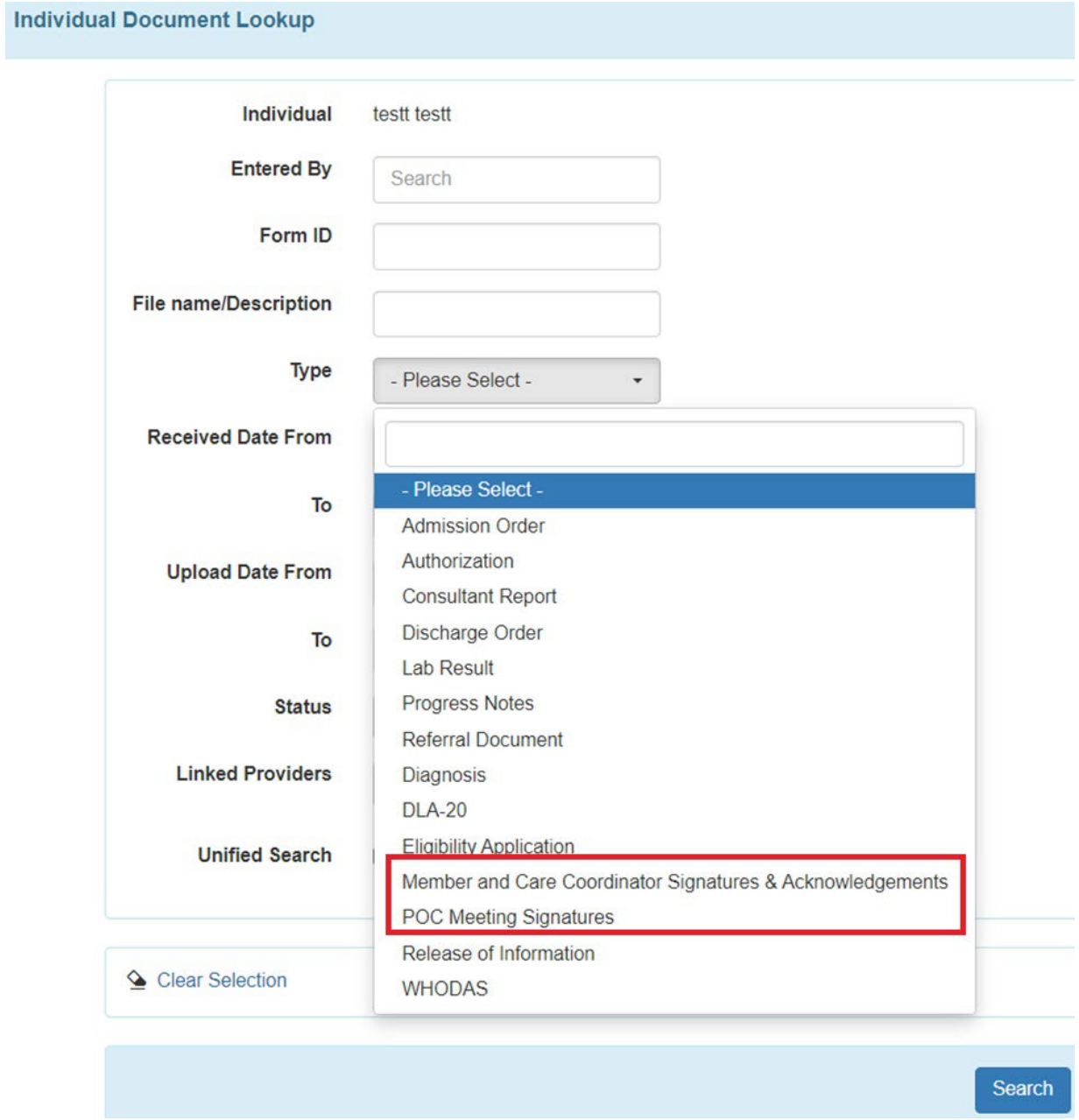
Document Checklist Jump to

CheckList	Attachment	Description	Uploaded By	Upload Date	Action
Meeting Attendee Signatures (required for initial POCs and Annual POC reviews)					Add File | Scan File
Member Rights and Responsibilities					Add File | Scan File
Member and Care Coordinator Signatures & Acknowledgements (required for all POCs and Interim/Quarterly Reviews)					Add File | Scan File

Attach Other File

Document Checklist – selecting from Individual Document Lookup

If you have uploaded these documents to the Member's **Document Storage** you can attach these documents to the POC using the **Individual Document Lookup** button. You will access this after you have clicked on Add File.



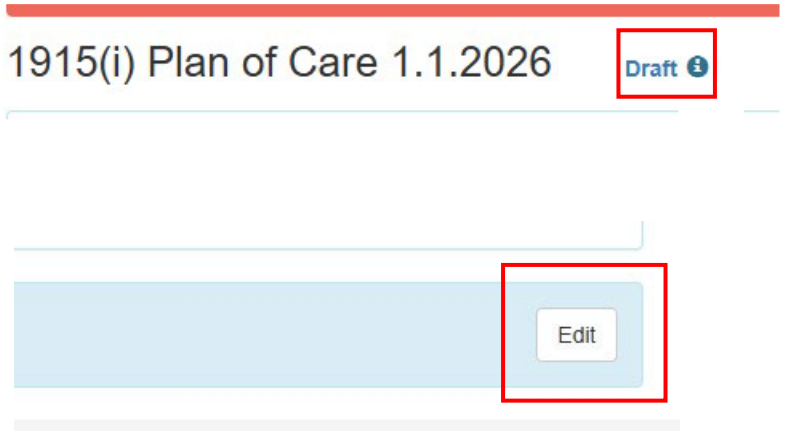
See the North Dakota 1915i Service Authorization trainings Webinars on Therap's North Dakota 1915(i) Support webpage

Adding Service Authorizations to a Plan of Care

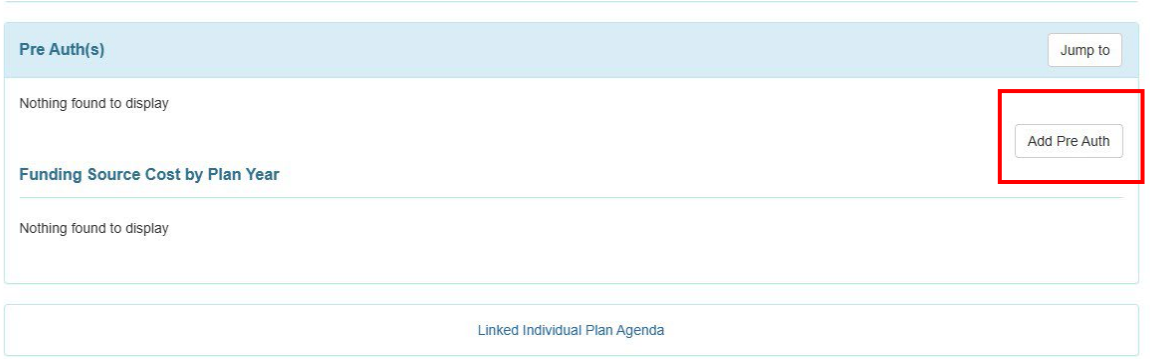
- Care Coordination must have a service authorization, even if there is no Care Coordination Goal on the POC
- Each 1915(i) Service on the POC must have a service authorization

The first step to adding a service authorization is to save the POC. Once the POC has been saved, and is in a Draft status, you will then be able to add a pre-auth (pre-auths become service authorizations once they are acknowledged by the providers).

Scroll down the POC and click Edit to open the POC to continue editing (working) on it.



Now you can go to the Pre Auth(s) section of the POC, and click on Add Pre Auth to start adding the pre-auths.



Pre-Auth Basic

Program: Select if the member is on Medicaid or Medicaid Expansion.

Service: Select which 1915i Service this service authorization is for. You will need to have a service authorization for care coordination, even if there is not a care coordination goal

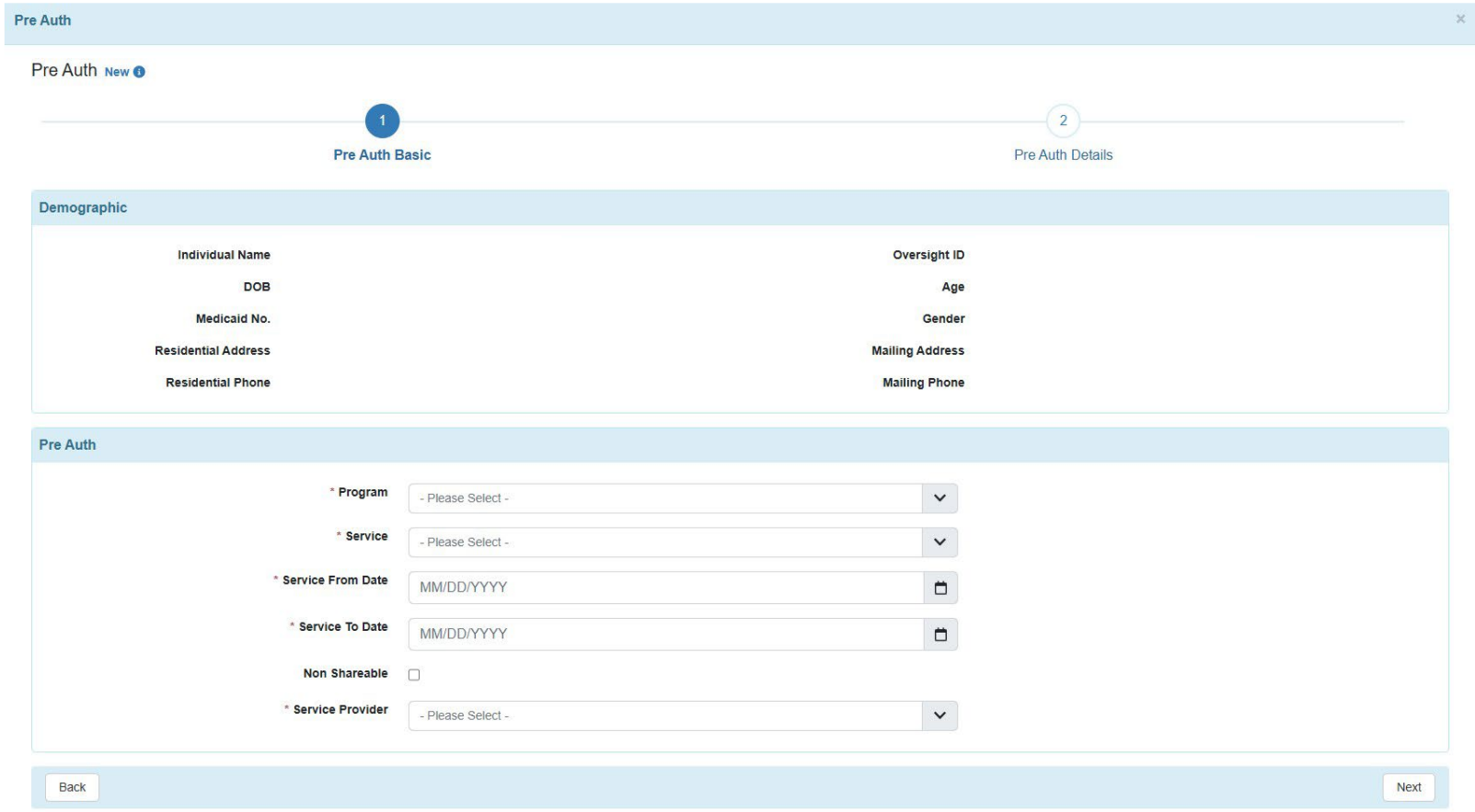
Service From Date: That is the first date that the provider of this service can render services.

Service to Date: that is that last day the provider can render services. It will usually be their 1915(i) end date.

Non-Shareable: Do <u>not</u> select this

Service Provider: That is the provider that is rendering the service for this pre-auth. If it is for a service provider, the referral process must be fully completed for them to populate in this dropdown.

Once you have entered everything in, click on Next.



Pre Auth Details

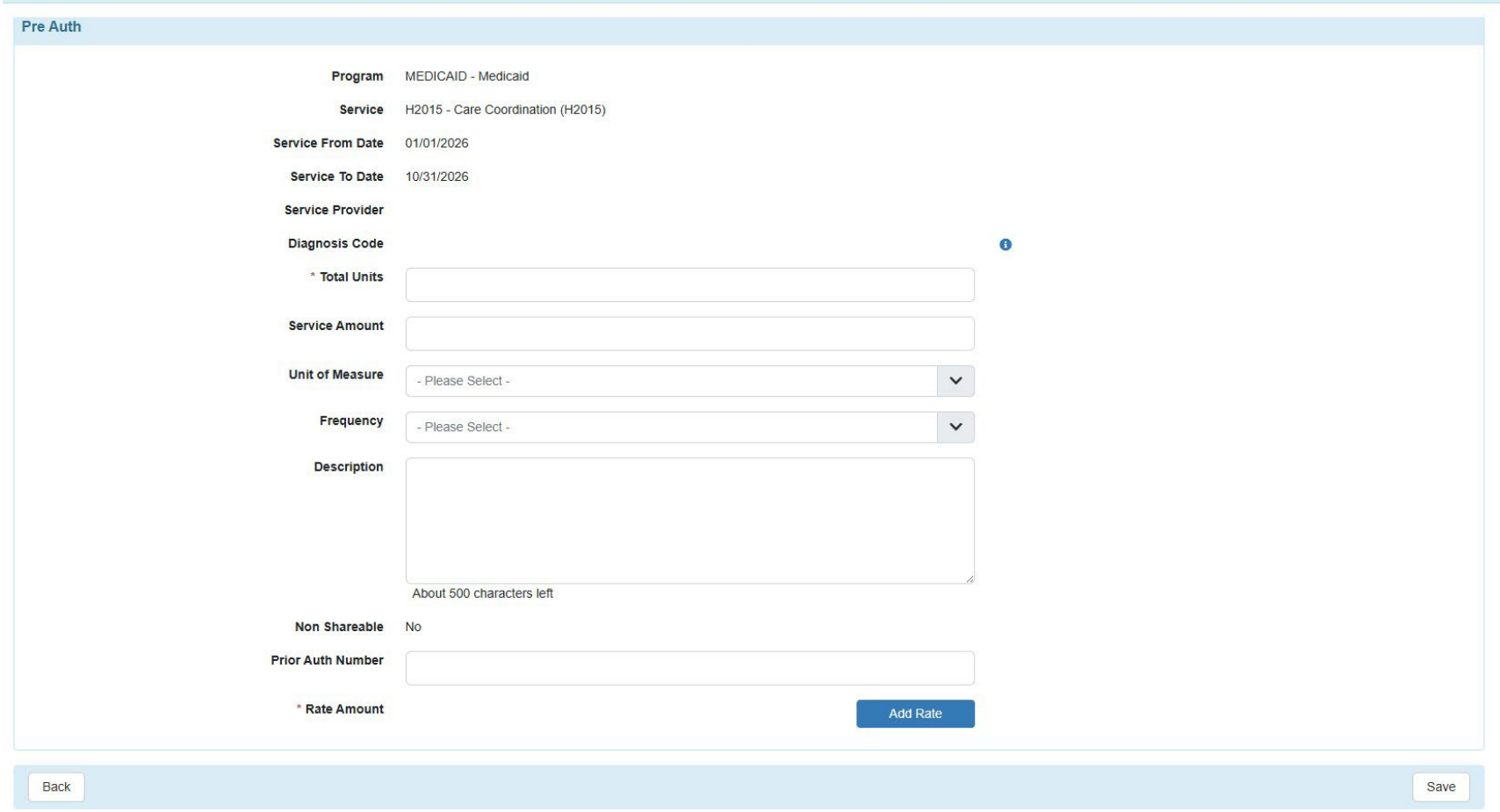
Total Units: Enter in the total units for the pre-auth. The units cannot be more than the number of units the goal is approved for. But it can be less if that is the business decision the provider wants to make.

Service Amount, Unit Measure, Frequency, Description are optional.

You will <u>not</u> enter anything in for Prior Auth Number.

Once you have the Total Units entered, you will click on **Add Rate** to add the rate to the pre-auth.

Then you will click on Save.



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Once you have saved the Service Authorization it will be in **Draft** status.

You will need to click on the pre-auth and open it. You can Edit, Copy, Submit or Delete the pre-auth when it is in a Draft status. If you are good with it, and you do not need to make any changes, and the POC is ready for the state to review it, click on Submit in the pre-auth.

Once you submit the pre-auth, the Status changes to **Pending Approval**. If this is a service authorization on a POC that has NOT been approved by the state (or BCBS), you cannot approve the pre-auth yourself. Once the POC is approved, the pre-auths in a Pending Approval status will become Approved with the POC.

Once a pre-auth is **Approved** it will be automatically sent to the service provider it is for. It is now the responsibility of the Admin for that service to review their To Do tab, and Acknowledge any Pending Acknowledgements under the Pre Auth Service Authorization line.


Pre Auth(s)

Jump to

Filter

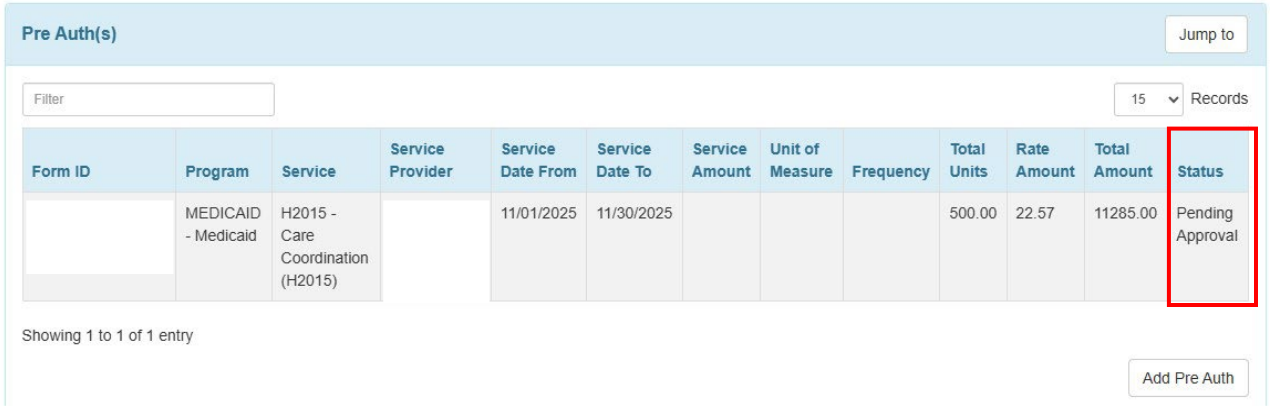
15 Records

Form ID	Program	Service	Service Provider	Service Date From	Service Date To	Service Amount	Unit of Measure	Frequency	Total Units	Rate Amount	Total Amount	Status
	MEDICAID - Medicaid	H2015 - Care Coordination (H2015)		11/01/2025	11/30/2025				500.00	22.57	11285.00	Draft

Showing 1 to 1 of 1 entry

Add Pre Auth

Funding Source Cost by Plan Year


Pre Auth(s)

Jump to

Filter

15 Records

Form ID	Program	Service	Service Provider	Service Date From	Service Date To	Service Amount	Unit of Measure	Frequency	Total Units	Rate Amount	Total Amount	Status
	MEDICAID - Medicaid	H2015 - Care Coordination (H2015)		11/01/2025	11/30/2025				500.00	22.57	11285.00	Pending Approval

Showing 1 to 1 of 1 entry

Add Pre Auth


Pre Auth(s)

Jump to

ilter

15 Records

orm ID	Program	Service	Service Provider	Service Date From	Service Date To	Service Amount	Unit of Measure	Frequency	Total Units	Rate Amount	Total Amount	Status
	MEDICAID - Medicaid	H2015 - Care Coordination (H2015)		09/01/2025	04/30/2026				1000.00	22.57	22570.00	Approved

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If a pre-auth is being added to a POC that has already been submitted and approved by the state (or BCBS), you as the care coordinator must approve the pre-auth.

For an approved POC, if the **only** thing that you are doing is adding a Service Authorization that is for a goal that has already been approve on the POC, and you are making **no** other changes to the POC, then you only need to Create Change Form to add the service authorization. In the Change Form you will detail in the Other Reason box that you are adding a service authorization for a specific goal that is already on the POC. Once you select Activate and Edit Individual Plan in the Change Form, you will be taken to the POC, where you will update the POC.

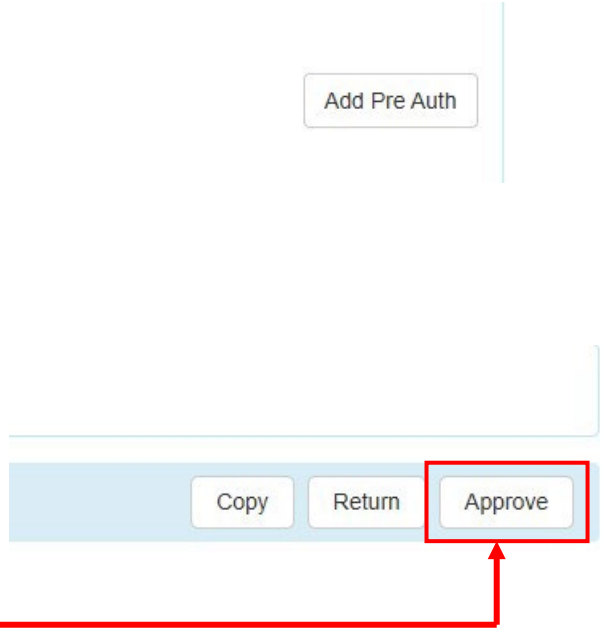
To add a pre-auth to a POC that is already approved you will click on the **Add Pre Auth** button.

You will add the pre-auth, doing the same steps that you did on the previous slide.

Once you have saved the pre-auth it will be in **Draft** status. As you did on the previous slide, you will need to click on the pre-auth in **Draft** status and then **Submit** it. This will now put the pre-auth into **Pending Approval** status.

Because this POC is already approved, you must click on the pre-auth in **Pending Approval** status again. This time when you do, you will see that there is an **Approve** button. Click on the **Approve** button. Once you do this, the pre-auth will be **Approved**, and it will be sent to the service provider for them to acknowledge.

On approved POCs, until the care coordinator Approves the pre-auth it will stay in Pending Approval status, and it will not be sent to the provider for them to acknowledge.



This slide details what to do if you are adding a pre-auth to a POC that has already been approved by the state (or BCBS). If you don't need to do this right now, go ahead to the next slide.

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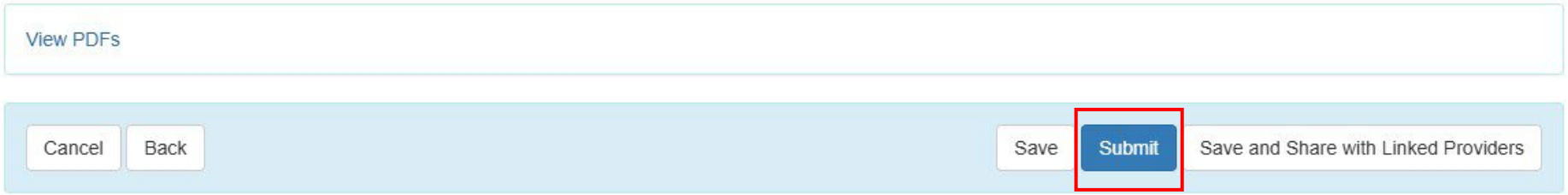
Submitting a Plan of Care for Approval

All Plans of Care must be approved by 1915(i) administrators prior to rendering services (other than care coordination services rendered to develop and write the POC and provide Care Coordination Crisis Goal service). When you are ready for the POC to be reviewed and approved, click on **Submit**.



Returned Plans

If a Plan needs changes, the plan will be returned to your work queue, and you will **Submit** it again, after you made the needed changes.

An Approved Plan will come to you for Acknowledgement

An Approved Plan will show up on your To Do tab. Check this tab regularly and click through and **Acknowledge** plans that need acknowledging. Here is how to see what updates have been made to a plan.