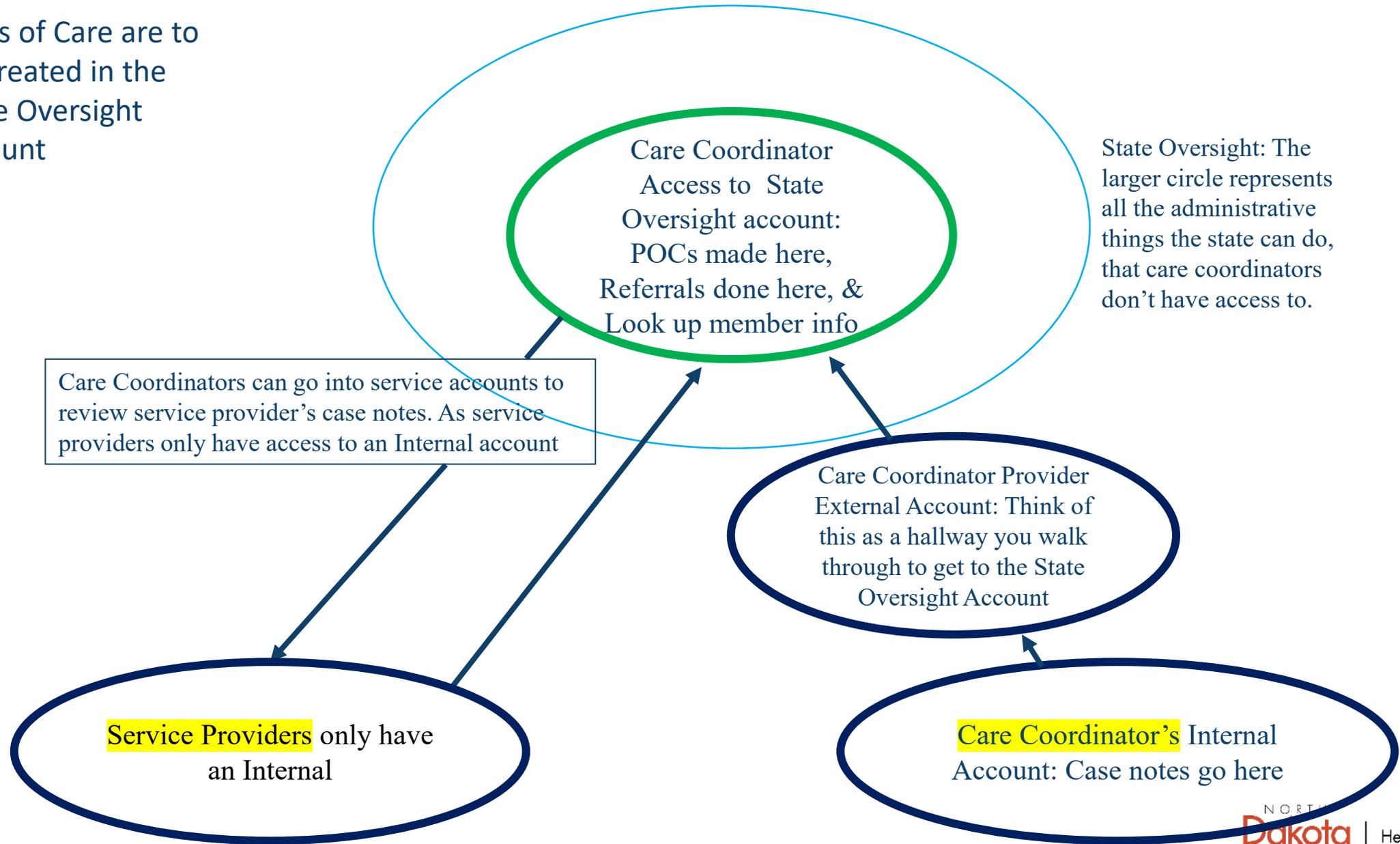


**1915(i)
Behavioral
Health Services
& Supports**

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

The screenshot shows the Therap Provider Home Page. At the top, there is a yellow header with the Therap logo, 'Provider HomePage', a search bar, a user profile icon, and the text '(SPA-ND / CC1915BTND-ND) Logout'. Below the header is a red banner with the text 'TEST ENVIRONMENT - Do Not Enter Real Data'. The main content area is divided into a left sidebar, a central main panel, and a right sidebar. The left sidebar has 'Tabs' and 'Sections' sections. The 'Sections' section is expanded, showing options like 'To Do', 'Individual Home Page', 'Intake', 'Assessment and Planning' (highlighted), 'Case Management', 'Individual', 'Fiscal', and 'Settings'. The central main panel is titled 'Individual Plans' and contains a table with the following rows:

Item	Actions
Personal Focus Worksheet	New Search
Individual Plan Agenda	New Search
1915(i) Plan of Care 1.1.2026	New Search Expiration Report
1915(i) Plan of Care 1.7.2025	New Search Expiration Report
Individual Plan	Acknowledge Search

The 'New' button for the 1915(i) Plan of Care 1.1.2026 row is highlighted with a red box. The right sidebar contains three sections: 'Today' (Tue, 3 Feb 2026), 'HomePage' (Switch to Legacy, Configure Favorites, Collapse Sections), and 'Issue Tracking' (New, My Issues).

[Release Notes for 2025.10.0](https://help.therapservices.net/s/article/8320) go over the new Therap Home page
help.therapservices.net/s/article/8320

[Legacy Dashboard/FirstPage to HomePage Mapping](https://help.therapservices.net/s/article/8327) lays out the new homepage when compared to the Legacy Dashboard
help.therapservices.net/s/article/8327

Meeting Date 01/05/2026

Start Date 01/01/2026

End Date 12/31/2026

Filing 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.

Go To

- Address List
- Advance Directives
- Album
- Allergy Profile
- Assessment List
- Attached Files
- Case Status
- Contact List
- Custom Fields**

Custom Fields ⊕

Individual testt testt

Oversight Fields : 1915i State Plan Amendment Oversight Account (SPA-ND)

1915(i) Eligibility End Date	12/31/2026
1915(i) Eligibility Start Date	01/01/2026
Medicaid	Traditional
Medicaid Redetermination Date	12/31/2025

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.

Meeting Date	<input type="text" value="01/05/2026"/>	
Start Date	<input type="text" value="01/01/2026"/>	
End Date	<input type="text" value="02/02/2026"/>	

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

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.

Service Date From	Service Date To

Meeting Date	<input type="text" value="02/04/2026"/>	
Start Date	<input type="text" value="02/03/2026"/>	
End Date	<input type="text" value="12/31/2026"/>	

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

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.

1915(i) Eligibility Dates

Current 1915(i) Start Date	01/01/2026
Current 1915(i) End Date	12/31/2026
Previous 1915(i) Start Date (if applicable)	

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.

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.

Care Coordination Contacts and Meeting Information

Date of member's initial contact with care coordination agency	02/03/2026
Date of first in-person meeting after accepting member for care coordination services	02/04/2026
Date "Member Rights and Responsibilities" form is signed by and provided to member.	02/04/2026
If this is the member's first plan of care with your agency, was it completed within 30 days of the member's initial contact with you?	Yes

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

About Me

About Me Jun

What People Admire about Me

B *I* U [Align Left] [Align Center] [Align Right] [Justify] [List Bulleted] [List Numbered] 12pt [Decrease Indent] [Increase Indent] [Undo] [Redo]

P

What is Important to Me

B *I* U [Align Left] [Align Center] [Align Right] [Justify] [List Bulleted] [List Numbered] 12pt [Decrease Indent] [Increase Indent] [Undo] [Redo]

P

How to Support Me Best

B *I* U [Align Left] [Align Center] [Align Right] [Justify] [List Bulleted] [List Numbered] 12pt [Decrease Indent] [Increase Indent] [Undo] [Redo]

P

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.

Legal Decision Makers

Legal Decision Makers Jump to ?

Nothing found to display

Add/Remove Legal Decision Maker

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.

Home Profile Plans

ISP Programs

No isp programs found to display

Modules

- ▶ Case Note
- ▼ Document Storage
 - New
 - List
 - Search
- ▶ Individual Plan
- ▶ Individual Plan Agenda
- ▶ Personal Focus Worksheet
- ▶ Pre Auth
- ▶ Referral

Questionnaire Section

Strength and Preference
Assessment >

Conflict of Interest Exemptions

Eligibility & Initiation

Member Goals & Services

Member Goals & Services
(continued)

Risk Management/Crisis Plan

HCBS Setting Assessment
Questions

Plan of Care Reviews - Quarterly
and Interim

Care Coordinator Contact
Information

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.

What did you do to make those dreams come true?

Open

Action Plans Jump to ?

Nothing found to display

Import from Individual Plan Agenda Add Action Plan

Nothing found to display

Cancel Back Save Submit

Administrative POC Update Question

Directions

Enter N/A for questions that don't apply. Ask all questions unless otherwise directed.

- * Administrative Plan of Care update due to billing module implementation.
- yes
 no

Hints: If you are creating a plan of care in the 1.1.2026 template only



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.

Strength and Preferences Assessment

Strength and Preference Assessment



Conflict of Interest Exemptions

Eligibility & Initiation

Member Goals & Services

Member Goals & Services
(continued)

Risk Management/Crisis Plan

HCBS Setting Assessment
Questions

Plan of Care Reviews - Quarterly
and Interim

Care Coordinator Contact
Information

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

Strength and Preference
Assessment



Conflict of Interest Exemptions

Eligibility & Initiation

Member Goals & Services

Member Goals & Services
(continued)

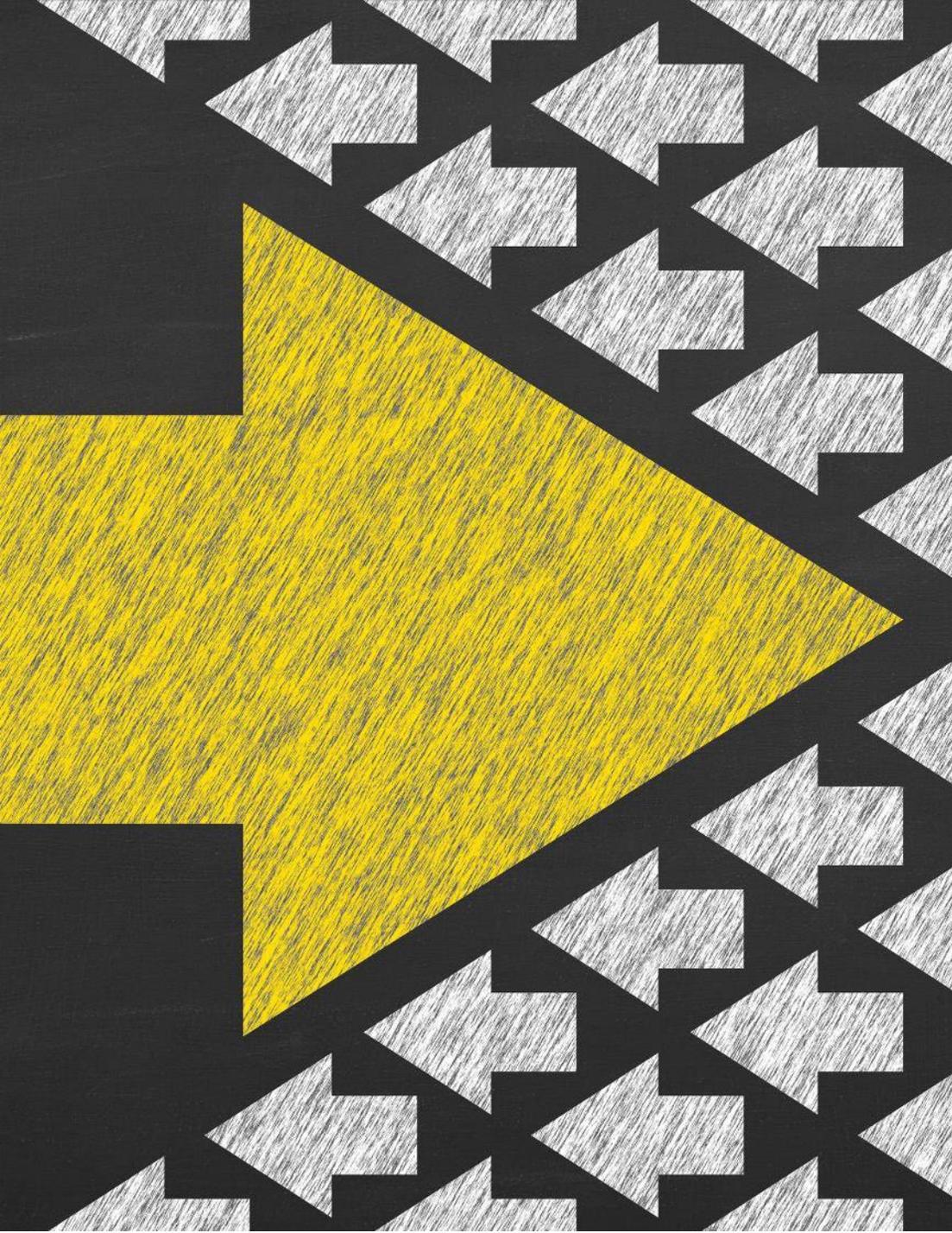
Risk Management/Crisis Plan

HCBS Setting Assessment
Questions

Plan of Care Reviews - Quarterly
and Interim

Care Coordinator Contact
Information

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

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.

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 planning 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

Strength and Preference
Assessment



Conflict of Interest Exemptions

Eligibility & Initiation

Member Goals & Services

Member Goals & Services
(continued)

Risk Management/Crisis Plan

HCBS Setting Assessment
Questions

Plan of Care Reviews - Quarterly
and Interim

Care Coordinator Contact
Information

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.

Member Goals & Services

Strength and Preference
Assessment >

Conflict of Interest Exemptions

Eligibility & Initiation

Member Goals & Services

Member Goals & Services
(continued)

Risk Management/Crisis Plan

HCBS Setting Assessment
Questions

Plan of Care Reviews - Quarterly
and Interim

Care Coordinator Contact
Information

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

Risk Management/Crisis Plan

Strength and Preference
Assessment >

Conflict of Interest Exemptions

Eligibility & Initiation

Member Goals & Services

Member Goals & Services
(continued)

Risk Management/Crisis Plan

HCBS Setting Assessment
Questions

Plan of Care Reviews - Quarterly
and Interim

Care Coordinator Contact
Information

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.

Strength and Preference
Assessment >

Conflict of Interest Exemptions

Eligibility & Initiation

Member Goals & Services

Member Goals & Services
(continued)

Risk Management/Crisis Plan

HCBS Setting Assessment
Questions

Plan of Care Reviews - Quarterly
and Interim

Care Coordinator Contact
Information

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

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.

Provider Question

* Is the member receiving 1915(i) services in a provider-owned or controlled residential setting?

Hints

- Yes. The Provider-Owned or Controlled Setting section of this Questionnaire must be completed.
- No. Skip the Provider-Owned or Controlled Setting section of this Questionnaire.

This means that a provider either owns or operates the member's residential location.



Provider-Owned or Controlled Setting



Setting Modifications

Strength and Preference
Assessment >

Conflict of Interest Exemptions

Eligibility & Initiation

Member Goals & Services

Member Goals & Services
(continued)

Risk Management/Crisis Plan

HCBS Setting Assessment
Questions

Plan of Care Reviews - Quarterly
and Interim

Care Coordinator Contact
Information

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

Strength and Preference Assessment >

Conflict of Interest Exemptions

Eligibility & Initiation

Member Goals & Services

Member Goals & Services
(continued)

Risk Management/Crisis Plan

HCBS Setting Assessment
Questions

Plan of Care Reviews - Quarterly
and Interim

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)

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.

Individual Document Lookup

Individual	testt testt
Entered By	<input type="text" value="Search"/>
Form ID	<input type="text"/>
File name/Description	<input type="text"/>
Type	- Please Select -
Received Date From	<input type="text"/>
To	- Please Select -
Upload Date From	Admission Order
To	Authorization
Status	Consultant Report
Linked Providers	Discharge Order
Unified Search	Lab Result
	Progress Notes
	Referral Document
	Diagnosis
	DLA-20
	Eligibility Application
	Member and Care Coordinator Signatures & Acknowledgements
	POC Meeting Signatures
	Release of Information
	WHODAS

 Clear Selection

Search

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.

1915(i) Plan of Care 1.1.2026

Draft ⓘ

Edit

Pre Auth(s)

Jump to

Nothing found to display

Add Pre Auth

Funding Source Cost by Plan Year

Nothing found to display

Linked Individual Plan Agenda

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 not 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

Pre Auth New

1 Pre Auth Basic 2 Pre Auth Details

Demographic

Individual Name	Oversight ID
DOB	Age
Medicaid No.	Gender
Residential Address	Mailing Address
Residential Phone	Mailing Phone

Pre Auth

* Program - Please Select -

* Service - Please Select -

* Service From Date MM/DD/YYYY

* Service To Date MM/DD/YYYY

Non Shareable

* Service Provider - Please Select -

Back 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 not 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.

Pre Auth

Program	MEDICAID - Medicaid
Service	H2015 - Care Coordination (H2015)
Service From Date	01/01/2026
Service To Date	10/31/2026
Service Provider	
Diagnosis Code	
* Total Units	<input type="text"/>
Service Amount	<input type="text"/>
Unit of Measure	- Please Select - <input type="button" value="v"/>
Frequency	- Please Select - <input type="button" value="v"/>
Description	<input type="text"/> About 500 characters left
Non Shareable	No
Prior Auth Number	<input type="text"/>
* Rate Amount	<input type="text"/>

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

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)		09/01/2025	04/30/2026				1000.00	22.57	22570.00	Approved

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 approved 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.

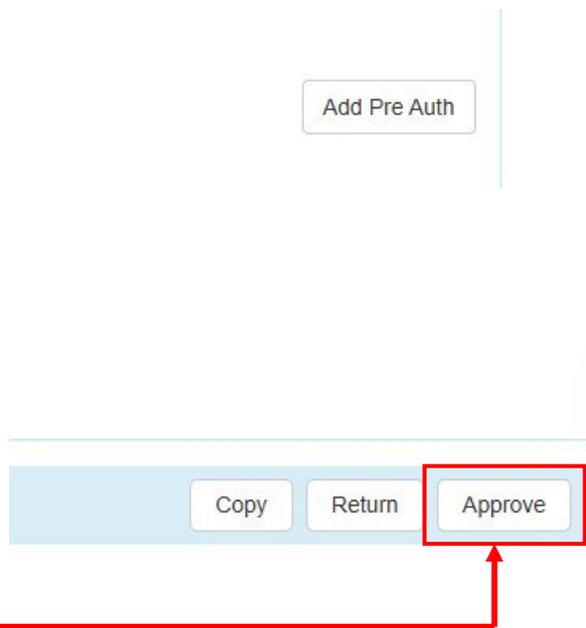
To add a pre-auth to a POC that is already approved you will click on the **Add Pre Auth** button.

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.

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**.



View PDFs

Cancel Back Save **Submit** Save and Share with Linked Providers

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.