Creating the 1915(i) Person-Centered Plan of Care

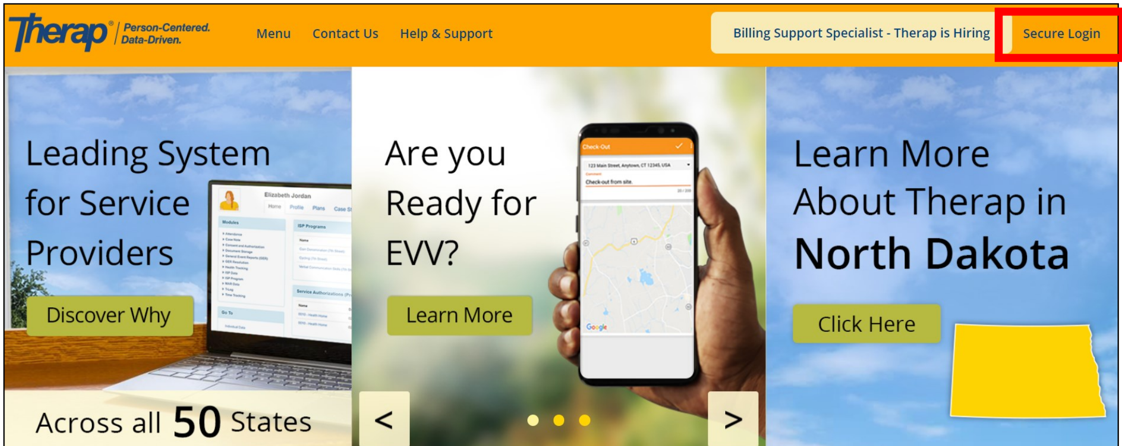
Revised 8/2023

NORTH Dakota | Human Services

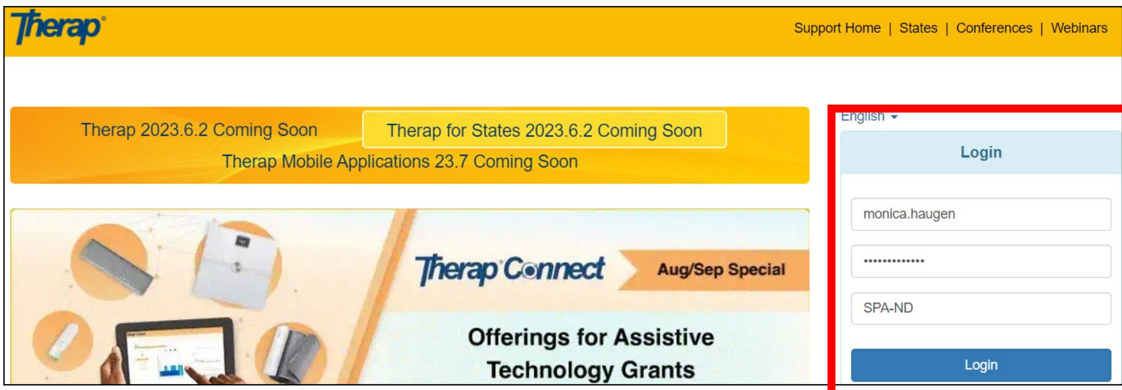
Be Legendary.™

Start Here: https://www.therapservices.net

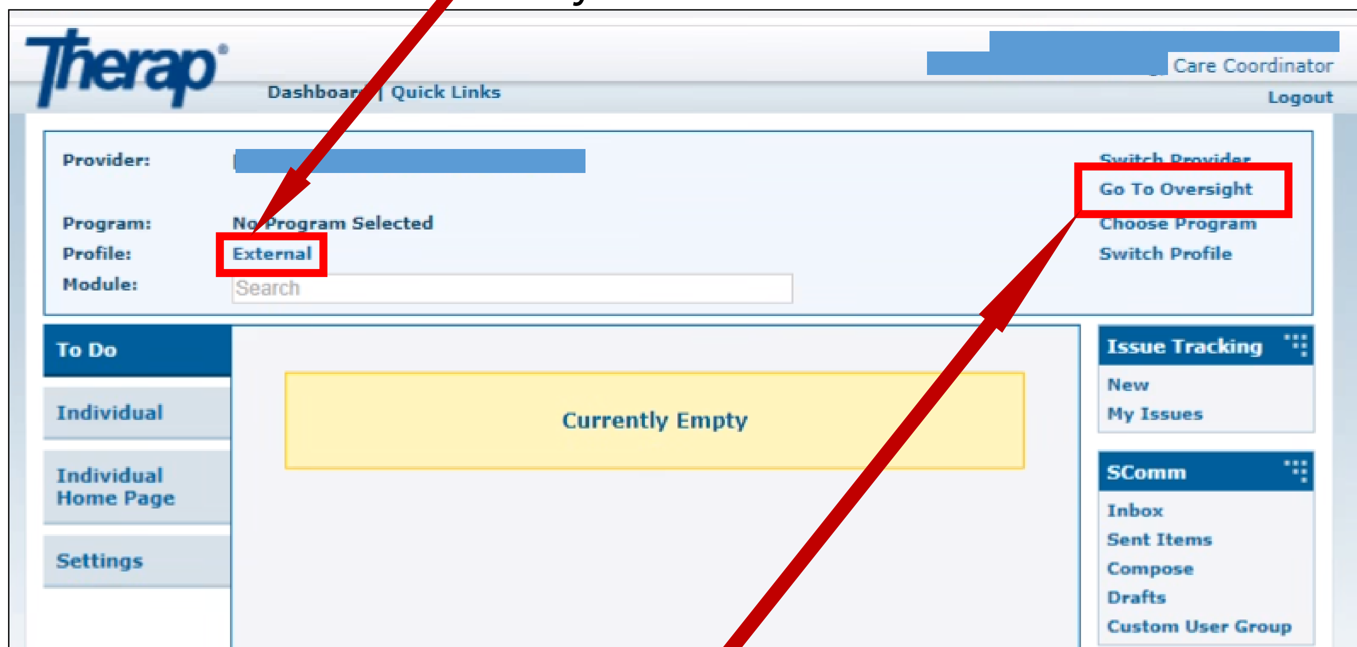
Choose "Secure Login":



You will be assigned unique login information. Enter it here:



Use your "External" Profile:



Choose "Go To Oversight":

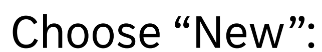
- **Individual**
- Agency
- Admin
- Agency Reports
- Individual Home Page
- Settings

Care

T-Log	Search | Archive
Case Note	New | Search | Bulk PDF
General Event Reports (GER)	New | Search
Witness	Search
ISP Data	Search | Report | Search Report | Dashboard
ISP	Search
ISP Program	New | Search | Acknowledgement Report
ISP Program Template Library	Approved | Search
Individual Demographics	Search | Custom Fields | Insurance | Contact List
Individual Medical Information	Diagnosis List | Advance Directives | Allergy Profile | Medication Profile | Medication Reconciliation

Individual Plans

Personal Focus Worksheet	New | Search
Individual Plan Agenda	New | Search
1915(i) Plan of Care 3/2023	New | Search | Expiration Report
Individual Plan	Acknowledge | Search



Choose the desired individual from your list. You may filter by first letter of last name, or type a last name in the search box:

Individual List

All | A | B | C | D | E | F | G | H | I | J | K | L | M | N | O | P | Q | R | S | T | U | V | W | X | Y | Z

Filter

15 Records

Last Name	First Name	Individual ID	Birth Date	Oversight ID
Sahr	Barbara		04/14/1980	ND4717656 (SPA-ND)
Sample	Daniel		01/22/1972	ND4603502 (SPA-ND)
Sanders	David		06/28/1974	ND4702643 (SPA-ND)
Sandlin	Timothy		10/09/1968	ND4698106 (SPA-ND)
Sandvig	Gabriel		09/17/2001	ND4871509 (SPA-ND)
Saxin	Daren		05/23/1961	ND4672392 (SPA-ND)
Schiele	Carson		03/20/2001	ND3399568 (SPA-ND)
Schily	Bianca		03/20/2012	ND3093626 (SPA-ND)
Schmitz	Rick		09/28/1965	ND4679386 (SPA-ND)
Schmo	Joe		11/23/2009	ND1234567 (SPA-ND)
Schmo	Joe			ND123456 (SPA-ND)
Schoenheit	Quintin		07/15/1973	ND3216296 (SPA-ND)
Schrenk	Tiffany		05/20/1989	ND3439176 (SPA-ND)
Schroeder	Michaela		01/16/1984	ND3074974 (SPA-ND)
Schroeder	Michaela		01/16/1984	ND 3074974 (SPA-ND)

Showing 1 to 15 of 45 entries (filtered from 405 total entries)

Previous | 1 | 2 | 3 | Next

Enter these important dates:

1915(i) Plan of Care 3/2023 Draft

T-Notes

Save and Continue Editing

Individual	Joe M. Schmo	Photo
Oversight ID	ND1234567 (SPA-ND)	
Date of Birth	11/23/2009	
Medicaid Number	ND1234567	
Residential Address	237 Park Lane, Ypsilanti, ND 58328, USA	
Residential County		
Meeting Date	MM/DD/YYYY	
Start Date	MM/DD/YYYY	
End Date	MM/DD/YYYY	

This pre-populates:

Date of meeting to finalize POC:

1915(i) Eligibility Start Date:

1915(i) Eligibility End Date:

Complete these questions- use the individual's words and reflect their voice:

About Me

Jump to ?

What People Admire about Me

B I U 11pt ?

What is Important to Me

B I U 11pt ?

How to Support Me Best

B I U 11pt ?

Most of the POC is contained in the “Questionnaire” section, which includes the Self-Assessment, HCBS Rule compliance verification, Individual Goals and Services, Risk Management/Crisis Plan, required POC review attestations:, Care Coordinator contact information, and information on required attachments to the POC:

Questionnaire Jump to

Person-Centered Plan of Care 3.2023 final

Person-Centered Plan of Care
Eligibility
Home and Community-Based Settings (HCBS) Rule
Individual Goals & Services
Individual Goals & Services Continued
Risk Management/Crisis Plan
Plan of Care Reviews/Attestations & Signatures/Attachments

Person-Centered Plan of Care Development

Required HCBS compliance verification measures must be completed prior to submission of the POC and approval of service authorizations.

Service providers must submit the Person-Centered Plan of Care with the request for service authorization in the North Dakota MMIS Web Portal (for Traditional Medicaid), or in the System required by the MCO (for Medicaid Expansion.)

Self-Assessment

Items 1 – 12 are regulations from Paragraphs (a)(1)(vi)(A) through (D) of the Home and Community-Based Settings Federal Rule at 42 CFR 441.710 which must be verified as compliant in this self-assessment.

If the answer to any of the questions below is "No", the HCBS Settings Modifications section of the POC must be completed (HCBS 2).

I live in and regularly have the chance to participate in activities of my choice in integrated environments. Yes

Scroll to the bottom, and choose “Open”:

based on their residence being in a county which has a provider shortage?

If "Yes", please list the names of at least one other staff member who will be providing any/all other 1915(i) services. If not applicable, please type N/A. N/A

Open

Complete the questionnaire, starting with the Self-Assessment:

Person-Centered Plan of Care >

Eligibility

Home and Community-Based Settings (HCBS) Rule

Individual Goals & Services

Individual Goals & Services Continued

Risk Management/Crisis Plan

Plan of Care Reviews/Attestations & Signatures/Attachments

Person-Centered Plan of Care

Person-Centered Plan of Care Development

Required HCBS compliance verification measures must be completed prior to submission of the POC and approval of service authorizations.

Hints: Individual settings compliance measures including Person-Centered Planning and the Self-Assessment are completed for all individuals. Additional settings compliance measures must be completed for individuals receiving services in their place of residence.

Service providers must submit the Person-Centered Plan of Care with the request for service authorization in the North Dakota MMIS Web Portal (for Traditional Medicaid), or in the System required by the MCO (for Medicaid Expansion.)

Self-Assessment

Items 1 – 12 are regulations from Paragraphs (a)(1)(vi)(A) through (D) of the Home and Community-Based Settings Federal Rule at 42 CFR 441.710 which must be verified as compliant in this self-assessment.

If the answer to any of the questions below is "No", the HCBS Settings Modifications section of the POC must be completed (HCBS 2).

* I live in and regularly have the chance to participate in activities of my choice in integrated environments. — (●) Yes ( ) No

Hints: I am able to use and interact

*The Self-Assessment serves to determine if the individual is able to receive Person-Centered support considering their current living arrangement and circumstances. If any questions are answered “No”, the HCBS Settings Modifications section of the POC must also be completed.

Complete the Guardianship Information, as applicable:

Guardianship Information

* Does this individual have a legal guardian? — (●) Yes ( ) No
Hints: Parents count for those under 18

Legal guardian's name, if applicable: Jane Smith
Hints: Type guardian's name

Legal guardian's relationship to individual, if applicable: Legal Guardian
Hints: parent, family member, corporate guardian, other?

Legal guardian phone number, if applicable: 701-212-8746

Legal guardian's email address, if applicable: jsmith@xyzguardians.com

Complete the "Conflict of Interest Exemptions" section, as applicable:

Conflict of Interest Exemptions

* Has your agency been granted an exemption to the Conflict of Interest Rule for this individual based on cultural or language considerations?
Hints: Exemption will allow the WHODAS Administration, Care Coordination

(selected) Yes
No

* If "Yes", please list the names of at least one other staff member who will be providing any/all other 1915(i) services. If not applicable, please type N/A.

Mary Johnson will provide PSS and Housing Support

* List the circumstances which exist that make the exemption to the Conflict of Interest rule necessary.
Hints: ex: primary language spoken, ethnic or cultural group inclusion..

We are the only agency with Swedish speaking staff

* Has your agency been granted an exemption to the Conflict of Interest Rule for this individual based on their residence being in a county which has a provider shortage?

Yes
(selected) No

* If "Yes", please list the names of at least one other staff member who will be providing any/all other 1915(i) services. If not applicable, please type N/A.

n/a

Save | Save & Next | Next

Choose "Save and Next" to move forward.

Enter 1915(i) eligibility start and end dates (yes, again…):

Person-Centered Plan of Care
Eligibility
Home and Community-Based Settings (HCBS) Rule
Individual Goals & Services
Individual Goals & Services Continued
Risk Management/Crisis Plan
Plan of Care Reviews/Attestations & Signatures/Attachments

Eligibility

1915(i) Eligibility Dates

* Current 1915(i) Start Date (CMS 2a): 08/01/2023

* Current 1915(i) End Date (CMS 2c): 07/31/2024
Hints: When is the eligibility redetermination due?

* Previous 1915(i) Start Date (CMS 2c): n/a
Hints: This may not apply. Type "N/A" if this is the individual's first

Enter required "Contact and Process Record" information:

Contact and Process Record

* Date individual first made contact with Care Coordination agency (POC 6): 08/08/2023
Hints: Date the individual contacted your agency to request Care Coordin

* Date of first in-person meeting after referral took place: 08/10/2023

* Date "Member Rights and Responsibilities" form signed and a copy offered to the individual. (POC 11): 08/10/2023

* Date this Plan of Care was completed (POC 6): 08/12/2023

* Is this the Individual's first 1915(i) Plan of Care?
- (selected) Yes
- No

* If this is the individual's initial POC, was it completed within 30 days of their first contact with the Care Coordination agency?
- (selected) Yes- it was completed within 30 days
- No- it took longer to complete than 30 days
- N/A- this is not the individual's initial Plan of Care

* If no, when was the previous POC was completed? (CMS 1b): n/a
Hints: If this is the initial POC, type "N/A"

* POC Team Meeting Date and Time: 8/12/2023 10:30am
Hints: required for initial POC and Annual POC Update

* POC Team Meeting Location: Joe's home
Hints: required for initial POC and Annual POC Update; virtual is an opt

* Was this meeting held at a place and time of the Individual's choosing? (POC 12):
- (selected) Yes
- No

* Did the individual lead the meeting to the best of their ability, or to the level they desired? (POC 13):
- (selected) Yes
- No

* Did the individual choose who attended their meeting? (POC 14):
- (selected) Yes
- No

Enter WHODAS Information

WHODAS 2.0 Assessment Domain and Complex Scores (CMS 1a, 2a, 2b)

Field	Value
* Communication:	28
* Mobility:	45
* Getting Along:	63
* Self-Care:	18
* Life Activities:	42
* Participation:	68
* Overall Score:	44
* Date WHODAS 2.0 Assessment Administered:	07/13/2023

Enter "Other Medicaid Services" Information (email nd1915i@nd.gov to inquire about other services):

Other Medicaid Services

* Does this individual receive any other Medicaid funded services? *Hints: ex: "C" Waiver Services, Targeted Case Management, etc.*
  - ○ Yes
  - ◉ No

* If above answer is yes, please select service
  - ☐ Autism Waiver - ND.0842
  - ☐ Medically Fragile Waiver - ND.0568
  - ☐ HCBS Aged and Disabled Waiver - ND.0273
  - ☐ ID/DD Waiver - ND.0037
  - ☐ Technology Dependent Waiver - ND.1266
  - ☐ Children's Hospice Waiver - ND.0834
  - ☐ Targeted Case Management
  - ☐ Psychosocial Rehabilitation
  - ☐ Mental Illness Case Management
  - ☐ Other
  - ☐ N/A

If "Other" please describe:

* Date Care Coordinator verified the POC does not include duplicative services (POC 8): 08/12/2023
Hints: ex: Other Medicaid or Waiver Services, Individuals with Disabilit

Previous | Save & Prev | Save | Save & Next | Next

Choose "Save and Next" to move forward:

HCBS Rule compliance verification:

Person-Centered Plan of Care
Eligibility
Home and Community-Based Settings (HCBS) Rule
Individual Goals & Services
Individual Goals & Services Continued
Risk Management/Crisis Plan
Plan of Care Reviews/Attestations & Signatures/Attachments

Home and Community-Based Settings (HCBS) Rule

HCBS Rule Compliance Verification

* Will the Individual receive 1915(i) services in a provider owned or controlled residential setting?:
- (selected) Yes, and I have completed a site visit and the 1915(i) Initial HCBS Settings Review form; or I have obtained verification of compliance.
- No

* Will the Individual receive 1915(i) services in a residential setting presumed to have qualities of an institution?:
- Yes, and I have completed the Heightened Scrutiny process and form; or I have obtained verification of compliance.
- (selected) No

* Date Care Coordinator verified HCBS Rule Compliance (CMS 4a): 08/12/2023

HCBS Modifications (complete only if "Yes" answers present on Self-Assessment):

HCBS Modifications (HCBS 1)

If no modifications are present, select: (selected) N/A

If applicable, for which specific setting(s) are the modifications to the individual's environment required?

About 3000 characters left

If applicable, explain how the modification(s) address a specific identified need(s)?

About 3000 characters left

If applicable, document any positive interventions and supports used prior to the implementation of modifications described above:

About 3000 characters left

If applicable, describe less intrusive attempts to meet the need made in the past which were not successful:

Choose "Save & Next":

Previous | Save & Prev | Save | Save & Next | Next

Establish at least one Goal for each service needed:

Goal/Service 1- Care Coordination

* Goal #1 (reflect Individual's own words): *Hints: This is a goal related to Care Coordination. Must be associated w*	Over the next year, I would like to have assistance to connect with supportive services to help me work on getting along with others. About 2867 characters left
* In relation to this goal, what outcomes do I desire; what do I already have to celebrate; what progress have I already made toward this goal; and what are any other important things to mention? (POC 9 & 18): *Hints: list realistic, meaningful action steps/objectives which will hel*	I would like help connecting with a peer support who can help me overcome my social anxiety. About 2907 characters left
* The need(s) from my WHODAS 2.0 Assessment this goal helps address is/are (CMS 1a): *Hints: Choose one or more from the following*	☐ Communication ☐ Mobility ☑ Getting Along ☐ Self-Care ☑ Life Activities ☑ Participation
* Which 1915(i) service would I like to receive to help me achieve this goal (POC 10):	Care Coordination

*Can be authorized on its own, does not require authorization of Rate #2

**Can NOT be authorized on its own; MUST be requested in conjunction with Rate #1

* Total Units or Dollars Requested *Hints: How much? Units or Dollars, as applicable.*	5000
* Frequency Requested (POC 1 & POC 10): *Hints: How often?*	weekly
* Duration Requested (POC 10): *Hints: Through what date?*	Through 8/15/2024
If exceeding the maximum service limit, describe how the additional services requested will prevent an institutional/higher level of care admission.	About 3000 characters left
* Provider Name *Hints: Which agency has committed to providing this service?*	MYH Care Coordination

*Goals must be SMART and must relate to an assessed need. For more information/ training on SMART Goals and the necessary connection between Needs, Goals, and Services, please visit the 1915(i) Training Page.

Each service requested must be appropriate to assist the individual to work toward their goals, and the Care Coordinator is responsible to establish all SMART Goals. Each service requested will need to be delivered within its established scope. Care Coordinators must understand the scope of each of the 1915(i) services and assist with goal setting accordingly.

Complete the Risk Management/Crisis Plan:

Person-Centered Plan of Care
Eligibility
Home and Community-Based Settings (HCBS) Rule
Individual Goals & Services
Individual Goals & Services Continued
Risk Management/Crisis Plan
Plan of Care Reviews/Attestations & Signatures/Attachments

Risk Management/Crisis Plan

Risk Management/Crisis Plan (POC 7)

A risk management/crisis plan is in place to ensure I have access to needed assistance if my regular services and supports are not available.

Individuals available to provide temporary assistance to me include informal natural supports such as a caregiver, my family, my friends, or another responsible adult.

My crisis plan may include electronic devices, relief care, providers, other individuals, other services, or other settings.

* List all qualifying diagnoses *Hints: List F-code(s) and the name of diagnosis(es)*: Schizophrenia; Cannibis Use Disorder- Moderate
About 2954 characters left

* Primary Physician: *Hints: Name and phone number; indicate "N/A" if no primary physician exi*: Dr. Jule Jones

* Psychiatrist/Psychologist/Prescribing Physician/Medication Management Provider: *Hints: Name and phone number; indicate "N/A" if none exist*: Dr. Annie Anderson

* Current Medications: *Hints: Indicate "N/A" if the individual does not take medications*: Depakote 200mg 2X
About 2977 characters

* Emergency contact *Hints: Name and phone number for a friend, family, or non-provider conta*: Cindy Schmo- 701-7

Below are known risks to my health and well-being, things that could potentially trigger a crisis, how I have responded to these triggers in the past, measures in place to minimize my risks, and safeguards.
Hints: Safeguards detail the support I need to keep me safe from harm and actions that need to be taken when my health and welfare are at risk.

* Risk: Auditory Hallucinations
About 2977 characters left

* Trigger(s): forgetting to take my medications
About 2967 characters left

* Known Responses: calling 911
About 2989 characters left

Safety measures in place: Reminder by phone of others to call instead of 911
About 2950 characters left

Safeguards: Med minder device and reminder alarms on cell phone

Addressing at least one risk:

The care coordinator, at a minimum, must provide 24/7 backup contact information to the individual within the first week of initial contact.

* Date backup phone number (either provider on-call or community resource) provided: *Hints: backup/crisis phone number should be shared at first meeting with*: 08/12/2023

* Indicate number provided: 0

Previous | Save & Prev | Save | Save & Next | Next

Complete this section and choose "Save & Next:

Interim/Quarterly Reviews: each POC must be reviewed a minimum of quarterly, or more often as appropriate; upload updated POC to the current SA for Care Coordination; share updated plan with team, including all other 1915(i) providers.

Person-Centered Plan of Care

Eligibility

Home and Community-Based Settings (HCBS) Rule

Individual Goals & Services

Individual Goals & Services Continued

Risk Management/Crisis Plan

Plan of Care Reviews/Attestations & Signatures/Attachments >

Plan of Care Reviews/Attestations & Signatures/Attachments

Interim/Quarterly Review 1

Quarterly/Interim Meeting Date & Time:

Was this meeting held at a place and time of the Individual's choosing? (POC 12)
- ○ Yes
- ○ No

Is this POC being reviewed/revised due to changes in the Individual's circumstances or needs, or is this a quarterly review? (CMS 1c)
Hints: Face-to-face quarterly reviews are required; Individuals may requ
- ○ Review due to changes or individual request
- ○ Quarterly face-to-face review

For Quarterly Review Only: Was this face-to-face POC review with the Individual held within 90 days of the previous face-to-face POC review (POC 4)?
- ○ Yes
- ○ No

For Quarterly Review Only: Did this interim review include reviews of all monthly provider updates (POC 5)?
- ○ Yes
- ○ No

Provide Care Coordinator Contact Information:

Care Coordinator Contact Information

* Care Coordinator name:	Monica Haugen
* Care Coordination Agency/Organization Name:	MYH Care Coordination
* Care Coordinator phone number:	701/785-3214
* Care Coordinator e-mail address:	myhcarecoordination@gmail.com

Visit the 1915(i) Forms web page to download the 2 required POC attachments:

1915(i) Forms

1915(i) Eligibility Application
Translation available - please submit requests to nd1915i@nd.gov

Care Coordination Request Report

- HCBS Settings Assessment Guide - *revised 6.24.2021*
- HCBS 1915(i) Heightened Scrutiny Visit Form - *revised 6.24.2021*
- Initial 1915(i) HCBS Settings Review - *revised 6.30.2021*
- Person-centered Planning Guide

Community Transition Plan of Care - *revised 1.1.2022*

Individual Acknowledgement/Care Coordination Attestation/Signatures - revised 7.10.2023

Member Rights and Responsibilities - *revised 12.01.2022*

Meeting Attendee Signatures

Request for Service Provider - *revised 8.29.2022*

Therap POC Creation Guide - *revised 8/2022*

Individual Provider Review Report - *revised 5.25.2023*

Provider Agency Review Report - *revised 5/25/2023*

Attest that you will attach, then choose "Save" then "Close":

Required Attachments

Meeting Attendee Signatures- Required for initial POC and Annual POC Review *Hints: located in "forms" section on the 1915(i) website*	○ N/A- this is not an initial POC or an Annual POC Review ◉ Yes, completed and attached
* Individual Acknowledgement/Care Coordinator Attestations/Signatures- Required for all POCs and Interim/Quarterly Reviews. *Hints: located in "forms" section on the 1915(i) website*	◉ Completed and Attached

Close | Previous | Save & Prev | Save

Scroll to the bottom of the main POC page:

1915(i) Plan of Care 3/2023 New

Save and Continue Editing

Individual: Joe M. Schmo

Oversight ID: ND1234567 (SPA-ND)

Photo

Nothing found to display

Add Action Plan

Discussion Records

Jump to ?

Nothing found to display

Add Discussion Record

External Attachments

Jump to

The total size of all attachments cannot exceed 250 MB

Add File | Scan File

Cancel | Back | Save | Submit | Approve

Choose “Add File” to upload attachments after they have been completed, signed, and scanned:

External Attachments

Jump to

The total size of all attachments cannot exceed 250 MB

File Name	Description	Size	Date	Attached By	Action
JS Attestations.Signatures.pdf		66.53 KB	08/13/2023	Monica Haugen, Therap Admin	PDF View | Remove
JS Meeting Attendees.pdf		66.53 KB	08/13/2023	Monica Haugen, Therap Admin	PDF View | Remove

Total uploaded 133.07 KB and remaining 249.87 MB

Add File | Scan File

Cancel | Back | Save | Submit | Approve

Choose “Save”:

The POC still needs to be reviewed and approved, prior to attaching it to your Service Authorization for Care Coordination.

Find the POC by looking in your "Worklist":

Individual Plans

Plan Template	1915(i) Plan of Care 3/2023	Individual Plan
New	New	Search
Search	Search	Unified Search
Manage Services	Expiration Report	Worklist (13)
Manage Reasons Not Available		Approve (2)
Manage Reasons Declined		Acknowledge (70)
Manage Supports		Active Change Form (13)
Manage Support Types		
Manage Provider Types		

Age Configuration | Location Library

Form ID	Individual	Plan Type	Name	Status	Date	Start Date	End Date	Entered By	Entered Date	Provider	Zone
OISP-SPAND-MAE4ZDYZJEPLW	Schmo, Joe	Individual Support Plan	1915(i) Plan of Care 3/2023	Draft				Haugen, Monica / Therap Admin	08/13/2023 01:01 AM	1915i State Plan Amendment Oversight Account	US/Central

Choose "Edit":

External Attachments Jump to

File Name	Description	Size	Date	Attached By
JS Attestations.Signatures.pdf		66.53 KB	08/13/2023	Monica Haugen, Therap Admin
JS Meeting Attendees.pdf		66.53 KB	08/13/2023	Monica Haugen, Therap Admin

View PDFs

Cancel | Back | SComm | Delete | Edit

Review POC, making any necessary edits, then choose "Approve":

JS Meeting Attendees.pdf		66.53 KB	08/13/2023	Monica Haugen, Therap Admin	PDF View | Remove

Total uploaded **133.07 KB** and remaining **249.87 MB**

Add File | Scan File

View PDFs

Cancel | Back | Save | Submit | Approve | Save and Share with Linked Providers

Choose “Display PDF (Portrait)”:

Print POC in PDF form; print the forms you attached (they don’t print as part of the POC, but they are required):

1915i State Plan Amendment Oversight Account

Individual Name Joe Schmo
Date of Birth 11/23/2009

1915(i)

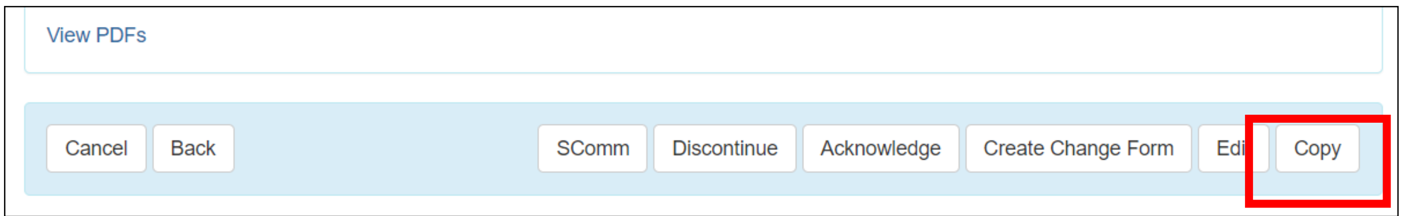
Individual Acknowledgment*

I acknowledge I have been a part of my Person-Centered Plan of Care development process and participated to the best of my ability. I agree with what is written in my plan. I was informed of my right to be free of abuse, neglect, exploitation, and the use of restraints. I understand my

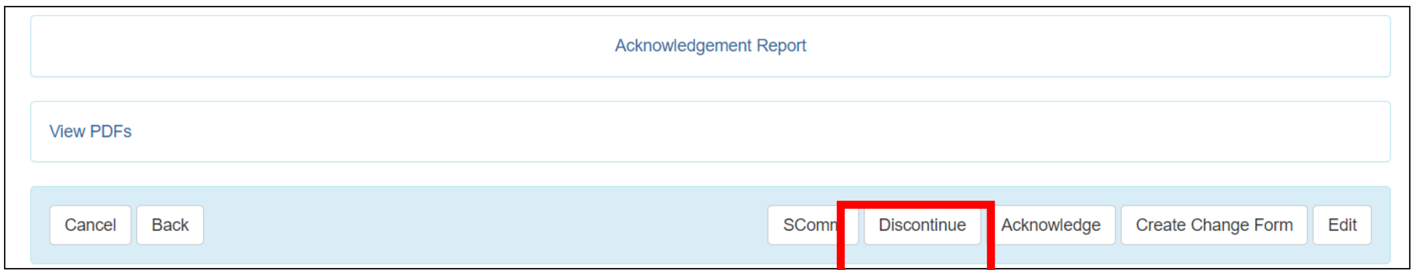
Meeting Attendee Signatures *(POC 2)*	
Name:	Name:
Relationship:	Relationship:
Signature:	Signature:
Date:	Date:
Name:	Name:
Relationship:	Relationship:

Scan all pages together to create one PDF document. This is the full POC. Attach it to your Service Authorization request, and provide to the individual, their team and any other 1915(i) service providers.

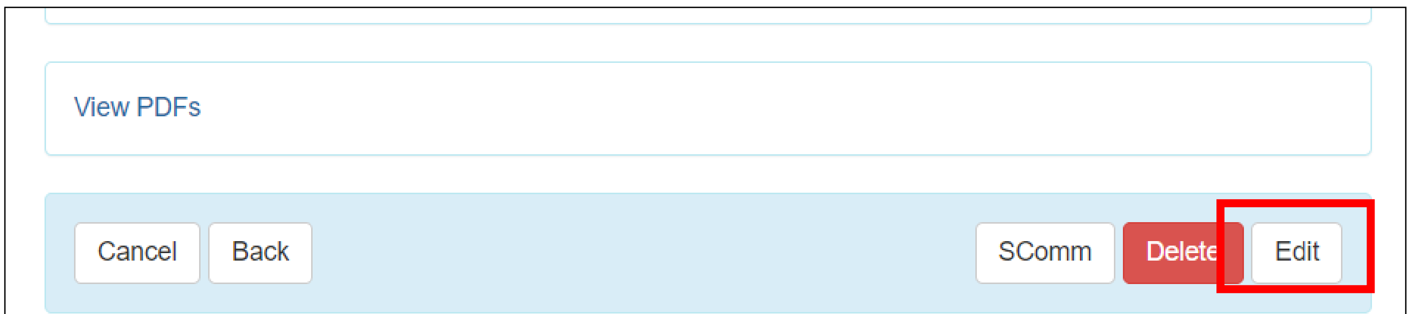
To make quarterly/interim, or annual updates, open the approved plan, scroll to the bottom and choose "Copy."



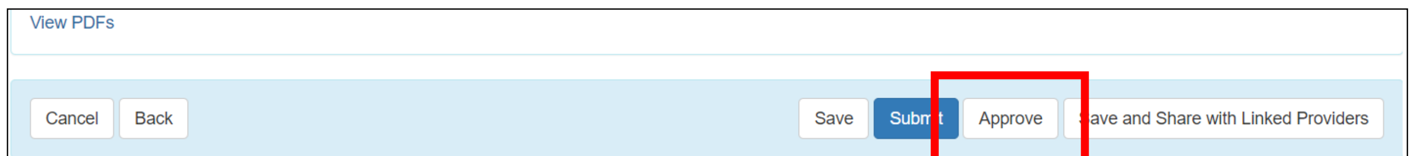
Make the updates to the "Draft" POC. Only one Approved POC is allowed for each individual. When the updated draft is ready to be approved, return to the previously approved POC, scroll to the bottom and choose "Discontinue":



Upon discontinuing the previous POC, return to the draft POC and chose "Edit":



Make any additional changes necessary, then scroll to the bottom and choose "Approve":



Share new POC with team and upload it to existing or new Care Coordination Service Authorization.