Overall Service Plan

Aligns with OSP Revision Dated May 1, 2024

OSP Information

OSP Type: _____ **Primary Provider:** _____

OSP Start Date: _____ **OSP End Date:** _____

Medicaid Redetermination Date: _____

- Update the Medicaid Redetermination Date
  - Typically, Medicaid benefits must be renewed and redetermined every 12 months.
  - List the date when the next or future Medicaid re-determination is due, if available.

- This information is entered by the DDPM and transfers from the stateside View Details page as well as the Shared Contacts within the IDF that is on the DDPM's side.
- This must be updated on the DDPM's IDF before the new plan is created otherwise updated information will not carry over into the new OSP.

Demographic Information

Individual Name: _____ **Therap ID:** _____

Goes By: _____ **Date of Birth:** _____

Residential Address: _____ **Ethnicity:** _____

_____

Gender: _____

Person lives with: _____

Comments: _____

Legal Decision Maker(s): _____

Primary Oral Language of Person: _____

Primary Written Language of Parents: _____

Interpreter need for: _____ **Phone:** _____

DD Program Manager Name: _____ **Email:** _____

Cell: _____

ISP

Service, Provider & Location	**Service** PROGRAM MANAGEMENT **Provider** Regional Human Service Center **Location** Regional Human Service Center		
Start Date	01/01/2025	**End Date**	12/31/2025
Disposition	AUTHORIZED	**Funding**	Other
Amount		**Termination Date**	
Service, Provider & Location	**Service** INDIVIDUAL EMPLOYMENT SUPPORTS **Provider** _____ **Location** _____		
Start Date	01/01/2025	**End Date**	12/31/2025
Disposition	AUTHORIZED	**Funding**	TTLXIX-HCBS
Amount	20 Hours / Week	**Termination Date**	
Service, Provider & Location	**Service** INDEPENDENT HABILITATION **Provider** _____ **Location** _____		
Start Date	01/01/2025	**End Date**	12/31/2025
Disposition	AUTHORIZED	**Funding**	TTLXIX-HCBS
Amount	60 Hours / Month	**Termination Date**	

- The ISP section is **entered by the DDPM** and is the authorization for payment of DD authorized services.
- The ISP must list all services the person is receiving regardless of funding source.
- The ISP also contains information regarding the disposition of services, provider of services, funding source, start date and end date of services, termination date of services, location, setting, and amount/unit/frequency.
- The ISP must be updated anytime the DD authorized service changes.

Virtual Supports

Service	
Start Date	
End Date	
Termination Date	

Comments	• This section is completed by the DDPM.
	• If the person receives this, the Virtual Supports Checklist (SFN 1522) will be completed with the team and attached by the DDPM. This determines if the person meets criteria.
	• Services that can be provided virtually include:
	  • Behavior Consultation
	  • Independent Habilitation
	  • Individual Employment Services
	  • Parenting Supports
	• This area will cover the following:
	  • Tasks, supports, objectives that can be delivered remotely.
	  • Technology platform used.
	  • Estimated number of hours.
	  • Any other team discussions, decisions.

Learning Objectives at a Glance:

When writing learning objectives, each objective should have a **condition**, **behavior**, **criteria 1**, and **criteria 2**.

- **Condition**: Defines the antecedent(s) that should set the stage for performance of the target behavior.
- **Behavior**: An observable action.
- **Criteria 1**: A statement of the minimal acceptable standard for the person's performance of the behavior; how well the person must perform the behavior for it to be considered mastered.
- **Criteria 2**: A measurement of the person's ability to consistently and reliably meet part one criterion over time; how long and regularly the person must perform the behavior for it to be considered mastered.

These are color coordinated in the examples below.

Outcomes

	Overall Goals	Learning and Support Objectives
1	I will save money for my dream vacation to the beach.	**Learning Objective:** Once a month, I will independently make a deposit into my savings account completing 3 out of 4 steps for 6 consecutive deposits. **Support Objectives:** 1. Staff will assist me in exploring the beach destination and developing a budget for the costs (travel, hotel, food). 2. Once a month, review with me the amount of money I have saved and home much more I need to save.
2	I will get better at using the cash register so I can be a cashier at work.	**Learning Objective:** After scanning all the items to complete a customer's transaction, I will select the correct register keys on the first try for 30 consecutive days. **Support Objectives:** 1. Assist me in assuring that I give the correct amount of change back if the customer is paying cash.

PCSP

PCSP Meeting Date: _____

- List the date of the OSP team meeting.
- This includes Annual, Admission, 30-day Comprehensive, Team Review, and ISP Updates.
- If changes are made to the OSP without a team meeting, list the date changes were made in the PCSP meeting date section.

Assessment Review

Review of plan and progress towards outcomes:

- Should include how the goals went from the previous year and what **the person** with support from their team has decided to work on for the upcoming year. Be thorough - you can also include overall data and/or percentages from the previous year.
- If objectives were not achieved or no progress noted, discuss why and determine if these should continue/be a priority for the next year.
- Focus on successes and highlights of the person's life over the past year. Reflect significant family, medical, travel, other information.
- Important events and how person was impacted.
- Celebrate the person's accomplishments, achievements and highlight any significant changes.
- Reflect how **natural supports or self-directed services** assist the person with services, supports, and achievement of identified goals.
- May also document any team discussion, recommendations and decisions made regarding this section.

Review of the Self-assessment:

- This section needs to capture who the person really is.
    - Summarize vital/essential aspects of person's history, identity, individual experiences, uniqueness, skills, interests, personality, values, what/who is important to them, non-negotiables, natural supports, how they communicate, **strengths, likes, dislikes, preferences** and **where they are currently living/working** (this information represents what is important TO the person to feel happy, content, fulfilled, and satisfied).
    - Reflect on and highlight educational (school) services, natural supports, self-directed services, and any other generic services or activities the person participates in.
    - Summarize the person's daily schedule or describe a typical day and activities based on their preferences. May indicate that days and activities may vary based on choices.
    - Address any barriers to the person's preferences.
    - Reflect what the person wants to do for the next year and in the future.

Review of the Risk assessment:

- This should not just state the Risk Assessment was reviewed.
- Only areas of identified risk need to be reviewed at the team meeting and mitigated within the plan.
    - Review/highlight all risks identified in the RMAP as well as team discussion related to the identified risks.
    - Review any changes made to the RMAP from last year.
    - It may be helpful to list the sections of the RMAP where risks are identified and then any risks identified under each corresponding section.
- Mitigation can be documented per identified risk within this section or throughout the OSP

Review of the Residential assessment:

- This section should include the person's abilities, preferences, and supports. This would include information about their mobility, eating, personal cares, dressing, household chores, safety awareness, community participation, and communication/social skills. Indicate strengths and supports needed in these areas.
- Summarize any applicable assessments. Risks identified in RMAP that fall into residential area can be described along with supports/actions to remediate the risks if not addressed in the Review the Risk Assessment section.
- May indicate:
    - Describe where the person is living and indicate whether it be alone or with a roommate.
        - How did the person exercise their choice in a roommate(s).
    - Describe how the person privacy is respected and promoted.
        - If living in a provider-owned residence, does the person have a lockable bedroom door with only appropriate staff having keys.
            - If not, why? This may be considered a rights restriction if they desire one, but the team determines due to health and safety reasons, they cannot. Be sure due process is applied.
            - If so, under what circumstances would staff utilize the key to access the person's bedroom?
    - Describe the person's choice in furnishings/decorations within their bedroom/home and how this reflects their personal interests and preferences
    - Describe the person's choice and preferences in their daily schedules and/or activities
    - Describe how the person is able to freely access their personal belongings (money, medication, phone, etc.)
    - Describe the person's preferences to food/meal options and their ability to have access to food at any time
    - Describe how the person's ability to have visitors of their choosing at any time is respected and promoted.

If there are limitations around any of these experiences, ensure this is identified as a rights restriction and that due process is completed and documented in the Safeguards section.

Vocational/employment/Day Supports/VR:

- List name of program and provider. Review any assessment results. Include team discussion in this section.
- Summarize/Highlight
    - Specific skills, strengths, supports, needs, preferences, likes, dislikes, etc. that are important to the person in this area.
- Provide an overview of where the person works (including the setting), their hourly wage, the person's activities, jobs, volunteering, interests, hours, participation in day supports, school, etc.
- Risks identified in RMAP that fall into this area can be described along with support/actions to remediate the risks if not identified in the Review of Risk Assessment section.
- If a person is
    - In Day Supports,
        - Indicate the person's preference of activities or schedule of days involved in day support and describe their typical day.
    - If receiving Day Supports in their residence,
        - The situation, reason, and individual's need must be justified and documented in this section (medical or behavioral).
        - Must include other strategies/options that have been tried and were not successful – personal preference must also be considered and documented.
    - In school,
        - This section needs to reflect their typical day at school and what their IEP is focusing on.

- Should indicate the person's grade level and whether they attend Extended School Year (ESY)/summer school.

Health and Welfare

Health status review section

Physical Exam (date of last exam): **Add date here**

- List name of the physician and clinic location
- Provide summary of visit with no medical jargon
    - This may include:
        - primary health issues
        - impressions
        - any new concerns
        - changes in healthcare protocol
        - studies or tests performed
        - recommendations from physician
        - future follow up
        - other

Nursing Services (Public/Home Health) (date of last exam): **Add date here**

- Name of agency/nurse and office location
- Summarize type of services provided (public health, home health services, agency nurse)
- Describe the tasks provided by the nurse
- May also include:
    - Current status of the person
    - Issues identified in nursing care plan and how they are being addressed
    - Monitoring provided by nurse

Diagnoses Review (date of last exam): **Add date here**

- List date of most recent diagnoses
- List all current diagnoses, including any:
    - ID
    - mental health
    - personality disorders
    - medical diagnoses
- If you can, try to simplify complex diagnoses for the understanding of all team members.
    - *For example, high blood pressure instead of hypertension.*

Medication Review (date of last exam): **Add date here**

- Include:
    - Date of exam/med review
    - Name and location of physician
    - Date/schedule of next exam/review
    - What conditions, diagnoses or medical conditions medication is taken for.
        - Example: *medication for high cholesterol; supplements for bone and overall health; water retention; constipation, etc.*

        - **Note**: Do not need to list specific medications and dosages as these may change over the life of the OSP.
    - Where MAR and medications are kept
    - Specific side effects that need to be monitored.
- May also include:
    - Who is responsible for ensuring medication refills
    - Level of independence in medication administration

Lab Work (date of last exam): Add date here

- Include:
    - Date and result of most recent lab work
    - Location completed
    - Note frequency of lab work (if applicable)
    - What conditions/diagnoses the labs are completed for

Allergies: Add date here

- List all allergies/symptoms of allergic reaction
- Indicate any necessary precautions
- Emergency medication (Example: Epi-pen) is needed,
    - list where located
    - protocol for use
    - who responsible to ensure it is not expired
- If no allergies known, list "No Known Allergies"; Do not list "N/A"

Immunizations Up To Date?: Add date here

- Indicate if immunizations are up to date.
- If not up to date, indicate
    - which immunizations are needed
    - who will arrange to have them administered
- May also indicate
    - Where immunization records are located
    - If there are preferences due to religious beliefs, cultural considerations, etc.

Review Checklist for recommended (date of last exam): Add date here

- Refer to the recommended screenings/exams from the Centers for Disease Control or American Cancer Society.
- Indicate whether the recommended screenings/exams or appointments are up to date.
    - If not, why not and any actions that will be taken
- List screenings that have been completed or are due and when.
- Indicate who is responsible to ensure these are scheduled.

Nutrition/ dietary (date of last exam): Add date here

- List date of last consultation, name/title of evaluator, and location of office
- Date of next consultation if applicable
- Summarize any related discussion or concerns regarding nutrition or diet based on the medical information regarding the person's current weight, etc.
- May indicate special diets, consistency, dietary supplements, preferences, or other orders
    - Examples: Low sodium, decrease in calories, cut up food, dietary supplements, etc.

- Summarize results/recommendations and status including whether the person chooses to follow the recommendations, success with recommendations, supports provided, etc.

Vision (date of last exam): Add date here

- Date of most recent exam, name of ophthalmologist/optometrist and location of office
- Summarize findings, whether glasses or corrections are needed and if so, are they worn.
    - If not worn, why not.
    - Indicate any action needed.
- Date of next exam/follow up (if needed)

Hearing (date of last exam): Add date here

- Date of most recent exam, name of evaluator and location (e.g., Sanford clinic)
- Summarize results, whether hearing aid or corrections are needed and if so, are they worn.
    - If not worn, why not.
    - Indicate any action needed.
- Date of next exam/follow up (if needed)

Dental Status (date of last exam): Add date here

- List date of most recent exam, name of dentist and office location
- Summarize results of the exam including orders, recommendations, or concerns
- Schedule for next exam/cleaning
- Describe if chemical restraint/sedation or physical or personal restraint, desensitization is utilized for dental visits. (This should also be listed in the Safeguard section).
- Indicate if on the list of persons *"approved for additional dental reimbursement through Medicaid due to challenging medical or behavioral issues"*

Psychological (date of last exam): Add date here

- List date of most recent evaluation, name of the psychologist and office location
- Summarize findings
    - Do not need to indicate the diagnosis as this would be listed in the diagnosis section
- Indicate any team discussion of what the person is currently receiving (if they see someone regularly for appointments/counseling)
- Team's determination whether updated psychological evaluation is needed or if existing evaluation reflects current level of functioning and diagnosis.

Psychiatric (date of last exam): Add date here

- List date of most recent evaluation, name of the psychiatrist and office location
- Summarize findings
    - Do not need to indicate the diagnosis as this would be listed in the diagnosis section
- Indicate any team discussion of what the person is currently receiving (if they see someone regularly for appointments/counseling)
- Team's determination whether updated psychiatric evaluation is needed or if existing evaluation reflects current level of functioning and diagnosis.

Neurological (date of last exam): Add date here

- Date of most recent exam, physician and office location
- Summary of visit
    - Reason for visit
    - Recommendations
    - Future follow up

- History of seizures
- If there are specific precautions that need to be taken for the person due to seizures etc. this must be listed

Cardiac (date of last exam): Add date here

- Date of most recent exam, physician and clinic location
- Summary of visit
    - Reason for visit
    - Recommendations
    - Future follow up
- If there are specific precautions that need to be taken for the person, this must be listed

Other (date of last exam): Add date here

- List date of any additional appointments, consultations, or exams that have not been addressed
    - May include chiropractic, urology, podiatrist, gastroenterologist, etc.
- Name of physician/examiner, office/clinic and location
- Summarize exam results
    - Reason for visit
    - Recommendations
    - Future follow up
- May also indicate if the team recommends a consult

OT (date of last exam): Add date here

- List date of most recent exam, name of therapist, office/clinic and location
- Summarize exam results
    - Reason for visit
    - Recommendations
    - Future follow up
- May also indicate if the team recommends a consult

PT (date of last exam): Add date here

- List date of most recent exam, name of therapist, office/clinic and location
- Summarize exam results
    - Reason for visit
    - Recommendations
    - Future follow up
- May also indicate if the team recommends a consult

Speech (date of last exam): Add date here

- List date of most recent exam, name of therapist, office/clinic and location
- Summarize exam results
    - Reason for visit
    - Recommendations
    - Future follow up
- May also indicate if the team recommends a consult

Adaptive, orthotic, corrective, communication equipment/supplies (augmentative devices):

- List the equipment or devices used by the person and the reason for the support.
- Indicate the situations in which it is to be applied or used, a schedule for use.

- Indicate the condition of the equipment and if any equipment is in need of repair. If so, document the plan for follow up.
- If applicable, list the maintenance schedule of each device and who is responsible.
- The use of devices such as splints, braces, bedrails to prevent injury, wheelchair harnesses and lap belts to support a person's proper body positioning and alignment must be included in this section including medical necessity and procedures for their use. Address under the Safeguard section as appropriate.
- If there is adaptive equipment or technology that the person does not have, but the team believes the person can benefit from, this should also be listed in this area.

Level of supervision/assistance for medical:

- Describe the level of assistance needed to:
    - Schedule appointments
    - Arrange transportation
    - Attend appointments
    - Communicate information to providers and/or staff
    - Understand and implement recommendations or instructions made by the professional
- Indicate who provides assistance that may be needed
- May also indicate
    - Their ability to self-administer medications
    - Whether or not they fill their own medications, purchase or refill meds

Comments:

- May indicate any relevant comments for this section here.

Behavioral Health:

- Describe any behavioral/mental health issues/services that have not been included in the other assessment sections including behavior support plans or mental health interventions that are being utilized.
    - Include types of therapy (person, family, group, play etc.).
    - Do not state "see attached" instead indicate the supports/interventions and the target areas for remediation these are addressing.
- **Behavior support plans must be attached to OSP**
- Behavior support plans must include a functional assessment, and the FA must be completed prior to writing the behavior support plan.
- Any restrictive plans must be approved by person/guardian, BMC/HRC before implemented and must be listed in the Safeguards section.

Safeguards

Rights Limitation and Due Process (check all that apply)

☐ **Individual and/or guardian approval (Release signed specific to plan restrictions):**

- Any restrictions should be identified in this area
    - Some examples include:
        - Restrictive interventions/restraints used - including those used for medical, surgical or dental procedures.
            - These include chemical, mechanical, and/or physical
        - Restrictions on lockable doors, roommate selection, access to food, furnishing apartment, schedule control, and visitors
        - Limited access to personal items (medication, money, soda, phone, etc.)

Something to consider: *If a method you are considering was imposed on you, would you have a problem with it? If so, it's likely restrictive to the person too and should receive due process.*

- **When documenting limitations/restrictive interventions, you must include all the components listed here**:
    1. The **limitation/restrictive intervention being implemented**.
    2. The **specific, individualized assessed need for the limitation/restrictive intervention**.
        - *A diagnosis/disability cannot be the sole reason for the restriction. It may accompany the justification, but the situation and reasons are individualized and according to assessments.*
    3. The **positive interventions/supports and less intrusive methods tried in the past that were not effective**.
    4. The collection of **data reviewed to measure the ongoing effectiveness**.
    5. Established **time limits for periodic reviews to determine if the modification is still necessary or can be faded/terminated**. Modifications that affect a person's rights should not be without time limitations or be on a continuous basis.
        - *Fading does not necessarily mean complete removal. The team should discuss opportunities to scale back a restriction if/when appropriate.*
    6. Document that informed **consent has been obtained** and assurance that the **interventions and supports will not cause harm to the person**.
        - *Informed consent is **written consent** to the implementation of the intervention(s) that indicates the person is fully aware of the intervention and the potential risks and benefits of the intervention. These sometimes also include a statement that the person has the right to attend the committee's review of their restrictions and that their consent has not been coerced.*

☐ **Behavior Support Committee approval:**

- List the date committee reviewed and approved.
- List date of next review or review schedule.

Please Note:

- *Approval of any rights restrictions or restrictive behavioral interventions must be obtained prior to limiting rights or implementing restrictive interventions or plan.*
- *Behavior plans attempting to modify a behavior or involving techniques that include restraints (physical, mechanical, or chemical) should be reviewed a minimum of every six months, or sooner if needed, and in accordance with current DD Policy.*
- *Approval timelines for physical interventions and medication(s) used for behavioral support should not exceed a period of six months.*
- *All behavior plans with restrictions should be taken through both the Human Rights Committees and the Behavior Support Committee, with Human Rights Committee reviewing last.*

☐ **Human Rights Committee approval:**

- List the date committee reviewed and approved.
- List date of next review or review schedule.

Please Note:

- *Approval of any rights restrictions or restrictive behavioral interventions must be obtained prior to limiting rights or implementing restrictive interventions or plan.*
- *Behavior plans attempting to modify a behavior or involving techniques that include restraints (physical, mechanical, or chemical) should be reviewed a minimum of every six months, or sooner if needed, and in accordance with current DD Policy.*
- *Approval timelines should not exceed one year.*
- *Approval timelines for physical interventions and medication(s) used for behavioral support should not exceed a period of six months.*
- *All behavior plans with restrictions should be taken through both the Human Rights Committees and the*

Behavior Support Committee, with Human Rights Committee reviewing last.

☐ **Review dates for limitation:**

- May indicate anticipated review schedule here.

☐ **Review of Guardianship status:**

- Document the date of the most recent guardianship review and the date of the next review, if known.
- Describe type of guardianship, name/relationship of guardian, and if continues to be appropriate.
- If determined person needs legal guardian but does not have one; or needs change in guardian/ guardianship status, reflect discussion and include who will follow up.
    - Teams should also discuss other options that are available as a least restrictive alternative to guardianship such as Supported Decision Making, Power of Attorney, etc.
- Review and document guardian responsibilities and participation regarding program planning, decisions, signing consents, PCSP/ISP and QER visits and contacts.

☐ **Specific guardian requests (specific contacts, notification, spending limits, etc.):**

- Describe guardian requests such as notifications and/or preapproval for medication changes, medical appointments, immediate notification of injury or other incidents, spending limits, once monthly phone contacts, etc.
- Indicate who is responsible to ensure the requests are carried out.
- **Please also consider whether guardian requests are restrictive and should be taken through appropriate committees.**

☐ **Representative Payee: review responsibilities of payee, spending limits:**

- List the person or agency and position within the agency that is serving as the representative payee for Social Security benefits
- Clearly specify who is responsible for carrying out the following tasks:
    - Monthly bills
    - Budget spending money, holding spending money
    - Completing benefit applications. Notifications, redeterminations to Medicaid, SNAP, housing assistance, etc. List name of representative payee for Social Security benefits.

☐ **Durable Power of Attorney:**

- List the name of the DPOA and the powers they have.
- List the date signed and where located (agency records, person file, legal decision maker, hospital, physician's office).
- If the person does not wish to discuss, may indicate this.

☐ **Healthcare Directives:**

- Describe the directives/code status
- List the date directives were signed and dated and where the directives are located (agency records, person file, legal decision maker, hospital, physician's office)
- If the person does not wish to discuss, may indicate this.

☐ **Do they have a Living Will?:**

- List the status and when documents were signed and dated and where the directives are located (agency records, person file, legal decision maker, hospital, physician's office)
- If the person does not wish to discuss, may indicate this.

Benefits and Insurance (check all that apply)

☐ **SSI:**

- If appropriate:
  - Team will discuss the benefits
  - Need to spend down to remain eligible for Medicaid benefits
  - Other

☐ **SSDI:**

- If appropriate:
  - Team will discuss the benefits
  - Need to spend down to remain eligible for Medicaid benefits
  - Other

☐ **Other Income/benefit:**

- If appropriate:
  - Team will discuss the benefits
  - Need to spend down to remain eligible for Medicaid benefits
  - Other

☐ **Earnings from employment:**

- Indicate hourly wage
- If appropriate:
  - Team may wish to address the amount of benefits
  - Need to spend down to remain eligible for Medicaid benefits
  - Other
- Indicate who is responsible to report earnings to the county for Medicaid eligibility

☐ **Trust/Estate/Special Needs Trust-Contact:**

- List the specifics if a person has a trust. Document that this area was discussed.
- Opportunity to inform/remind person/legal decision maker that a trust/estate/special needs trust can affect continued Medicaid eligibility if trust/estate is not handled in compliance with Medicaid requirements.
- Family should contact Legal Advisory Unit in Department of Human Services for information regarding continued MA eligibility and requirements related to trusts, etc.

☐ **Burial account-where located:**

- Indicate if person has a burial account.
- If they do, what is the current value and who is managing the account.
- If the person does not wish to discuss, may indicate this.

☐ **Medicaid:**

- List:
  - County where it is from
  - List who is responsible for notifying/completion of applications/annual renewals

***Please Note**: If you choose not to include the Medicaid Redetermination Date in this section, be sure to indicate this at the top of the OSP in the designated area.*

☐ **Recipient Liability/Worker's with disabilities premium:**

- Indicate if person has a Recipient Liability or if receiving Worker's with Disabilities benefit.
- List who is responsible for notifying/completion of applications/annual renewals

☐ **Medicare Type:**

- List all types of Medicare the person participates in or receives
- List policy type

☐ **Private Insurance(s)- health, renters, vehicle, life etc.:**

- Indicate policies person carries
  - May include Health, Renters, Vehicle, Life, Other
- May additionally indicate:
  - Private insurance options that have been reviewed
  - Person responsible to assure policies are kept up to date

☐ **Room and Board Costs:**

- DD Waiver services-Responsibility of the person
  - It is best practice to acknowledge that for people who reside in any provider-owned residential settings, that the person has a lease which is signed by the person and/or legal decision maker
  - List the cost for the person's room and board (Individual setting and group home) at the time of the OSP meeting-*may note subject to change*
  - ICF-IID Services-Included in the ICF/IID rate, so indicate N/A if person resides in an ICF/IID

☐ **Housing Assistance:**

- Has the person applied
- Is she/he eligible?
- If eligible list who is responsible for notifying/completion of applications/annual renewals

☐ **Food Stamps:**

- Has the person applied
- Is she/he eligible?
- If eligible list who is responsible for notifying/completion of applications/annual renewals

☐ **LIHEAP (fuel assistance):**

- Has the person applied
- Is she/he eligible?
- If eligible list who is responsible for notifying/completion of applications/annual renewals

☐ **Phone Assistance:**

- Has the person applied
- Is she/he eligible?
- If eligible list who is responsible for notifying/completion of applications/annual renewals

☐ **Other:**

- Has the person applied
- Is she/he eligible?
- If eligible list who is responsible for notifying/completion of applications/annual renewals

Additional Safeguards

a. Level of supervision for work, home and medical:

- Describe how much supervision is provided in each environment, including the community
- Indicate what type of support is provided
- Describe how long person can be left alone and under what circumstances
- The description could reflect the level/definition identified in the RMAP but additionally expand and include individual specific information

b. Emergency Back-up Plan (if provider was not able to provide services, what would the person do? Who would they contact?):

- This plan is specific to the person.
- Include a description of the setting.
- Describe the person's emergency preparedness knowledge, abilities to evacuate/respond independently, and support needs for:
  - Fire
  - Tornado
  - Blizzard
  - Flood
- If person cannot evacuate/respond independently, document how this will be mitigated and who is responsible to assist the person.
- List all specialized equipment or supplies, particularly electricity-dependent equipment required for health and safety. List the plan of action if unable to use due to unforeseen circumstances.
- *For those living in settings where staff/caregivers may not be continuously available,* indicate what will occur in the event scheduled staff for the person is not available (on-call staffing, notification of family/neighbors, routine/periodic checks by provider agency, etc.)
- *For persons who reside with primary caregiver or depend upon natural/unpaid supports* - include short- and long-term plan of action in the event caregiver is unable to provide care due to injury/illness. Note if caregiver is unwilling to discuss.
- Document discussion of whether the person would require staff supports in a hospital setting.
- **Annually and as needed**, the team will **discuss and document within the plan** if the person is to be hospitalized, that direct supports are needed in a hospital setting, the direct supports provided will ensure a smooth transition between the hospital and home setting, and the direct supports will preserve the person's functional abilities.

Please Note:

A person can receive direct support from provider staff in an acute care hospital setting for inpatient medical care or other related services for surgery, acute medical conditions, or injuries if authorized for the following services:

- *Residential Habilitation*
- *Independent Habilitation*
- *In-Home Supports*
- *Respite*

There must be a need for direct support in a hospital setting, direct support must meet the needs of the person that are not met through the provision of hospital services, and do not substitute for services that the hospital is obligated to provide under Federal or State law, or under another applicable requirement.

c. Emergency contact numbers:

- List the emergency contacts – Name and Number
  - Also include emergency contact information for the provider agency.
- Team will review emergency contact information to ensure information is up to date
- The DDPM will review the information in the Involved Individuals section in View Details on the State side to ensure the information is up to date.

DDPM final review and discussion

DD authorized services received to be placed in the ISP

a. Anticipated change in residence, services, supports, provider:

- Indicate any anticipated changes in services within the next year.
- **Document the person's choice in setting for where they live, work, and/or attend day supports**.
- Summarize the options that were available, considered, and visited by the person.
- Document the discussion with person and/or legal decision maker regarding ongoing options and their **right to make changes at any time**.
- If the place to live, work, and/or receive day supports was not chosen by the person, highlight the reasons, circumstances, or barriers that may have contributed and future steps in place to address the person's preferences.
    - If the person has a legal guardian who makes the decision regarding service settings, this should be noted.
- If a child is placed out of the home into a DD licensed service (ECF/IID, FCO, Residential Habilitation), document the discussion/review of need, lease restrictive alternatives, and appropriateness of the out of home placement.

b. Authorizations to disclose information:

- Review the current Authorization to Disclosure/Release of Information forms and have them signed and dated.

c. Signature and Consent Forms:

- Review the ISP including the Rights Statements at the top and obtain signatures from the person and/or legal decision maker and provider representatives.

d. Self-Directed services through traditional waiver, DDPM will bring up if individual qualifies:

- Review or address any Self-Directed Services, including the purpose and how the person controls the aspects of the service (equipment, supplies, environmental modifications that the person has or is eligible for and may benefit from).

e. Review of timelines for approvals:

- List date the written OSP is to be submitted to the DDPM
- List date the plan must be approved by the DDPM (Approval Date)
- Document if the plan was not submitted within the required timelines, reasons for the delay and/or contacts made.

Comments:

- Describe any additional follow-up required including planned OSP team reviews OSP updates or change of annual OSP schedule etc.
- **16-21-year-old non-school days:**
    - If the team determines that additional hours are needed for non-school days for a person who is 16-21 years old, the DDPM will document here that these additional hours are needed to account for these non-school days, that the person is in school, and eligible for IDEA.
- **School aged individuals ages 18-21:**
    - If a person will be graduating early and enters any DD authorized Day or Employment services prior to age 21, the DDPM must verify and document that a person has met their education requirements, no longer qualifies, or are not eligible for VR services.
- **SIS/ICAP/Outlier:**
    - Document any relevant team discussion regarding SIS/ICAP hours, staffing supports, decision to submit to an outlier, etc.

OSP Participants/Attendees

Participants

NAME	TITLE	ORGANIZATION
	Program Coordinator – **Internal Monitor of Services and Plan**	
	DDPM – **In-Depth Monitor of Services & Plan**	

Absent OSP Review Team Members

NAME	TITLE	ORGANIZATION

- Identify OSP Team Members that **were in attendance and those that were absent**.
- The people or entity responsible for monitoring the plan must be identified. Verbiage will be added after the title of the Program Coordinator and DDPM.

  The verbiage provided below is to be consistently used among providers and regional HSC.

  - **Program Coordinator- internal monitor of services & plan**
  - **DDPM- in-depth monitor of services & plan**
- Meeting participants are updated in the OSP document anytime there is a team meeting.

Attachments

Attachment	Title of Attachment	Date of Upload	Uploaded by
Current RMAP in PDF format			
Behavior Support Plan, if applicable			
Medical protocols			
OSP Signature page			
Self-assessment in PDF format			
Environmental Scan checklist			
Assessment Results Form if applicable			
All ISPs associated with the plan period			
SFN 1800 Employment Readiness Assessment, if applicable			
EHHC: Nursing Plan of Care, nursing assessment, physician order for Home Health Care/Skilled Nursing Care			
Virtual Support Checklist SFN 1522, if applicable			

Waiver & Level of Care Check

Is this individual receiving services though the Traditional DD HCBS waiver, and screened for the ICF/IID HCBS Level of Care?

- The DDPM will check:
  - "Yes" if the person is receiving waiver services
  - "No" if the person is receiving ICF/IID services

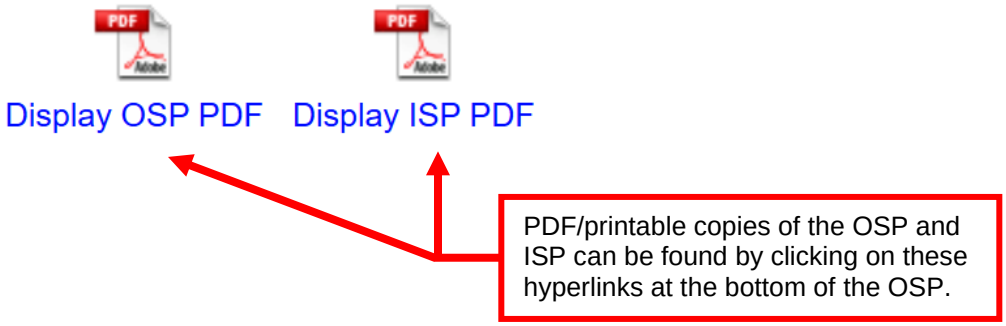
Acknowledgement

Any Active OSP existing in the system for this Individual will be discontinued once this Approved OSP is Activated by the system.

☐ By approving this document, I acknowledge that identified risks have been addressed in the plan.

☐ By approving this plan, I acknowledge that all checklist items have been discussed.

- "By approving this document, I acknowledge that identified risks have been addressed in the plan."
  - The DDPM, as a representative of the state Medicaid agency, checks this box to indicate for a waiver assurance that the identified risks in the RMAP are addressed and mitigated throughout the plan.
  - By checking this box, the DDPM is acknowledging they have read the RMAP and PCSP, and to the best of their knowledge risks have been addressed, especially the priority risks.
- "By approving this plan, I acknowledge that all checklist items have been discussed."
  - The DDPM, as a representative of the state Medicaid agency checks this box to indicate for a waiver assurance that all required plan components have been discussed and reflected in the plan.



OSP Form Buttons

- **Save** – The user must "Save" the draft OSP so that it is in Draft status. Once saved, the DDPM who has access can search to find the Draft OSP.
    - Once the OSP is "saved" and in Draft status, the OSP Type and Primary Provider fields are no longer editable.
- **Send to Provider** – Once the OSP type, primary provider and the ISP section has been completed, the DDPM will select the "send to provider" button. Once the OSP is sent to the Linked provider, the status changes to Pending for Provider Input and under the OSP section it shows a count.
- **Approve** – Once the Program Coordinator of the primary linked provider has completed the written OSP and submitted it to the DDPM (oversight provider) for approval, the Approve link section will show a count. The DDPM user will "Approve" the OSP once it is determined all criteria are met.
    - Once the OSP is APPROVED by the DDPM oversight agency, the Primary provider can review the approved OSP. The secondary provider cannot see the OSP until it becomes Active.
- **Delete** - Only the state Oversight user- DDPM or RDDPA has the ability to "Delete" a Pending OSP.

- **Copy** – OSPs can be copied so that relevant information does not need to be re-entered by the user. This is used to initiate a new OSP.
    - If copying the OSP to create an OSP Update, changes to the OSP should be summarized in the "Reason" box at the top of the OSP and should be reflected throughout the OSP in their applicable section(s).
- **Update** – This button is used to add/remove attachments. Add/remove the attachments, then click update to save the changes.
- **Discontinue** – This button is only available for DDPMs. Please see the OSP instructions for detailed instructions.

References

- *Overall Service Plan Instructions:*
    - ND Developmental Disabilities Section- Overall Service Plan Instructions
- *Risk Management (RMAP) Instructions:*
    - 15.3.a. Risk Assessment Instructions.pdf
- *HRC/BSC Provider Toolkit:*
    - hrc-bsc-guidebook.pdf (nd.gov)
- *Person-Centered Approach to Risk Toolkit:*
    - Person-Centered Approach to Risk Toolkit.pdf (nd.gov)
- *Person-Centered Approach to Risk Quick Guide:*
    - Person-Centered Approach to Risk Quick Reference.pdf