

Person-Centered Support Plan

Instruction Manual

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Person-Centered Support Plan Instructions

Introduction to the Person-Centered Support Plan

The Agency for Persons with Disabilities (APD) is excited implement a new format for the Support Plan. This support plan was developed with feedback from Waiver Support Coordinators (WSCs), self-advocates, and other stakeholders. This form will be an effective format for WSCs to engage in person-centered conversations with the individuals they serve.

The support plan is a written tool that contains information provided by the individual and those that know them best regarding his or her goals for the future and needs for support to achieve those goals. The Support Plan is the guiding document from which services are authorized and provided.

The role of the WSC in the support planning process is to help the individual identify key information about him or herself and to develop a vision for their future, while coordinating resources and supports to make the vision a reality. A completed support plan is the result of the collaborative efforts of people chosen by the individual. It identifies informed choices made by the individual and provides mechanisms to implement actions that identify:

- Where the individual wants to live and with whom
- Employment and the opportunity to earn competitive wages
- How to be involved in their community
- What personal goals, accomplishments, or experiences they would like to achieve
- How to meet health, behavioral, medical, or environmental needs

The Support Plan form is intended to guide the conversation between the WSC, the individual, and those involved in the support planning process.

Compliance with State and Federal Requirements

The federal Centers for Medicare and Medicaid Services (CMS) authorizes the iBudget Home and Community-Based Waiver Services (HCBS) Waiver program under 1915c of the Social Security Act. It also provides rules and requirements for waivers to operate. In general, regulation require that every individual on the iBudget waiver have a current and approved support plan.

CMS published the final home and community-based services (HCBS) regulations (known as the “Final Rule”) on January 16, 2014 and it became effective March 17, 2014. Recent federal rules were designed to enhance the quality of HCBS services by establishing a more outcome-oriented definition of the services that is based on the nature and quality of the individual’s experience. CMS identified additional protections to group home residents and ensure full access to the benefits of community living.

Federal rules require that that service planning for participants in Medicaid HCBS programs must be developed through a person-centered planning process that addresses health, long-term services, and support needs in a manner that reflects individual preferences and goals. The federal rule includes six standards that all home and community-based services must meet:

Six standards of HCBS:

- 1) integration into the community;
- 2) individual choice;
- 3) individual rights;
- 4) autonomy;
- 5) choice regarding services and providers; and
- 6) person-centered planning.

WSCs can read this rule online at the following link: <https://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf>

Overview of Person-Centered Planning

Person-Centered Planning refers to a way of coordinating services that places the individual at the center of their support planning process. It differs from a traditional *medical* model that relies on assessments or input from “professionals” to describe the individual’s problems and what needs done to “fix” those problems.

Person-Centered Planning starts with the individual’s preferences and goals and includes input from assessments performed by professional to help plan for needed services and supports. Person-Centered Planning assists in identifying what is important to the individual whereas assessments identify what is important for the individual. For example, being able to choose their morning routine or having access to a park may be important to the individual, whereas taking a needed medication is important for the individual.

Characteristics of person-centered planning:

1. The individual is present at the meeting and chooses the time, location, and who will participate in the meeting with them (such as family, a guardian, staff)
2. The individual directs the process – they may facilitate their own meeting or choose someone else; they are in control of what is decided and the direction for their life
3. Is more of a conversation with the individual rather than professionals talking about all the things that need to be done for the individual
4. Focuses on the positive aspects of a person's life - what CAN be - rather than just a discussion of past problems or failures
5. The goals written in the support plan are based on what is important to the individual, not those serving them
6. Almost all Person-Centered Plans involve the creation of a drawing or other visual image intended to involve the person and others in the process and shows important aspects of their life, dreams, goals for the future, and how to help the person advocate for themselves and how to make progress toward goals.

Person-Centered Planning Methods

There are various methods and the WSC can use to facilitate a person-centered meeting with the permission of the individual. These might include, but are not limited to:

- Using charts paper or white boards to record ideas and use as a visual aid for communication
- PATH (Planning Alternative Tomorrows with Hope), which uses a graphic process for individuals to share future dreams, set targets, and move forward.
- MAP (Making Action Plans) focuses on the individual’s story.
- Creating picture boards to help consumers to communicate their choices

- Other person-centered thinking tools, such as forms and worksheets

The person-centered planning process is more than just filling out a form, but a process of getting a complete picture of the person's life, what they want for their future, and how they can get there. Person-centered planning is not a one-time event but should continue ongoing as the person's preferences, needs, and goals change.

Information can be gathered at various times and in many ways through discussions by phone or face-to-face, or by gathering information in writing. Ultimately, the WSC should ensure that the support plan process is based on a method that is convenient and desirable for the individual and meets the standards of the person-centered planning process as defined in the CMS rule 42 CFR 441.301(c)(1). These standards are as follows:

- Includes people chosen by the individual.
 - Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions and assisted where needed to make these choices.
 - Is timely and occurs at times and locations of convenience to the individual.
 - Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner, that is accessible to individuals with disabilities and persons who are limited English proficient
 - Includes strategies for solving conflict or disagreement within the process, including clear conflict-of interest guidelines for all planning participants.
 - Offers informed choices to the individual regarding the services and supports they receive and from whom.
 - Includes a method for the individual to request updates to the plan as needed.
- Records the alternative home and community-based settings that were considered by the individual.”

Person Centered Planning Resources:

The following websites offer helpful information, training videos, presentations, and free Person-Centered Planning tools:

- inclusive-solutions.com
- helenandassociates.co.uk
- pcp.sonoranucedd.fcm.arizona.edu

The Roles of the Support Plan Team Members

The Individual

The support plan process is focused on the individual. With support planning, the individual must be provided the opportunity direct the process to the maximum extent possible. This direction includes, but is not limited to:

- Choosing who they would like to participate in the planning process and who is invited to the meeting.
- Participating in the support planning meeting in a way that they choose.
- Communicating their desires, hopes, and dreams for their future, including what is working now in their life, what is not working, and what they would like to see different. This can happen anytime during the year.
- Signing the support plan to indicate agreement. If there are areas of disagreement within the plan, he/she conveys those concerns to the team.
- Requesting changes and approves changes or revisions to the support plan throughout the year as desired or needed.
- Communicating any concerns or feedback with the WSC throughout the year. If disagreements are not resolved, he/she may request that they are noted on the support plan before signing it.

Legal Representatives, Family, and Friends

Legal representatives must be involved in the support planning process. The individual may choose to invite other family and friends to participate.

42 CFR 441.301 states: “the individual’s representative should have a participatory role, as needed and defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual’s representative.”

The individual may choose to have others participate in the planning process, however, a designated guardian or legal representative must be included. Participation may include:

- Contributes to the person-centered information based on their own intimate knowledge of the individual.
- Helps to identify and address known risks.
- Assists the individual to plan for their future and provide support if requested.
- Reviews and approves the plan and other documents by signing the support plan.

- Shares any concerns or disagreements during the planning process with the WSC.
- Reviews and approves changes to the support plan throughout the year if needed.
- Shares any concerns or feedback with the WSC throughout the year.

Waiver Support Coordinator (WSC)

WSCs are key in facilitating person-centered planning and helping the individual achieve their desired outcomes. A WSC:

- Engages in an on-going conversation with the individual regarding what they want for their future and assists them to make changes to the support plan as necessary, documenting in the support plan when changes occur.
- Facilitates and completes the development of the support plan.
- Conducts a person-centered planning process that considers all supports that can be available to the person, whether waiver funded, funded by other sources, or by natural supports such volunteers.
- Ensures that the plan meets the person's current service needs and complies with requirements for the chosen service setting(s) and associated funding.
- Signs the support plan.
- Provides to the individual, the legal representative, or both, via secure e-mail, U.S. mail, or hand-delivered, a copy of the to the support plan, along with the APD approved cost plan.
- Documents in the progress notes the date and method by which the support plan was provided to the recipient or legal representative.
- Files a copy of the support plan and cost plan signature pages in the recipient's central record.
- Monitors service provision, progress on goals, and the person's satisfaction with their services and providers.
- Address and resolve issues identified by meeting with the recipient and pertinent providers.
- Assists the individual in communicating with providers to help the individual achieve their desired goals and outcomes.

Service Providers (paid and non-paid)

Providers are important to person-centered planning because they carry out services to help the individual achieve their goals. Providers often know the individual well and have regular contact with the individual. A provider:

- Assists the person to participate in the planning process as fully as possible.
- Contributes to the planning process as requested by the individual.

- Gathers information and shares it with the WSC prior to the meeting.
- Helps identify serious risks by providing medical or other historical information.
- Communicates with the WSC or other team members if the person's desired outcomes or support needs must be readdressed or updated.
- Carries out activities that assist the individual in achieving their goals.

Getting Ready for the Support Plan Meeting

WSC's should begin planning at least 60-90 days prior to the expiration of the current support plan. This will allow enough time for the "team" of supports to plan to attend and for the WSC to gather all the necessary information. The person (or their representative) chooses the time, day, the topics to discuss, and who can contribute to the planning process as well as who is invited to the actual meeting.

Prior to the formal support plan meeting, the WSC should conduct pre-support planning activities to gather information to facilitate the process:

- Talk to the individual and others involved in the individual's life, with their permission. Have the individual start thinking of personal goals, needs, and services prior to the meeting.
- Visit the person at home or spend time with them at other locations of the person's choice to gather the information. Review written documentation, including clinical reports, evaluations, their current QSI, and provider documentation from service providers.

Keys to successful support planning:

- Gather information in a way that respects the individual, their family, and what they desire to communicate. They may choose to not answer some of the questions.
- Everyone communicates, but in different ways. Find out how the individual communicates and assist them to be fully heard. This may require finding others who know the person to help in the process.
- Bring resources to help the individual express their desires and choices – communication devices, markers/pens, and paper, communication charts, and a willingness to 'listen' to their body language, gestures, sounds, and even silence.
- If the individual speaks another language or they use sign, schedule an interpreter.

Some resources include:

interpreterresource.com

languageline.com

fadcentral.org/interpreting-services

Support Plan Submission Timelines

Upon an initial enrollment to the waiver and then on an annual and on-going basis, the WSC will follow established time frames and guidelines for submitting the support plan to APD, the Individual, and all other participants in the support planning meeting.

Initial Support Plans

- For newly enrolled individuals or those new to a WSC caseload, the WSC must complete the support plan within 45 days of the person's selection of the WSC.
- For individuals enrolled onto the waiver due to a crisis, the updated support plan must be completed within 30 consecutive calendar days.
- Updates to the plan must be submitted as soon as additional information becomes available.

Annual Support Plan

- All individuals enrolled on the iBudget waiver must have a support plan meeting on a yearly basis and a new support plan that reflects the decisions made in that support plan meeting.
- Once completed, the WSC must provide copies of the support plan to the individual or legal representative within ten consecutive calendar days, and to providers within 30 calendar days of the effective date.

Support Plan Update

- The WSC works with the individual to revise their support plan as necessary.
- The support plan must be kept current always.
- If the desired change is related to a change in the individual's needs or circumstances, the WSC should notify the Region so determine a new Questionnaire for Situational Information (QSI) is appropriate.
- The WSC must provide a copy of the updated support plan within 10 consecutive calendar days of the effective date of the support plan.
- The WSC should follow up timely on any service needs and referrals that result from an updated support plan.

New Support Plan Features

The Person-Centered Support Plan will be part of the APD iConnect system. Prior to implementation of the iConnect system, WSCs will use the Word Document version. Some of the automation features of the word document, are described in this manual.

Funding Source	
Choose an item.	
Medicaid	
Public School	
Natural Supports	
Vocational Rehabilitation	
Medicare	
Private Insurance	doctor, Service F
Private Funds	
Other (list funding source)	

Drop-down menus

The Support Plan form has fillable sections as well as pre-populated drop-down menus to make filling it out as quick and easy as possible. When choosing the “other” option, the WSC will be prompted to type in a specific answer in the grey box below.

Fillable Sections

In most sections, the information necessary to capture an individual’s unique needs and goals require information that cannot be prepopulated. The Support Plan is designed so that information can be typed in directly and will expand if more space is required.

My Life ⓘ

My current day-to-day life: (This is a “day in the life” description of me: where I live, if alone or with others, my daily routines ⓘ, services received during the day and/or night. List the housing information ⓘ I was provided and where I choose to live in the future)
Thomas said, “I like living in my own home without roommates. I love exercise, sports, and want to be outside whenever I can. I need help managing my money and doing my house chores.” He works 3 days per week at a local landscape company. On his days off, he says that he works in his own yard and goes to the gym. Thomas said, “I visit with my grandparents on the weekends who live near me. I walk to their house.” Thomas owns his own home and stated, “I am staying put here.”

Additional information/instructions

My Life ⓘ

My current day-to-day life: (This is : services received during the day and

To provide additional information on how to develop the support plan, there are several areas on the plan where further instruction and examples are embedded within the template. These areas are designated by a ⓘ and can be viewed by placing your cursor over the header or icon.

Identifying Information About the Individual and Their Supports

About Me

This section records demographic information that the circle of supports will need to better serve the individual such as: Where they live, if they go by a nickname, the best way to contact them, their legal status, etc.

Review this section at each annual support plan meeting to make sure that the information is current and reflects what the individual desires.

My Legal Representatives(s)

Legal representatives include an individual's parent (for a minor), guardian, guardian advocate, a designated person holding a power of attorney for decisions regarding health care or public benefits, designated attorney or a healthcare surrogate, or in the absence of any of the above, a medical proxy as determined under Section 765.401, F.S. The individual's WSC is required to verify whether an individual has any of these representatives and inform the agency of the identity and contact information. When a legal representative is established, they must be included in the support planning process.

Refer to medical powers of attorney, healthcare surrogate, guardianship or guardian advocacy papers, and court orders to ensure accurate reporting of legal representative information. The WSC must maintain these documents are kept in the individual's central record.

If the individual has more than one established legal representative, create an additional section by clicking the triangle.

My Legal Representative(s)			
#1			
Last Name	First Name	Guardian/Legal Representative Type	
Relationship		Other	
Address	City	State	Zip
Day Phone	Night Phone	Cell Phone	
Email Address			
To include a second legal representative, click the ► below:			

WSC's are required to maintain this information in the agency's data systems regularly and must be reviewed at least annually.

My Waiver Support Coordinator

Be sure to include current contact information and ensure that the information in the iBudget system matches what is entered here.

My Family, Friends, and Support System

Social connections are an important part in the quality of life for everyone. Identify who is most important to the person. This does not include paid supports that would not be in the person's life if that paid relationship is discontinued.

Consider the following for this section:

- Who is the primary caregiver?
- Who is close to the person?
- Who would the person want to inform if they have an emergency or are upset?
- With whom would the person want to celebrate accomplishments?

Other People Who Support Me or Work for Me

List any additional people, paid or unpaid, who provide support to the person not already listed in My Family, Friends, and Support System. Supports listed here may receive payment through the waiver or other funding source. This may also include the CDC+ Representative.

Other Funding Sources for Supports

Identify any non-waiver funding sources that address critical support needs. List the need or specific support that they provide and then indicate from the drop-menu, the funding source.

Examples:

- Medicare
- Medicaid State Plan Services
- Job Coaching
- Division of Blind Services
- Churches
- Non-profit organizations
- Local school district services
- Vocational Rehabilitation

People Who Can Provide Information for My Support Plan

The individual has the right to choose who will be a part of their support planning process. Identify people chosen by the individual to provide information or help in any other way, and whether or not they are invited to the support plan meeting. If service providers are not attending the meeting, the WSC must be sure to get from them any important information and annual reports to show what services they provided and what progress was made this past year.

When an individual has a legal representative, they must always be involved in the support planning process.

My Life

The following sections contain person-centered information and provides a “snapshot” into the individual’s life. If first person statements are included, they should be indicated with quotations.

My current day-to-day life

Describe the person’s life. Identify where they live and if they live with others. If the person lives in a licensed facility or supported living, identify if they have their own room or if they share a room. Does the person attend school, work, or another day or evening activity on a regular basis? Do they receive other services or natural supports during the day? This is not intended to be a schedule to justify a service, but a “day in the life” description of the person.

CFR 441.301 states that the person-centered plan reflect that the “setting in which the individual resides is chosen by the individual”.

Include a description of what information the WSC provided to the individual so that they could make an informed choice regarding where they live. For example, brochures for other group homes or supported living apartments, or taking the individual to see other environments and whether they would like to live there. This section should state what choice the person made for this year regarding where to live and with whom.

My Life ⓘ

My current day-to-day life: (This is a “day in the life” description of me: where I live, if alone or with others, **my daily routines** ⓘ, services received during the day and/or night. List **the housing information** ⓘ I was provided and where I choose to live in the future)

Michael says, “I live in a house with 3 other guys. I have my own room with racecar posters.” Michael says he likes to get up early and help make breakfast. “Pancakes and eggs are my favorite.” On the weekdays, Michael says he goes to work. After work, Michael says, “I like to relax, hang out, play video games, and help make dinner.” Michael says usually he “goes to his room to watch tv until I am tired.” Michael says he visits his brother and other family on the weekends. Michael was provided information on another group homes in Tampa and some supported living apartment options that are closer to his brother. Michael said, “I want to stay where I am living, but I may want an apartment later.”

How I get around in my community

Choose an option from the drop down that identifies how the person gets around in the community on a day to day basis. This relates to how they use transportation the majority of the time, not just with waiver services. If the individual uses more than one form of transportation consistently, use the gray text box to enter other choices.

The screenshot shows a dropdown menu titled "How I get around in my community ⓘ". The menu is open, displaying a list of transportation options. The first option is "Choose an item." followed by a list of choices: "Licensed driver with my own car", "Licensed driver using parent's care", "Family/Friend transit" (highlighted in blue), "Church-provided transit", "School-provided transit", "Public mass transit (bus)", "Non-sponsored community coordinated transportation", "Waiver funded transportation as a discrete service", "Medicaid funded medical transport", "Transportation by provider in the course of service delivery", "Taxi/Uber", "Other hired driver", "Bicycle; Walking", "Mobilizing via wheelchair", and "Other (explain below)". To the right of the dropdown, the text "ces, and skills ⓘ:" is partially visible.

My interests, talents, abilities, preferences, and skills

Identify what the individual considers as their interests, strengths, abilities, preferences, etc. This information should be from their point of view and what is important to them.

My interests, talents, abilities, strengths, preferences, and skills:

Michael said, "I am good at the computer." He said, "I like to cook and I am good at it. My favorite movies are action and I do not like hanging out outside. Racecar driving is my favorite sport to watch." Michael uses some kitchen appliances and he is great at helping around the house. His brother said that Michael is friendly and fun loving.

Other person-centered statements for this section might include:

- Gloria said, "I prefer my own room."
- Louise indicated, "I want to get a job at the mall."
- Gloria is good at singing, acting, and gardening.
- Gloria's Aunt said that Gloria is a wonderful singer.

Things I would like to change

Information here is not just related to services, but the person's life as a whole. Identify issues, concerns, challenges, or changes the person is experiencing or wants to address.

Things I would like to change:

Michael said, "I need to get along better with my roommates."

He stated, "I want to have my shower at night...not in the morning." Michael also said, "I want people to talk to nicer to me and let me choose what chores I do and when I get to go out of the house. I don't want to be rushed."

Other person-centered examples for this section might include:

- Jonathan would like to have his own room due to medical needs at night.
- Louis stated, "I want to change jobs."
- Michael said, "I want start showering at night."
- Thomas's mom indicated that Thomas is sometimes unhappy at his group home and would like to look at other living arrangements.

Things I want to stay the same

What must the individual have on a daily or weekly basis to be happy as defined by them? This can include items, activities, routines, the way people approach them, etc. Other's input can be included as well.

Things I want to stay the same 1:

Michael stated, "I love watching car races and want to watch it on Saturdays on the big screen at my brother's house."

Michael said that he likes to get up early in the morning so that he gets to work 5 minutes early.

Other person-centered examples for this section might include:

- Jane is a Miami Dolphins fan and wants to watch each preseason and regular season game, including the post-game show on Channel 9.
- Jane wants to take a shower every night before she goes to bed.
- Louise said, "I do not want rock and roll, or country music played in my house."

Important aspects from my personal history

The information in this section provides a brief social history about the individual. This includes a summary of the individual's background with relevant facts that paint a picture of the social aspects and key events in the person's life. The social history can be updated once every 5 years, and the WSC must review it with the individual. Consider the following characteristics:

- **Respect:** Use language that is respectful to the individual.
- **Understandable:** Use language that can be easily understood by the individual.
- **Objectivity:** Use language that is descriptive and specific rather than judgmental.
- **Accuracy:** Pay attention to the accuracy of information and document the source. For example, “According to his mother, John was adopted at age 3...” “According to his guardian, Michael was in foster care until age 18 in the state of Washington.”
- **Conciseness:** Be as concise as possible.
- **Clarity and simplicity:** Avoid jargon and use simple language.
- **Relevancy:** Document relevant information to the situation.

Important aspects from my personal history (Medical, Social, Behavioral history)

John was raised by his grandparents until age 9. During this time, he had intermittent grand mal seizures and was in and out of the hospital. John’s grandparents decided that a group home placement would be best for him. In 2001, John graduated with a special diploma and had several part time jobs. He also did volunteer work. He likes working but has not maintained a job for a long period of time due to maladaptive behaviors related to anxiety. John likes to be independent and enjoys making friends outside of his group home on social media. This has led to exploitation in the past as John tends to be too trusting of others and they tried to take advantage of him financially.

Date: 3/15/17

How I communicate and make choices and decisions

Identify how the person makes and communicates their choices and decisions. This should include decisions the person make for themselves and those that they make with support from others.

Consider the following:

- How do I prefer to make choices and decisions? What do I consider?
- Who do I rely on to help me make simple decisions? Major life decisions?
- How do I communicate my likes and dislikes? How does the person express what they want?
- With whom do I share things important to me?
- How do I know others understand me?
- When I tell people what I want, how do they help me get it?
- How are my choices and decisions respected and used to help me?

It is important to ask people, particularly those in licensed facilities and supported living settings, whether there are any unwritten restrictions or “rules”, such as bed time, no access to snacks, scheduled bath times, etc. Find out how the person feels about any rules and restrictions and if they want different options.

How I communicate and make choices and decisions¹:

Michael says he tells people what he wants. “I ask my brother for help, but I make my own decisions.” When Michael is provided written information or needs to write something, he asks his brother for help.

Employment – what are my preferences and plans for employment

Employment is a natural course of adult life and provides the person with a chance to grow financially, contribute to society in a meaningful way and build self-esteem. We must start from the point of view that all individuals, no matter what their abilities can benefit from having the opportunity to work.

Have a conversation about the benefits of working, what resources are available to help them obtain a job or the skills necessary for employment such as Vocational Rehabilitation (VR), and long-term support on the job.

For individuals 18 and older, ask them about their desire to work and discuss how they can achieve their employment goals. If they want a job, what kind? If they have a job, do they want a different job?

Consider the following questions to begin a conversation:

- Have you thought how a job would be a positive in your life?
- What does working/having a job look like to you?
- What are some jobs that you think are interesting?
- What do you need to do to be ready to start working? (learn to fill out an application, get an ID, references, etc.)
- How much money would help you to live the life you want?

Identify paid and unpaid supports that would help the individual succeed in their employment goals.

Examples:

- Vocational Rehabilitation
- Supported Employment
- Volunteering at church
- Non-profits or other community organization to gain skills

Employment

Job I Have	Job I Want	What do I need to succeed in my employment goals?
I have a job (describe job below and if paid at, above, or below minimum wage) Michael works at a movie theater.	"Working with tools"	Job coach and assist with applications, updating resume, and improving interviewing skills

Indicate whether the person has tried to access services through VR in the past and what the outcome was. If they have not been referred to VR, this should be done. The WSC should help the person apply if needed and assist them to meet with the VR counselor to advocate on their behalf.

Have I tried to access services from Vocational Rehabilitation?	Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
What was the outcome? (identify the outcome of VR referrals, if any)	Louise applied for VR services 8 years ago, but did not end up getting services. WSC will assist in new VR Referral.

Other Services Needed for Health and Safety

Per 42 CFR 441.301, the support plan must “Reflect clinical and support needs as identified through an assessment of functional need.” The plan must “reflect risk factors and measures in place to minimize them, including individualized back-up plan and strategies when needed.”

The QSI is the agency’s assessment tool to identify needs and potential health and safety risks. Other supports should also be consulted: day program, residential staff, or family.

Significant risks are needs that, if not addressed, could result in institutionalization, medical attention, legal action, or place the person or others in danger.

Review the individual’s current QSI Comprehensive report and:

1. Mark all areas where the person has significant needs.
2. In the space provided, include a brief but specific description of the need or risk and how it is addressed.
3. Identify the service or support that is responsible to address the need.
4. Indicate the funding source for that service. If more than one service/support addresses the need, include those as well.

Gloria’s scenario:

Gloria is an accomplished gardener and is passionate about growing fruits and vegetables. Gloria is 43 and lives by herself. She has been generous in sharing the food she grows with others. Gloria is not able to walk or transfer on her own. She needs physical assistance to complete her personal hygiene tasks and she will sometimes aspirate on liquids. Notice how the risks were identified and there is a plan that includes measures to address risks across different settings.

Identified Need/Risk Area	Specific issue and measures in place to address/minimize risk	Service/Support	Source of Support
Functional (Choose all that apply)			
<input type="checkbox"/> Vision			Choose an item.
<input type="checkbox"/> Hearing			Choose an item.
<input checked="" type="checkbox"/> Eating	Requires total assist to eat, chokes on liquids. She has a dietary order for Thick-it. When visiting family and friends on the weekend, ensure that Thick-it is packed and available.	Personal Supports Dietician Services	iBudget Waiver Natural Supports
<input checked="" type="checkbox"/> Ambulation	Requires total assist with a manual wheel chair. Has a backup plan for Personal Supports.	Personal Supports	iBudget Waiver Natural Supports
<input checked="" type="checkbox"/> Transfers	Requires two staff to transfer or a lift. Has a backup plan for Personal Supports and funding to fix lift if needed.	Personal Supports	iBudget Waiver Natural Supports
<input type="checkbox"/> Toileting			Choose an item.
<input checked="" type="checkbox"/> Hygiene	Requires total assist for hygiene. There is a backup plan for personal supports. Due to choking of liquids, provide accommodations with toothbrushing.	Personal Supports	iBudget Waiver Natural Supports
<input type="checkbox"/> Dressing			Choose an item.
<input type="checkbox"/> Communications			Choose an item.
<input checked="" type="checkbox"/> Self-protection	Could not evacuate in case of emergency. Has a backup plan. Ensure plan in place during visits at home.	Personal Supports	iBudget Waiver Natural Supports
<input type="checkbox"/> Ability to Evacuate (Home)			Choose an item.
Behavioral (Choose all that apply)			

Back-up Plans for My Critical Needs/Risks

A back-up plan is a set of actions or additional supports that are agreed to ahead of time to keep the individual safe and healthy. The back-up plan is used when the individual's critical providers are either temporarily or permanently unavailable. A strong back-up plan uses those who are in the person's current circle of supports or are available community resources.

Gloria's Scenario:

The primary service/supports for Gloria is Personal Supports. The back-up plan in case her Personal Support staff is not available is that her Aunt Susie will help. The specific strategies are that Gloria has been instructed on how to use her medical alert pendent in

Back-up Plans for My Critical Needs/Risks (in case my primary supports are not available)		
Service/Support	Back-up Plan	Specific Strategies (as needed)
Personal Supports	Aunt Susie will provider care in case personal support does not come to work. Gloria also has a medical alert pendent.	Gloria has been instructed on how to use her medical alert pendent. She also has an assistive device to be able to call 911 or her Aunt in case of an emergency. In case of choking, staff have been trained to address and will call 911.

case of immediate danger. She also knows how to call her Aunt Susie or her WSC to get assistance.

Risk management strategies to consider (to help provide back-up):

- Paid or Unpaid/Natural Supports
- Assistive technology or devices such as medical alerts, communication devices
- Environmental Modifications (grab bars, locked cabinets for chemicals, door alarms)
- Protocols, safety plans, or financial plans
- Instruction/education for the person (what to do in case of...)
- Specific job descriptions/service agreements with paid providers
- WSC monitoring

What I Accomplished Last Year

The information in this section will be used as part of the WSC's annual report as required by Florida Statutes.

The Annual Report is the report of the supports and services received by a recipient throughout the year, a description of progress toward meeting individually determined goals, how their services and supports assisted them to achieve their goals, and any information about significant events in the recipient's life during the previous year.

Accomplishments should be described from the perspective of the person and where appropriate should reference annual reports produced by other support entities such as Behavioral Services, Physical or Occupational Therapies, or Residential Habilitation services. Other's input can also be included such as statements from family and friends.

Important

- Providers must submit their annual report to the WSC 60 days before the support plan's effective date (or 10 months past the effective date of the current support plan)
- The third quarterly summary can serve as the annual report.
- For those providers completing monthly summaries, the ninth monthly summary serves as the annual report.
- Service specific content for annual reports may be found under the respective service.

What I Accomplished Last Year¹

My accomplishments last year:

Michael had many accomplishments this past year. Michael now has a job at a movie theatre. He recently said, "I want to get a different job working with lumber and tools." He also had some conflict at work and lost hours most likely due to the theatre changing their staff schedules. Michael was not able to get tickets to a car race because he did not save enough money. He was able to watch all the races on the "big screen" and invited a co-worker over to watch it and hang out. Michael did not meet his short-term goals related to decreasing aggression at home. He continues to have conflict with one of his housemates, especially when he is stressed and feeling anxious. Michael's Behavior Analyst has been working with him and group home staff to on how to talk to with others and resolve disagreements. Michael has become more independent with personal hygiene and prefers to shower at night. He needs some prompts for hygiene activities, but will complete them independently. Michael still needs reminders to take medications. Michael said, "I had a pretty good year."

Goals I Worked on Last Year

Identify the goals from the previous support plan year and document progress made for the goals.

Goals I worked on last year	Progress on each goal
<ul style="list-style-type: none"> a. Get a paid job. b. Get along better with housemates. c. Go to a car race. d. Get ready on my own for work. e. Take medications without help. 	<ul style="list-style-type: none"> a. Accomplished goal and works at a movie theatre. b. Michael did not meet his short-term goals. Continues to engage in physical aggression when disagreements occur. c. Michael did not save enough money for a ticket this year due to working less hours. d. Michael needs less prompts and reminders to complete hygiene tasks now. e. Michael still needs reminders to take medications, but can take them once reminded.

My Personal and Future Plans

Use this section to document the accomplishments, supports, dreams, hopes, desires, interests, or activities the person would like to see in his/her life in the next few years. This information is from the perspective of the individual based on what is important to them.

The information captured here should be used for annual planning by all providers and is the basis for developing implementation plans as applicable. This is a fluid document and should be updated as desired by the individual throughout the support plan year.

My Personal and Future Plans

What I Want in the Next Few Years: (Supports, accomplishments, dreams, desires, interests, or activities I want in my life in the next few years)

Michael said, "I want to live in my own home close to my brother." He said, "I want to go to a car race." Michael also told his supported employment coach that he would like to change jobs and work at a hardware store with "lumber and tools." Michael also indicated that he would like to take medications on his own without being told when to do it. Michael says, "I want a girlfriend."

Personal Goals

42 CFR 441.301 states that the support plan must "Include individually identified goals and desired outcomes...Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports."

Personal goals are the outcomes that the individual has chosen based on what is important to them. Goals related to their assessed needs, or what is important for them, are necessary, but do not necessarily lead to a meaningful life. A well written support plan will have goals **that strike a balance** between the two, having goals that address both a person's assessed needs and desires at the same time.

Questions to develop clear personal goals

The following questions can be used to guide the person, their family, or guardian in choosing goals that will be meaningful to them:

- What are the most important areas of life you would like to see change?
- What do you want life to be like in the future?
- How do you want to spend your time (during the day, at night, weekends)?
- What do others who know you feel is a priority?
- What would success, progress, or a "positive" outcome look like this year?
- Sometimes an Individual may not know how to describe their skills/strengths, so it can be useful to ask more focused questions such as:
 - Do you enjoy cooking, swimming, being outdoors?
 - Do you like to meet new people? What do you like to do to meet people?
 - What are the things you like to do for fun?
 - What do other people like about you or tell you that you are good at?

Help them to be specific. If they say, I want to make more friends, you could ask, where would be the best place for you to meet friends? Would you like to join a social club or establish friends at school, ADT, or out somewhere like a park?

Goals based on what is important TO the individual:

- I want to get more involved in my community by visiting places I can walk to.
- I want to get a volunteer job at the local library or animal shelter.
- I will continue to grow a garden so that I can have fresh vegetables and be outside.
- I would like to be more physically active and join a soccer or volleyball team, or maybe tennis, hiking, or bicycling.
- I want to increase social skills so that I can make more friends.

Goals based on what is important FOR the individual:

- I need to continue to work on independent personal hygiene skills.
- I need to decrease my yelling and throwing objects at home with my housemates.
- Continue to learn about my medications and how to manage them independently.
- To be healthy and free from respiratory infections.

- I need to learn how to resolve conflict at home and at school.

Once personal goals are identified, help them to decide what service (or support) will help them to achieve each goal. Identify if they are paid or non-paid, and if the support is not paid, include what the relationship is of that person to the individual.

Natural Supports and Community Resources:

Remember to consider natural supports and community resources when developing goals. Natural supports are the services or supports available by family members, friends, other members of a social network, or community agencies, for which no payment for the service or support is required. WSC's are required to work with individuals and their families, other providers and APD staff to identify and develop community-based resources.

It is the WSC's responsibility to first ensure that the same type of service offered through the waiver cannot be accessed through other funding sources, such as:

- Natural and community supports
- Third Party Payer (private insurance)
- Medicare
- Other Medicaid programs (Medicaid State Plan or Medicaid managed care plan)

APD maintains this Resource Directory as an informational service to help individuals with disabilities learn about available resources and organizations in their respective areas. WSCs can search for resources online by topic by visiting:

<http://resourcedirectory.apd.myflorida.com/resourcedirectory/>.

APD also maintains the Florida Navigator. The Florida Navigator is an online tool used to help inform individuals with developmental disabilities, caregivers, and professionals about specific State of Florida services. WSC can access this information by visiting:

<https://navigator.apd.myflorida.com/>.

Personal Goals

The most important things I want to achieve this coming year. Identify goals/desired outcomes and be as specific as possible.	What service will help me?	Paid or Non-Paid. If non-paid, provide name and relationship.
<p>Michael indicated that he would like to work on the following this year:</p> <ul style="list-style-type: none"> a. Getting a new job working with lumber and tools. b. Going to go to a car race c. Increasing ability to do my own self-care and medications d. Getting along with my roommates and learn how to have less problems. e. Meet more friends besides my housemates. Join the local chapter for the racecar fan club and attend monthly meetings. 	<ul style="list-style-type: none"> a. Supported Employment b. Residential habilitation in coordination with his brother c. Residential Habilitation initially. Supported Living Coaching possibly in the future. d. Behavior Therapy. Also attending free <i>Communication Savvy</i> class offered at the local disability resource enter next month. e. Life Skills Development 1 - Companion. 	<ul style="list-style-type: none"> a. Paid b. Paid and non-paid (brother). c. Paid. d. Paid and non-paid (community resource and brother will accompany him). e. Paid.

Personal Rights

This section addresses personal rights that are not related to guardianship. All persons have the right to live their life in a way that is chosen by them and respected by those around them. Examples of rights include:

- Individuals have privacy where they sleep and live
- Individuals are able to lock their doors and only appropriate others have keys
- Individuals have a choice in roommates
- Individuals have the freedom to furnish and decorate
- Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.
- Individuals are able to have visitors of their choosing at any time.
- Where the individual lives is physically accessible

Florida Statutes, Chapter 393.13 requires that services for individuals with developmental disabilities be designed to meet their needs and protect the integrity of their legal and human rights. The *Bill of Rights for Persons with Developmental Disabilities* provides a description of those personal rights. The intent is to guarantee individual dignity, liberty, pursuit of happiness, and protection of the civil and legal rights of persons with developmental disabilities. Review the *Bill of Rights* annually with the individual and their legal representative. The individual's signature on the last page of their support plan will indicate that they understand their personal rights. Indicate if there is a personal right that the individual would like to learn more about. If so, take time to help the individual to understand what this means for them in their life. Additionally, for individuals who live in licensed facilities, the WSC should review the *Resident Rights for Individuals Living in APD Licensed Facilities*. Copies of the *Bill of Rights* and *Resident Rights* can be found in Appendices A and B.

Personal Rights: (not related to guardianship)

Signatures on the last page indicates that the individual and/or their legal representative is aware of the individual's personal rights and the Bill of Rights for Persons with Developmental Disabilities.

Is there a right in which I would like to learn more? Yes No

42 CFR 441.301(c)(4)(vi)(F) states that the support plan must "Document that any modification of the additional conditions, under paragraph (c)(4)(vi)(A) through (D) of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

- a) *Identify a specific and individualized assessed need.*

- b) Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
- c) Document less intrusive methods of meeting the need that have been tried but did not work.
- d) Include a clear description of the condition that is directly proportionate to the specific assessed need.
- e) Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
- f) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- g) Include informed consent of the individual.
- h) Include an assurance that interventions and supports will cause no harm to the individual.”

If the individual has a specific limitation on one of their rights, such as limited access to food (locked cabinet doors or fridge), not being able to lock their bedroom door, etc., **fill out the table (see below):**

1. Explain the specific right being limited
2. The historical reason for the limitation and less intrusive methods were tried prior
3. What is being done to help them obtain their full rights
4. When it will be reviewed for effectiveness and termination

Right Limited	Reason (the assessed need for the restriction and what less intrusive methods were tried but did not work out)	What is being done to help me obtain my full rights?	When will it be reviewed to determine ongoing effectiveness, or to terminate restriction?
Cabinets and refrigerator are locked outside of meal and snack times.	History of PICA, ingesting poisonous items and uncooked foods. Behavior Plan alone has not prevented incidents and 911 has had to be called.	Staff following Behavior Plan, working with Jonathan to communicate using iPad/board. Working with behavior assistant to extinguish behavior.	2/20/18 – LRC will review Behavior Plan and restrictions.

WSC, initial as assurance that the interventions and supports cited above will not be harmful DW

It is the WSC’s role to ensure that the items listed in the federal regulation above (a-h) are addressed in this section and that the interventions and supports described in this section will not be harmful to the individual.

The Safety Plan

The Safety Plan is component of the support plan required only for individuals who have a documented history of engaging in sexual aggression, sexual battery or otherwise

engaged in nonconsensual sexual behavior with another individual, with or without police involvement, that addresses their unique needs and creates safe environments for everyone and facilitates successful community living.

A Safety Plan is a written and agreed upon plan developed in consultation with the behavior analyst that addresses the individual's unique needs and creates safe environments for everyone and facilitates successful community living.

The safety plan should include the following:

- Brief summary of historical behavior and any related criminal charges, court order, probationary or registration requirements;
- Information related to preventing the reoccurrence of offenses;
- Identify preventative measures, including triggers and high risk situations for the individual; and
- Document known predatory grooming behaviors, any limitations on access to media or community outings, any avoidance behaviors requiring training or prompting, level and type of supervision throughout the day, and any need for alarms or monitoring devices.

If the safety plan impacts the individual's rights, the Local Review Committee (LRC) must provide oversight.

My Health

Use this section to document important information about the individual's health. This would include any diagnoses, history of medical complications, surgeries or hospitalizations, and medication trials.

Important Health History about Me

Describe any significant events, diagnoses, or other health information related to the person. Include their current health situation as well. Consider:

- Are they still experiencing any medical concerns?
- Are their new medical concerns that now need to be addressed?

This will assist in anticipating and planning current health supports, as well as needs for preventive health.

My Health

Important health history about me ⓘ :

Gloria has spina bifida and an intellectual disability. She uses a wheelchair for ambulation. She has a history of surgeries to correct contractures and had a spinal fusion at the age of 17. Currently, Gloria is under weight and continues to lack strength in arms in legs to assist with activities of daily living and transfers. Gloria requires close supervision when eating to avoid aspiration. She requires thick-it for all liquids.

Hospitalizations

If the person was hospitalized for any reason during the last 12 months, include specific information about the reason, how long they were in the hospital.

Hospitalizations in the past year Yes No

If yes, why I was hospitalized?

Gloria had pneumonia earlier in the year. She was hospitalized for 2 days and her health has been stable since she returned home. However, she needs to gain weight that she lost as a result of the pneumonia.

My Medication Information

Include all prescriptions, over the counter drugs, as well as homeopathic (natural) remedies current on the date the plan is written.

Over-the-counter drugs could include: pain relievers, cough syrups, cold and flu products, laxatives, vitamins, etc.

Homeopathic remedies could include products purchased at a health food store such as: Melatonin, Saw Palmetto, Black Cohosh, Echinacea, etc.

The dosage and frequency prescribed at the time of the Support Plan meeting should be included, as well as the purpose of the medications and possible side effects or problems. Side effects include any symptoms that the person is experiencing related to the medication.

Allergies

Identify if the individual has allergies. This may include allergies to medications or other environmental factors. If there are special precautions that must be in place (i.e. epi-pen), this must be identified here.

My critical health follow-up areas and preventative health plan:

These are areas defined by a health care practitioner, legal representative, or others involved in the person's life and where their health would be at risk without a plan to address it.

My critical health follow-up areas and preventative health plan¹ : (How will I maintain my Health and Health Stability?)

Gloria's aunt indicated that she lost weight when she had pneumonia earlier this year. She is underweight. Gloria is on a high calorie diet to assist her in returning to her normal weight. She is scheduled for a bone density test next month and follow up with her physician to ensure that she is not experiencing a loss in bone mass.

Health Care Contact Information/ Health Care Decisions Maker

Include in this section all doctors, therapists, or alternative medicine practitioners the person sees. Indicate the last visit and what was the result of that visit, including any follow activities.

Often an individual may have someone designated to act as their decision maker in health-related issues, whether it is formally (as in a health care surrogate), or informally (they've chosen someone such as their parent to help them make health-related decisions).

Identify who this health decision maker is, what their specific role is in relation to the person's health, and current follow up activities that they are committed to carrying out.

My Health Care Contact Information: Include all doctors you see, any therapists, and anyone you have designated to act as your decision maker in health-related issues (health care surrogate)

Name	Date of Last Visit	Findings	Follow Up Activities
Dr. Brown	2/1/17	Health stable	None- Continue Annual Checkups
Dr. Smith	1/15/17	Removed mole	Recheck moles on arm for changes in 6 months

Health Care Decision Maker Name	Role	Follow Up Activities
Joshua Johns	Father and Legal Guardian	Contact for information on any medical appointments or needs.

Equipment and Supplies

Indicate in this section if the individual is currently using or is in need of any specialized equipment or adaptations to their home.

List any adaptive or specialized equipment such as a Hoyer lift, transfer boards or gait belts, communication devices, glasses, hearing aids, or grab bars in the home.

List all consumable supplies that the person requires such as briefs, wipes, gauze pads, etc. This should include both those available through the waiver and those covered by other resources such as Medicaid State Plan.

Equipment and Supplies

Do I use any adaptive equipment, special equipment, glasses, hearing aids or need any adaptations made to my home?

Yes No If yes, please list below.

Wheelchair. Power wheel chair (needs fixed). Transfer board. Adaptive utensils. Need a ramp for the backyard.

Do I need any consumable supplies? Yes No If yes, please list below.

Briefs, wipes.

Personal Disaster Plan

Identify whether the individual has a Personal Disaster Plan and the date it was completed or updated. A Personal Disaster Plan format is available on the APD website and should be completed annually. Please visit <http://apd.myflorida.com/waiver/support-coordination/>.

Signature Page

The WSC must obtain the signature of the individual or legal representative on the worksheet during the support plan meeting. Their signature will document the individual has chosen to receive home and community services and the decisions made in the support plan, including any restriction on their rights, implementing a safety plan, or health care plan.

If the legal representative participates by telephone in the support plan meeting, the signature must be obtained within 10 calendar days. Electronic signatures are also acceptable.

Once completed, the plan must contain signatures of the individual, legal representative, and others invited by the recipient who participated in the support plan meeting.

Appendix A – Bill of Rights for Persons with Developmental Disabilities

Appendix A

Bill of Rights for Persons with Developmental Disabilities

- (a) Persons with developmental disabilities shall have a right to dignity, privacy, and humane care, including the right to be free from abuse, including sexual abuse, neglect, and exploitation.
- (b) Persons with developmental disabilities shall have the right to religious freedom and practice. Nothing shall restrict or infringe on a person's right to religious preference and practice.
- (c) Persons with developmental disabilities shall receive services, within available sources, which protect the personal liberty of the individual and which are provided in the least restrictive conditions necessary to achieve the purpose of treatment.
- (d) Persons with developmental disabilities shall have a right to participate in an appropriate program of quality education and training services, within available resources, regardless of chronological age or degree of disability. Such persons may be provided with instruction in sex education, marriage, and family planning.
- (e) Persons with developmental disabilities shall have a right to social interaction and to participate in community activities.
- (f) Persons with developmental disabilities shall have a right to physical exercise and recreational opportunities.
- (g) Persons with developmental disabilities shall have a right to be free from harm, including unnecessary physical, chemical, or mechanical restraint, isolation, excessive medication, abuse, or neglect.
- (h) Persons with developmental disabilities shall have a right to consent to or refuse treatment, subject to the powers of a guardian advocate appointed pursuant to s. 393.12 or a guardian appointed pursuant to chapter 744.
- (i) No otherwise qualified person shall, by reason of having a developmental disability, be excluded from participation in, or be denied the benefits of, or be subject to discrimination under, any program or activity which receives public funds, and all prohibitions set forth under any other statute shall be actionable under this statute.
- (j) No otherwise qualified person shall, by reason of having a developmental disability, be denied the right to vote in public elections.

Appendix B – Resident Rights for Individuals Living in APD Licensed Facilities

Appendix B

Resident Rights for Individuals Living in APD Licensed Facilities

(a) Clients shall have an unrestricted right to communication:

1. Each client is allowed to receive, send, and mail sealed, unopened correspondence. A client's incoming or outgoing correspondence may not be opened, delayed, held, or censored by the facility unless there is reason to believe that it contains items or substances which may be harmful to the client or others, in which case the chief administrator of the facility may direct reasonable examination of such mail and regulate the disposition of such items or substances.

2. Clients in residential facilities shall be afforded reasonable opportunities for telephone communication, to make and receive confidential calls, unless there is reason to believe that the content of the telephone communication may be harmful to the client or others, in which case the chief administrator of the facility may direct reasonable observation and monitoring to the telephone communication.

3. Clients have an unrestricted right to visitation subject to reasonable rules of the facility. However, this provision may not be construed to permit infringement upon other clients' rights to privacy.

(b) Each client has the right to the possession and use of his or her own clothing and personal effects, except in those specific instances where the use of some of these items as reinforcers is essential for training the client as part of an appropriately approved behavioral program. The chief administrator of the facility may take temporary custody of such effects when it is essential to do so for medical or safety reasons. Custody of such personal effects shall be promptly recorded in the client's record, and a receipt for such effects shall be immediately given to the client, if competent, or the client's parent or legal guardian.

1. All money belonging to a client held by the agency shall be held in compliance with s. 402.17(2).

2. All interest on money received and held for the personal use and benefit of a client shall be the property of that client and may not accrue to the general welfare of all clients or be used to defray the cost of residential care. Interest so accrued shall be used or conserved for the personal use or benefit of the individual client as provided in s. 402.17(2).

3. Upon the discharge or death of a client, a final accounting shall be made of all personal effects and money belonging to the client held by the agency. All personal effects and money, including interest, shall be promptly turned over to the client or his or her heirs.

(c) Each client shall receive prompt and appropriate medical treatment and care for physical and mental ailments and for the prevention of any illness or disability. Medical treatment shall be consistent with the accepted standards of medical practice in the community.

1. Medication shall be administered only at the written order of a physician. Medication shall not be used as punishment, for the convenience of staff, as a substitute for implementation of an individual or family support plan or behavior analysis services, or in unnecessary or excessive quantities.

2. Daily notation of medication received by each client in a residential facility shall be kept in the client's record.

3. Periodically, but no less frequently than every 6 months, the drug regimen of each client in a residential facility shall be reviewed by the attending physician or other appropriate monitoring body, consistent with appropriate standards of medical practice. All prescriptions shall have a termination date.

4. When pharmacy services are provided at any residential facility, such services shall be directed or supervised by a professionally competent pharmacist licensed according to the provisions of chapter 465.

5. Pharmacy services shall be delivered in accordance with the provisions of chapter 465.

6. Prior to instituting a plan of experimental medical treatment or carrying out any necessary surgical procedure, express and informed consent shall be obtained from the client, if competent, or the client's parent or legal guardian. Information upon which the client shall make necessary treatment and surgery decisions shall include, but not be limited to:

- a. The nature and consequences of such procedures.
- b. The risks, benefits, and purposes of such procedures.
- c. Alternate procedures available.

7. When the parent or legal guardian of the client is unknown or unlocatable and the physician is unwilling to perform surgery based solely on the client's consent, a court of competent jurisdiction shall hold a hearing to determine the appropriateness of the surgical procedure. The client shall be physically present, unless the client's medical condition precludes such presence, represented by counsel, and provided the right and opportunity to be confronted with, and to cross-examine, all witnesses alleging the appropriateness of such procedure. In such proceedings, the burden of proof by clear and convincing evidence shall be on the party alleging the appropriateness of such procedures. The express and informed consent of a person described in subparagraph 6. may be withdrawn at any time, with or without cause, prior to treatment or surgery.

8. The absence of express and informed consent notwithstanding, a licensed and qualified physician may render emergency medical care or treatment to any client who has been injured or who is suffering from an acute illness, disease, or condition if, within a reasonable degree of medical certainty, delay in initiation of emergency medical care or treatment would endanger the health of the client.

(d) Each client shall have access to individual storage space for his or her private use.

(e) Each client shall be provided with appropriate physical exercise as prescribed in the client's individual or family support plan. Indoor and outdoor facilities and equipment for such physical exercise shall be provided.

(f) Each client shall receive humane discipline.

(g) A client may not be subjected to a treatment program to eliminate problematic or unusual behaviors without first being examined by a physician who in his or her best judgment determines that such behaviors are not organically caused.

1. Treatment programs involving the use of noxious or painful stimuli are prohibited.

2. All alleged violations of this paragraph shall be reported immediately to the chief administrator of the facility and the agency. A thorough investigation of each incident shall be conducted and a written report of the finding and results of the investigation shall be submitted to the chief administrator of the facility and the agency within 24 hours after the occurrence or discovery of the incident.

3. The agency shall adopt by rule a system for the oversight of behavioral programs. The system shall establish guidelines and procedures governing the design, approval, implementation, and monitoring of all behavioral programs involving clients. The system shall ensure statewide and local review by committees of professionals certified as behavior analysts pursuant to s. 393.17. No behavioral program shall be implemented unless reviewed according to the rules established by the agency under this section.

(h) Clients shall have the right to be free from the unnecessary use of restraint or seclusion. Restraints shall be employed only in emergencies or to protect the client or others from imminent injury. Restraints may not be employed as punishment, for the convenience of staff, or as a substitute for a support plan. Restraints shall impose the least possible restrictions consistent with their purpose and shall be removed when the

emergency ends. Restraints shall not cause physical injury to the client and shall be designed to allow the greatest possible comfort.

1. Daily reports on the employment of restraint or seclusion shall be made to the administrator of the facility or program licensed under this chapter, and a monthly compilation of such reports shall be relayed to the agency's local area office. The monthly reports shall summarize all such cases of restraints, the type used, the duration of usage, and the reasons therefor. The area offices shall submit monthly summaries of these reports to the agency's central office.

2. The agency shall adopt by rule standards and procedures relating to the use of restraint and seclusion. Such rules must be consistent with recognized best practices; prohibit inherently dangerous restraint or seclusion procedures; establish limitations on the use and duration of restraint and seclusion; establish measures to ensure the safety of clients and staff during an incident of restraint or seclusion; establish procedures for staff to follow before, during, and after incidents of restraint or seclusion, including individualized plans for the use of restraints or seclusion in emergency situations; establish professional qualifications of and training for staff who may order or be engaged in the use of restraint or seclusion; establish requirements for facility data collection and reporting relating to the use of restraint and seclusion; and establish procedures relating to the documentation of the use of restraint or seclusion in the client's facility or program record. A copy of the rules adopted under this subparagraph shall be given to the client, parent, guardian or guardian advocate, and all staff members of facilities and programs licensed under this chapter and made a part of all staff preservice and inservice training programs.

(i) Each client shall have a central record. The central record shall be established by the agency at the time that an individual is determined eligible for services, shall be maintained by the client's support coordinator, and must contain information pertaining to admission, diagnosis and treatment history, present condition, and such other information as may be required. The central record is the property of the agency.

1. Unless waived by the client, if competent, or the client's parent or legal guardian if the client is incompetent, the client's central record shall be confidential and exempt from the provisions of s. 119.07(1), and no part of it shall be released except:

a. The record may be released to physicians, attorneys, and government agencies having need of the record to aid the client, as designated by the client, if competent, or the client's parent or legal guardian, if the client is incompetent.

b. The record shall be produced in response to a subpoena or released to persons authorized by order of court, excluding matters privileged by other provisions of law.

c. The record or any part thereof may be disclosed to a qualified researcher, a staff member of the facility where the client resides, or an employee of the agency when the administrator of the facility or the director of the agency deems it necessary for the treatment of the client, maintenance of adequate records, compilation of treatment data, or evaluation of programs.

d. Information from the records may be used for statistical and research purposes if the information is abstracted in such a way to protect the identity of individuals.

2. The client, if competent, or the client's parent or legal guardian if the client is incompetent, shall be supplied with a copy of the client's central record upon request.

(j) Each client residing in a residential facility who is eligible to vote in public elections according to the laws of the state has the right to vote. Facilities operators shall arrange the means to exercise the client's right to vote.