

The Support Planning Process

Supplemental Resources

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Defining the Support Planning Process

What is support planning? Support planning is the process of assisting the individual and their family in:

- Identifying their needs, abilities, and preferences,
- Visualizing their future and what they want in their life, and
- Supporting them to access both paid and unpaid resources so that they can achieve their goals and live the best life possible in the community.

Compliance with State and Federal Requirements

The federal Centers for Medicare & Medicaid Services (CMS) authorizes the Home and Community-Based Services (HCBS) waiver program under 1915c of the Social Security Act. It also provides rules and requirements for waivers to operate.

In general, regulation requires that every individual on the APD waiver have a **current and approved person-centered support plan**.

CMS published the final HCBS regulations (known as the “Final Rule”) on January 16, 2014.

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: <https://www.gpo.gov/fdsys/pkg/FR-2014-01-16/pdf/2014-00487.pdf>

Overview of Person-Centered Planning

Person-centered planning is a way of coordinating services that places the individual at the center of their support planning process.

Person-Centered Planning Video:

Learn more about person-centered versus system-centered planning by Beth Mount.

<https://www.youtube.com/watch?v=2REk6fYDZ0Y>

Characteristics of Person-centered Planning:

While there may be some variation regarding the actual practice of person-centered planning, the following are the primary characteristics that should guide the support planning process.

The principles of self-determination are at the center of person-centered planning.

Self-Determination Theory

The following website houses a wealth of information on self-determination such as research, publications, videos, and more.

- <https://selfdeterminationtheory.org/research/>

The individual is present at the meeting and directs the process.

The planning is a conversation with the individual.

Goals address what is important to the individual.

The planning includes a visual image.

Person Centered Planning Resources

The following websites offer helpful information, training videos, presentations, and free person-centered planning tools:

- inclusive-solutions.com
- helensandersonassociates.co.uk
- pcp.sonoranucedd.fcm.arizona.edu
- clearwatercog.org/2017/11/dream-inspired-planning

The Role of the Circle of Support

Supporting the individual is not limited to just the Waiver Support Coordinator. A full “circle of support” is required to effectively assist the individual in the many facets of their life.

Here is a summary of the roles of each member of the circle of supports.

The Individual

The support plan process is focused on the individual. With support planning, the individual must be provided the opportunity to 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 that he or she participated in the support planning meeting
- Requesting changes and approving 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, they may request that they are noted on the support plan before signing it

Family and Friends

The individual may choose to have members of their family or close friends participate in the planning process. While family and friends may not be involved daily, the WSC must not underestimate the importance of their involvement. Family and friends may participate in the following ways:

- Provide information based on their intimate knowledge of the individual
- Identifying strengths and positive attributes; helping to identify and address known risks
- Assist the individual to plan for their future and provide support (if requested)
- Share with the WSC any concerns, disagreements, or feedback during the planning process and throughout the year
- Be a natural support system for the individual and give meaning to his or her life

Legal Representatives

If the individual is under 18 or has a designated legal guardian, the legal representative must be part of the support planning process.

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 legal guardian should be consulted during the support planning processes and encouraged to participate on behalf of the individual in the following ways:

- Contributing to the person-centered information based on their own intimate knowledge of the individual
- Helping to identify and address known risks
- Assisting the individual to plan for their future and provide support
- Reviewing and approving the plan and other documents by signing the support plan
- Sharing any concerns or disagreements during the planning process with the WSC
- Reviewing and approving changes to the support plan throughout the year if needed
- Sharing any concerns or feedback with the WSC throughout the year

Service Providers (paid and unpaid)

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.

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 ongoing conversation with the individual regarding what they want for their future and assists them in making 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 funded by natural supports like 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 or their legal guardian, via secure e-mail, U.S. mail, or hand-delivered, a copy of the support plan and cost plan.
- Documents in the progress notes the date and method by which the support plan was provided to the individual or legal representative.
- Ensures all service providers receive a copy of the approved support plan.
- Files a signed copy of the support plan in the recipient's central record.
- Monitors service provision, progress on goals, and the person's satisfaction with their services and providers.
- Addresses and resolves issues by meeting with the recipient and providers.
- Assists the individual in communicating with providers to help the individual achieve their desired goals and outcomes.

The following is an informative tool that the “many hats” of the Waiver Support Coordinator in the support planning process.

Roles of the Support Coordinator Within the Support Planning Process

A Waiver Support Coordinator (WSC) wears many “hats” throughout the course of the day. This is especially true during the support planning process when the individual, their family, and the rest of the circle of supports must work together and make important decisions. The following is an overview of how the WSC functions in different roles:

1) Listener

Listen first, give advice second! Seek opportunities to understand the individual and their family and encourage them to express their concerns, priorities, needs, and desires. Listen to what and how the person communicates and acknowledge what is being expressed. Some pointers for listening and observing include:

- Observe cultural and personal values that are important to the individual and family.
- Listen for who the person identifies as important to them or already a part of the support network. This could be family, friends, neighbors, or others.
- Listen for and observe interests, needs, and strengths that might link the individual to a wider network of supports and provide key information to know how to best serve him or her.
- Listen to and observe how the person typically approaches solving problems.
- Listen for concerns, hopes, needs, and desires.
- Acknowledge and validate the individual’s concerns, preferences, and choices.

2) Consultant

Provide information and guidance in response to requests made by the individual, his or her family, or others who support them. An important aspect of the WSC’s consultant role is to be a source of information so that individuals can make genuinely informed choices.

3) Resource

WSCs function as a natural resource for individuals, since they have and are aware of connections to the community. Share information about different sources of support, services, and funding that can meet the individual’s needs.

4) Facilitator

Assist the individual and their family in planning, developing, and implementing the support plan. It's up to the WSC to create an environment for meetings that allows opinions and choices to be expressed and respected. The facilitator also creates opportunities for individual to become skilled at obtaining access to available resources and supports.

The WSC as a facilitator:

- Assists the individual in developing a vision for their future.
- Acts as a spokesperson for services that promote community inclusion.
- Looks for ways that people can make a difference in the course of their everyday life.
- Is not hindered by inadequate resources but looks for innovative, creative ways to access resources.
- Does not voice their own opinions or values or try to control situations, but rather creates a climate that encourages the person and their family to make choices and access supports that are most important to them.

5) Mobilizer

Make the individual or family aware of untapped resources and sources of support. An important role of the WSC is to link the individual or family to others that can provide both proven best practices as well as new or alternative ways to meeting their needs. The support coordinator as a mobilizer also identifies existing gaps in resources, supports, and services and contributes to the development of new supports and services.

6) Mediator

Develop cooperation and collaboration between providers, the individual, and family to reach support plan goals and outcomes. The WSC as a mediator takes on the responsibility to clarify and resolve conflicts and to guide others to work in collaboration for the good of the individual.

7) Advocate

Protect the individual's personal preferences, desires, and rights. The WSC as an advocate also works to empower the individual with the skills to advocate for their own needs and rights.

Pre-Support Planning Activities

WSCs should begin planning at least 60-90 days prior to the expiration of the current support plan. Prior to the formal support plan meeting, the WSC should conduct pre-support planning activities to gather information to facilitate the process:

Getting to Know the Individual

The best way to get to know people is to spend time with them. Talk with the individual. Go places with him or her. Pay attention to not just what the person says, but also to what he or she does. This will provide you with a lot of information about the person as an individual. During this time, have the individual start thinking of personal goals, their needs, and potential services for the upcoming year.

In addition, getting to know the individual includes reviewing written documentation, such as clinical reports, evaluations, their current QSI, and provider documentation from service providers.

The Initial Contact

When planning supports for someone new to you, it is especially important to take additional time getting to know them, observing how they make choices and communicate, and what their strengths and challenges are.

Topics to discuss during this initial contact include:

- The reason for the referral for services
- Where the individual lives, with whom they live, their current routines and daily activities, what they like to do, and what is important to them, such as employment and other future goals
- The individual's health history, current status, including medications, risk areas or concerns, and supplies the individual may need to be as healthy as possible
- Waiver and non-waiver support and services to enhance each area of life

As a best practice, be sure to bring information that explains the waiver services such as:

- APD brochures through the regional office
- A quick reference tool that you create yourself
- The APD waiver Handbook.

The following are some helpful guidelines on how to engage with your clients as you get to know them.

Getting to Know the Individual

Conversations from a Person-Centered Perspective

How we communicate says a lot about what we feel and think about the person we're talking to. This is no different when talking to individuals with disabilities. Being aware of how the person is experiencing the conversation will show that you value him or her and believe what he or she says is important to you. Consider the following when getting to know the individual:

Be aware of your meeting space:

- ❖ **Keep the surroundings free from distractions** for yourself and for the individual.

Be aware of how you speak:

- ❖ **Talk at eye level.** Standing over a person can be perceived as aggressive or domineering. If the person you are speaking with is sitting, you should also sit and speak with them face-to-face.
- ❖ **Speak clearly**, emphasize key words, and repeat important statements. You may need to use different words if the listener does not seem to understand.
- ❖ **Speak in concrete terms.** Give examples and demonstrate as needed.
- ❖ **Respect the individual, their family, and what they desire to communicate.** Keep in mind that the person may choose not to answer some of the questions. Everyone communicates, but in different ways.
- ❖ **Check in frequently** to be sure the person understands and take a break when you notice disinterest or fatigue.
- ❖ **Watch out for excessive flattery**, which can seem condescending and insincere.
- ❖ **Do not treat adults like children**, regardless of their "functioning level."
- ❖ **Talk to the person**, not about him or her.

Be aware of how you listen:

- ❖ **Listen with full attention.** Do not interrupt but encourage the person to take the time they need to say fully what they think and feel. For someone whose disability results in a slower speech pattern, give them extra time to communicate their thoughts. Do not seek for someone else to speak on their behalf. Allow members of the support team to speak and listen to their opinions, but always remain person-centered. The person who best conveys wants and needs is the individual you serve!
- ❖ **Give occasional acknowledgements.** Acknowledge the person at the beginning by saying their name. Occasional acknowledgements throughout your conversation show that you are listening and understand.
- ❖ **Don't pretend to understand;** ask for a repeat of what was said if needed.

Support Planning Documentation

APD's process for support planning requires that several documents be filled out and submitted during the initial support planning process and then annually thereafter. The WSC is responsible to coordinate filling them out and knowing when they are due.

Please note that some of these forms may need to be filled out at a time other than during the support planning process depending on your clients' needs.

The following are some of the required documents that must be reviewed and completed during the initial support planning process.

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.

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 therefore. 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 in-service 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.

iBudget Florida HCBS Waiver Eligibility Work Sheet

Name: _____ SS# *: _____	
Region: _____ Support Plan Effective Date: _____	
<p>I. Level of Care Eligibility:</p> <p>The individual is an APD client with a Developmental Disability who meets one of the following criteria and is eligible to receive services provided in an ICF/DD. Check the criteria that are met.</p> <p>Option A. <input type="checkbox"/> The individual's primary disability is Intellectual Disability with an intelligence quotient (IQ) of 59 or less.</p> <p>Option B. <input type="checkbox"/> The individual's primary disability is Intellectual Disability with an intelligence quotient (IQ) of 60 to 69 inclusive and the individual has at least one of the following handicapping conditions OR the individual's primary disability is Intellectual Disability with an intelligence quotient (IQ) of 60 to 69 inclusive and the individual has severe functional limitations in at least three of the major life activities. Please check all handicapping conditions and major life activities that apply.</p> <p>Option C. <input type="checkbox"/> The individual is eligible under the category of Autism, Cerebral Palsy, Down Syndrome, Prader-Willi Syndrome, Spina Bifida, or Phelan-McDermid Syndrome and the individual has severe functional limitations in at least three of the major life activities. Please check all handicapping conditions and major life activities that apply.</p>	
Handicapping Conditions	Major Life Activities
<input type="checkbox"/> Ambulatory Deficits <input type="checkbox"/> Sensory Deficits <input type="checkbox"/> Chronic Health Problems <input type="checkbox"/> Phelan-McDermid Syndrome	<input type="checkbox"/> Behavior Problems <input type="checkbox"/> Autism <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Down Syndrome
<input type="checkbox"/> Epilepsy <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Prader-Willi Syndrome	<input type="checkbox"/> Self Care <input type="checkbox"/> Understanding and Use of Language <input type="checkbox"/> Learning <input type="checkbox"/> Mobility <input type="checkbox"/> Self Direction <input type="checkbox"/> Capacity for Independent Living
<p>II. Medicaid Eligibility:</p> <p>A. <input type="checkbox"/> Individual has a current Medicaid number. Medicaid # _____</p> <p>B. <input type="checkbox"/> Individual was referred for Medicaid eligibility on _____ (MM/DD/YY)</p> <p style="text-align: center;">The result was: Eligible <input type="checkbox"/> Ineligible <input type="checkbox"/> Date of Determination: _____</p>	
<p>III. Eligibility Determination: Check the correct statement:</p> <p>A. <input type="checkbox"/> Individual has met Level of Care Eligibility (I), has a Medicaid number (IIA), and is eligible for waiver services.</p> <p>B. <input type="checkbox"/> Individual has not met the Level of Care Eligibility in I and/or II and, therefore, is not eligible for waiver services.</p> <p>Support Coordinator (Signature): _____ Date: _____</p> <p>Agency: _____</p>	
<p>IV. Choice: Only to be completed at the time of initial Waiver enrollment and every 365 days thereafter. I have received an explanation of home and community-based services.</p> <p style="text-align: center;">(CHOOSE ONE OF THE FOLLOWING)</p> <p>A. <input type="checkbox"/> I have been offered waiver services, and I choose to receive community-based supports and services. I understand that I have a choice of enrolled eligible providers.</p> <p>B. <input type="checkbox"/> I choose to receive institutional services and prefer services to be provided in an institutional setting.</p> <p>Individual (Signature): _____ Date: _____</p> <p>Legal Representative or Witness (Signature): _____ Date: _____</p> <p>Printed Name of Rep. or Witness: _____ Relationship: _____</p>	

* Federal law requires the collection of your social security number as a condition of eligibility for Medicaid benefits under 42 U.S.C. 1320b-7 and the agency will collect, use, and release the number for administrative purposes as authorized under law.

AGENCY FOR PERSONS WITH DISABILITIES (APD) Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. *PLEASE REVIEW IT CAREFULLY.*

Your Information. Your Rights. Our Responsibilities. This notice applies to the information that we have about your health care and services that you receive through APD. APD is required by law to notify you of our legal duties and privacy practices, your rights, and describe the ways we may access, use, and disclose your protected health information. We must maintain the privacy of your health information and follow the terms of this notice.

Your Rights. When it comes to your health information, you have certain rights. You have the right to:

- ***Get a copy of your health records.*** You may review or get a copy of your health records except for psychotherapy notes, information compiled as part of a legal case, or as otherwise excluded by law. APD may impose a reasonable fee for copying, supplying, preparing, and mailing the requested records.
- ***Ask us to correct or change your health information if you believe it is incorrect or incomplete.*** Ask us how to do this. We may say no to your request but we will tell you in writing within 60 days.
- ***Confidential communications.*** If you ask us to contact you in a confidential way (for example, at a certain phone number, email address, or designated mailing address) we may grant reasonable requests.
- ***Ask APD to limit what health information we use or share.*** We do not have to agree if it would affect your care. If we do agree, we will limit the information unless it needs to be shared in an emergency.
- ***Get a list of those with whom APD has shared your health information.*** You can ask, in writing, for a list of the times we have shared your information (“accounting”), who we shared it with, and why it was shared, within the past 6 years, except for when it is used to carry out your treatment, pay for your care, for health care operations, disclosures you asked for, or prohibited by law. You are entitled to one free accounting a year.
- ***Receive a paper copy of this notice.*** You are entitled to a paper copy of this notice.
- ***Choose someone to act for you.*** Your legal guardian or someone with a medical power of attorney for you may exercise make choices about your health information.
- ***You have a right to file a complaint.*** If you feel APD has violated your rights, you may file a complaint with our office or the Secretary of the US Department of Health and Human Services. You will not be retaliated against for filing a complaint.

HIPAA Privacy Official
Office of the General Counsel
Agency for Persons with Disabilities
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Tallahassee, Florida 32399
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Centralized Case Management Operation
US Department of Health and Human Services
200 Independence Avenue, SW—Room 509F HHH Building
Washington, DC 20201
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OCRComplaint@hhs.gov

Your Choices. For certain health information, you can tell us your choice about what we share.

- ***In these cases, you have both the right and the choice to tell us to:*** Share information with your family, close friends, or others involved in the payment for your care. Share information in a disaster relief situation. *If you are unable to tell us your preference—such as if you are unconscious or during an emergency—we may share your information if we believe it is in your best interest. We may also share your information when it is needed to lessen a serious and imminent threat to health or safety.*
- ***In these cases, we will never share your information unless you give us written permission for:*** Marketing purposes or the sale of your information.

Our Uses and Disclosures of Your Protected Health Information. APD is permitted to use or disclose your health information for treatment, payment, and health care operations. If you are an APD Medicaid Waiver applicant or recipient, APD uses your health information to determine your eligibility for the Developmental Disabilities Individual Budgeting Medicaid Waiver program and to determine the amount of assistance that you need for your care. We also use it to manage the Developmental Disabilities Individual Budgeting Medicaid Waiver program. Here are some examples of how we typically access, use, and/or disclose your health information: We share information about your

diagnosis and care needs to determine your initial or ongoing eligibility for the program, as well as to coordinate supported living services and placement in a care facility. We share information to pay for your health care products and services, including federal and state funding programs such as Medicaid. It is used and disclosed to appropriate APD staff members, business associates, volunteers, as well as other government agencies who are involved in your treatment, payment for your care, health care operations and oversight, including those who evaluate the performance of people involved in your care.

How else can we use or share your health information? APD is allowed or required to share your information in other ways without your written authorization—usually in ways that help public health, safety, and research. We have to meet many conditions in the law before we can share your information for these purposes. Examples of other times when we can share your information include:

- We may disclose information to a family member or another person, if necessary, to assist you in an emergency.
- Reporting suspected abuse, neglect, or domestic violence, and preventing or reducing threats to you or another person's health or safety.
- With other state or federal agencies. For example, the US Department of Health and Human Services (HHS), Federal Emergency Management Agency (FEMA), the Centers for Disease Control (CDC), the Florida Agency for Health Care Administration (AHCA), the Florida Department of Children and Families (DCF), the Florida Department of Health (DOH), and other similar agencies.
- To conduct research that benefits persons with developmental disabilities and/or the Medicaid program.
- With organ procurement organizations, a coroner, medical examiner, vital statistics, or funeral director.
- For workers' compensation claims, law enforcement purposes, with health oversight agencies as authorized by law, and for functions such as military, national security, and presidential protection services.
- In response to a court order or administrative order, or in response to a subpoena.
- As required by federal or state law, we must use or disclose your information to the extent it is required by law.

Other Uses and Disclosures. Other uses and disclosures not described in this notice will be made only with your written authorization. If you give us written authorization, you may revoke it at any time.


Our Responsibilities. We are required by law to maintain the privacy and security of your protected health information. We are required to follow the duties and privacy practices described in this notice and give you a copy of it. We are required to let you know promptly if a breach occurs that may have compromised the privacy or security of your health information. We will not use or share your information other than described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time.

Changes to this notice. APD reserves the right to change the terms of this notice; and, the changes apply to all information that we have about you. The new notice will be on our web site and we will mail a copy to you.

Contact Information. If you have any questions, requests, or would like a printed copy of this notice, please contact your APD office in your area at the telephone number listed below. We may ask that you make a request in writing. **Northwest Region** (for Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Okaloosa, Santa Rosa, Wakulla, Walton, and Washington counties) call (850) 487-1992; **Northeast Region** (for Alachua, Baker, Bradford, Clay, Columbia, Dixie, Duval, Flagler, Gilchrist, Hamilton, Lafayette, Levy, Madison, Nassau, Putnam, St. Johns, Suwannee, Taylor, Union, and Volusia counties) call (904) 992-2440; **Central Region** (for Brevard, Citrus, Hardee, Hernando, Highlands, Lake, Marion, Orange, Osceola, Polk, Seminole, and Sumter counties) call (407) 245-0440; **Suncoast Region** (for Charlotte, Collier, DeSoto, Glades, Hendry, Hillsborough, Lee, Manatee, Pasco, Pinellas, and Sarasota counties) call (813) 233-4300; **Southeast Region** (for Broward, Indian River, Martin, Okeechobee, Palm Beach, and Saint Lucie counties) call (561) 837-5564; **Southern Region** (for Dade and Monroe counties) call (305) 349-1478; **Sunland Center** call (850) 482-9210; and **Tacachale Center** call (352) 955-5580

Who receives this Notice of Privacy Practices. APD sends this notice to every recipient household. This notice applies to all consumers served by the Agency. To comply with Section 504 of the Rehabilitation Act of 1973 or the Americans with Disabilities Act of 1990, please contact the HIPAA Privacy Official at the address shown on this Notice if you would like to receive this Notice in an alternate format such as Braille, large print, or audio.

APD OGC HIPAA Form #0000 (Effective date: August 11, 2017)

 agency for persons with disabilities State of Florida	Agency for Persons with Disabilities Consent to Obtain or Release Confidential Information	
Individuals Name:		Date of Birth
<input type="checkbox"/> Permission for Obtaining Record Information. I hereby give my permission and consent to the Agency for Persons with Disabilities or its representative to obtain the specified protected health information on the above named consumer from agencies, individuals and institutions identified below OR <input type="checkbox"/> I hereby request the specified protected health information on the above named consumer be sent to me OR <input type="checkbox"/> Permission for Release of Information. I hereby give my permission for the Agency for Persons with Disabilities or its representative to discuss matters related to my services or goals or to release protected health information to the following person, agency or institution.		
The information requested below will be used/disclosed for the following purposes:		
Medical Reports		Social Service Reports
Academic Records and Plans		Speech and Hearing Reports
Habilitation Plans/Support Plans		Physical Therapy Reports
Psychological Reports		Occupational Therapy Reports
Other (Please specify):		
Name, address, or fax # of individual or agency from whom information is to be obtained:		
Name, address, or fax # of individuals or agencies to whom information is to be provided:		
<ol style="list-style-type: none"> 1. I understand that information may only be re-released with my approval except as required by law. However, I understand that if the receiver of the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. 2. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain services or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization. 3. I understand that I may revoke this authorization in writing at any time by contacting my support coordinator, except when the requested information has already been sent, based on this authorization. 4. I certify that I understand the above statements either personally or through my legal representative. 5. I also understand that this form is valid for no longer than 90 calendar days unless otherwise indicated. I understand that I may specify that it be for a shorter period of time. Expiration date: _____ 		

 Signature of Client or Legal Representative

 Printed Name/Relationship to client

 Date

If this authorization has been signed by a personal representative (above) on behalf of an individual, his/her authority to act on behalf of the individual must be set forth here:

Suggested Personal Disaster Plan

A Plan for WSC's, Persons in the Family Home, Persons in Supported Living, and other Staff and Caregivers
(Can be used for individuals living in licensed residential facilities)

Name: _____ Address: _____
Ph#: _____ Roommate(s): _____
Emergency Contact/Relationship/Ph.# _____
SC/Ph#: _____ SLC/Ph.# _____ Other/Ph.#: _____

This Personal Disaster Plan should be updated annually, or as living situations change.
Most recent update: _____

Copies of Disaster plan to be provided to:

- _____ Consumer
- _____ Support Coordinator
- _____ Supported Living Coach
- _____ Personal Supports Provider
- _____ Other _____

For Tropical Events:

- In the case of a tropical event, always check local news for any evacuation information. To know your local evacuation zone, contact your local County Emergency Management Office: <https://www.floridadisaster.org/counties/>

PLAN A: My Personal Plan to Shelter in Place: My first choice will always be to shelter in my own home unless County Emergency Management mandates evacuation, or the emergency situation makes me feel that I may not be safe if I remain in my home. This is my plan to shelter in place:

- I have the following supplies reserved in my home for emergencies:
- 3-day supply of water (1 gallon/day for each person in my home; water replaced every 6 months)
 - 3-day supply of nonperishable food that requires little/no cooking and little/no water to prepare.
 - Battery-operated radio and extra batteries.
 - Flashlight for each person in the home and extra batteries.
 - First aid kit with bandages, cleansing agent, antiseptic, gloves, sunscreen, over-the-counter meds, etc.
 - Sanitary supplies including toilet paper, hand sanitizer, bleach, personal hygiene items, garbage bags.
 - Duct tape, precut plastic sheeting to cover ducts and all openings in interior room designated for shelter in event of a chemical or biological threat.

Suggested Personal Disaster Plan

A Plan for WSC's, Persons in the Family Home, Persons in Supported Living,
and other Staff and Caregivers

(Can be used for individuals living in licensed residential facilities)

- Other tools/supplies: disposable cups, plates and utensils; multipurpose utility tool; hand held can-opener; whistle; matches/lighter; rain gear; complete change of clean dry clothing; bedding/sleeping bag; charged cell phone and charger; cash; pet supplies; games, books, entertainment supplies.
- I maintain at least a 3-day supply of my prescription medication at all times, in the event of a potential disaster. The contact information of the person who will help me fill my prescriptions to obtain at least a two-week supply is:
Name: _____ Phone: _____
- I have a waterproof container that has copies of my identification, emergency contact information, insurance papers, list/proof of valuables; evacuation communicator, disaster plan, updated medical and prescription information, bank and credit card information, Social Security information and other important documents.
- I am dependent on the following special dietary supplies, durable medical equipment and/or consumable medical supplies:

- I will use the following interior space in my home to shelter in the event of a tornado, chemical or biological threat or similar emergency: _____
- The contact information of the person who helps me to ensure that all the above has been completed, all equipment is in working order, and that all personal information is current on a quarterly basis is:
Name: _____ Phone: _____
- If I need assistance as I shelter in my home, this person(s) will remain with me in my home:
Name: _____ Phone: _____

PLAN B: My Personal Plan When I Must Evacuate My Home: If I must evacuate my home during an emergency or disaster, I am prepared to follow this plan:

- Please see "Go Kit" on page 4.
- Please see "Pets" on page 5.
- I will evacuate to one of these locations if I can evacuate within the area:
 - First Choice
Name: _____ Address: _____
Phone Number: _____
 - Second Choice: If circumstances prevent me from evacuating to my first choice, I will evacuate to
Name: _____ Address: _____
Phone Number: _____

Suggested Personal Disaster Plan

A Plan for WSC's, Persons in the Family Home, Persons in Supported Living,
and other Staff and Caregivers

(Can be used for individuals living in licensed residential facilities)

- I have transportation arranged to get to both my first and second choices for both of my in-area and out-of-area evacuation destinations. The contact information for the person who has committed to assisting me in evacuating is:
Name: _____ Phone: _____
- If I need assistance when I evacuate, this person(s) will remain with me for the duration of my evacuation:
Name: _____ Phone: _____

PLAN C: My Personal Plan If I Must Go to a Shelter or Medical Facility: I understand that shelters operated by County Emergency Management and the Health Department are available but should only be used as a last resort and as a back-up to My Personal Sheltering Plans A and B. Note: Shelters may be crowded, noisy, lack privacy and may be especially challenging for persons with behavioral health needs. However, if circumstances make it necessary for me to go to a shelter or medical facility; this is my plan:

- I have determined what type of shelter or medical facility that I will need to go to (a general population shelter, a special needs shelter, or a medical facility.)
- This person helped me determine where I need to go:
Name: _____ Phone: _____
- Transportation: I have identified how I will get to my designated shelter.
- I will need to use transportation arranged and provided by County Emergency Management and have confirmed this with them.
- I will be transported by this person/company:
Name: _____ Address: _____
Phone Number: _____

General Population Shelter

- I will be able to go to a general population shelter because I do not need the type of care and supervision that is provided in a special needs shelter.
- The name and location of the general population shelter that I will go to is:
Name: _____ Address: _____
Phone Number: _____

Special Needs Shelter

- I will need to go to a **special needs shelter** because I need electricity for life supporting medical equipment, or basic nursing care, or oxygen therapy, or observation/monitoring by a healthcare professional, or assistance with medication and no one to assist me, or a chronic condition that requires assistance from a healthcare professional, or special medical requirements that do not require hospitalization or another special need that cannot be accommodated in a general population shelter. My condition may warrant a caregiver to go with me to a Special Needs Shelter to care for me while I shelter there.

Suggested Personal Disaster Plan

A Plan for WSC's, Persons in the Family Home, Persons in Supported Living,
and other Staff and Caregivers

(Can be used for individuals living in licensed residential facilities)

- I understand that there are eligibility criteria that I must meet to have access to a special needs shelter. I have submitted pre-registration to my County Emergency Management if I need or suspect I may need to shelter in either a special needs shelter or a medical facility or if I need transportation to evacuate to a shelter.
- This person submitted my preregistration on this date:
Name: _____ Phone: _____
Date: ____/____/____
- I received confirmation from my County Emergency Management regarding my pre-registration shelter assignment. Yes _____ or No _____
- The County Emergency Management has assigned the following special needs shelter or medical facility address as follows:
Name: _____ Address: _____
Phone Number: _____
- I will need to use transportation arranged and provided by County Emergency Management and have confirmed this with them.
- I will be transported by this person/company:
Name: _____ Address: _____
Phone Number: _____
- If I evacuate to a special needs shelter, this person(s) will remain with me for the duration of my evacuation:
Name: _____ Phone Number: _____

Medical Facility

- I will need to go to a medical facility because my special medical requirements exceed what can be provided in a special needs shelter. The contact information of the facility is:
Name: _____ Address: _____
Phone: _____

"Go Kit"

- I have an easy-to-carry "Go Kit" prepared that contains or can be readily packed to contain the following supplies that I have reserved in my home and will take with me to the shelter: at least a 7-day supply of meds; items required for special diet; a 3-day supply of water and non-perishable food and snacks; personal hygiene essentials; first aid kit; battery-operated radio and extra batteries; flashlight and extra batteries; cash; cell phone and charger; bedding/sleeping bag; at least one complete change of clean dry clothing; glasses; hearing aids; durable and consumable medical supplies; waterproof container that has copies of all of my important documents; multipurpose utility tool; whistle; matches/lighter; rain gear; games, books, entertainment supplies.
- This person will help make sure my "Go Kit" is readied if I need to go to a shelter:
Name: _____ Phone Number: _____

Suggested Personal Disaster Plan

A Plan for WSC's, Persons in the Family Home, Persons in Supported Living,
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(Can be used for individuals living in licensed residential facilities)

Pets

- I have a plan for my pet(s). My pet will either go to the designated pet shelter in my county or I have arranged for this person/veterinarian to take care of my pet(s) for me:
Name: _____ Address: _____
Phone: _____
- My pet(s)'s supplies and papers will be sent along with my pets.

My Personal Commitment to Disaster Preparedness:

- I understand that I have a personal responsibility for disaster preparedness and I am committed to working in a proactive manner with County Emergency Management and the people who support me to follow my Personal Plan for Disaster Preparedness.
- I have received training and information from this person about my personal responsibility for preparing for all types of disasters including hurricanes, tornadoes, wildfires, earthquakes, floods, chemical and biological spills/ attacks, nuclear power accidents, terrorist attacks, etc. from this person:
Name: _____ Phone Number: _____
- I review/practice/drill on this plan with this person _____ on at least a quarterly basis.
- I will call this person _____ at one of these numbers: _____
or _____ within 2 hours or as soon as possible after an emergency has passed to report on my health/safety status and needs.

Consumer Signature/Date

Support Coordinator Signature/Date

Personal Supports Signature/Date

Personal Supports Signature/Date

Conducting the Support Planning Meeting

Once you've spent time getting to know the individual, talked to others within their circle of support, and reviewed all important documentation, it's time to organize and facilitate the support planning meeting.

Organizing the meeting:

- Contact the individual to find out when they would like to meet and who they want to attend.
- If you do not already know, find out if they would like any special accommodations, such as a specific communication device, a translator, etc.
- Invite all people that the individual has requested to be at the meeting.
- Make sure that all sections of the support plan are filled in to the best of your ability based on previous conversations and document review.
- Come prepared to discuss any concerns, challenges, possible solutions, and things to celebrate.

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 language, schedule an interpreter.

Some resources include:

- interpreterresource.com
- languageline.com
- fadcentral.org/interpreting-services.html

Support Plan Submission Timelines

The final step in completing the Support Planning Process is submitting a copy of the signed plan to the individual, everyone who attended the support planning meeting, and the Regional APD office. There are specific time frames established in Rule, and they vary depending on the type of Support Plan being submitted:

An Initial Support Plan

- 45 calendar days of the individual choosing their WSC
- 30 calendar days for those in crisis

An Annual Support Plan

- Completed every 365 days
- Provide copies of the plan to the individual/legal representative within 10 calendar days of the support planning meeting
- Provide copies of the plan to providers within 30 calendar days of the effective date

A Support Plan Update

- Can be completed anytime throughout the year
- Provide copies of the plan to the individual/legal representative within 10 calendar days of the change
- Provide copies of the plan to providers within 30 calendar days of the change