Title: **AB-CFC/PAS 421**
Section: **ELIGIBILITY FOR SERVICES**
Subject: **Service Plan**
Reference: **ARM 37.40.1005 and 37.40.1114**
Supersedes: **AB-CFC/PAS 421 (April 1, 2018).**

PURPOSE

This policy serves to outline the purpose of the Service Plan (SLTC-170) as it relates to Community First Choice/Personal Assistance Services (CFC/PAS) service delivery and the provider agency's role and responsibility to complete the form. The Service Plan is a mandatory form that must be completed prior to delivering Agency Based (AB) CFC/PAS.

PROCESS

1. The development of a Service Plan is essential for the successful provision of person centered CFC/PAS services.
2. The Service Plan is an individualized plan designed to meet the needs of the member. To complete the Service Plan properly the agency must connect the following information into the development of the Service Plan:
    a. Member preferences; discussed during the Person Centered Planning (PCP) visit and documented on the PCP form (SLTC-200);
    b. Mountain Pacific Quality Health (MPQH) Service Profile (SLTC-155) and;
    c. CFC/PAS flexibility parameters (Refer to AB-CFC/PAS 716).
3. The Service Plan is used to document the member's preferences for service delivery within the parameters of the CFC/PAS program.
4. Completion of the Service Plan form is mandatory prior to delivering any CFC/PAS services. Failure to have a current Service Plan will result in repayment.
5. There are six circumstances that require the completion of the Service Plan. The type of

circumstance determines how the Service Plan is completed. The instruction section of this policy provides guidance on how to complete the Service Plan based on each circumstance.

6. All Service Plans must be reviewed and signed-off by the Nurse Supervisor. Some Service Plans may be completed by either the provider agency Nurse Supervisor or Qualified Designee. Other Service Plans must be completed by the Nurse Supervisor. The following is a list of Service Plan types, and whether the agency Nurse Supervisor or Qualified Designee can complete Service Plan:
   a. Nurse Supervisor: The Nurse Supervisor must complete Services Plans for the following circumstances.
      i. "Intake" (regular, change in agency, switch in option);
      ii. "High Risk", and
      iii. "Annual".
   b. Qualified Designee: The Qualified Designee or Nurse Supervisor must complete the Service Plan for the following circumstances:
      i. "Amendment";
      ii. "Temporary Authorization"; and
      iii. "Other".

➢SERVICE PLAN INSTRUCTIONS

The following are instructions to complete the Service Plan based on the type of circumstance. There are six types of circumstances: "Intake", "Annual", "Amendment", "Temporary Authorization", "High Risk" and "Other". The circumstance box must be marked at the top of Service Plan.

1. "Intake" and "Annual": The intake visit (includes all regular, change in agency and switch in option intake) and annual visits require the Nurse Supervisor to complete the Service Plan with the member.
   a. The Nurse Supervisor should review the

following with the member prior to completing the Service Plan.

i. Review scheduling preferences, specific requests, etc. with the member;

ii. Identify personal care attendant (PCA) training needs and document this on the Service Plan; and

iii. Document expected results for the member receiving services.

b. The Nurse Supervisor must enter the following information on the Service Plan:

i. Enter the current MPQH Service Profile date span, total bi-weekly profile units (bi-weekly total = two-week total), total ADL units, total IADL units, and total skill acquisition units.

ii. Complete the “Service Plan Schedule” to list member-specific requests and/or information that has not already been captured on the MPQH Service Profile This section is intended to reflect the member’s preference for receiving CFC/PAS services, as identified and documented on the Person Centered Plan (PCP) form (SLTC-210).

1. If the member elects to receive CFC/PAS services at the frequency identified on the current MPQH Service Profile, indicate “services delivered according to MPQH Service Profile”.

2. If the member elects to receive CFC/PAS services at a frequency that is different from the MPQH Service Profile using the flexibility parameters (refer to CFC/PAS 717), list the tasks, along with the new frequency, and provide a

comment.

3. If the member has specific comments related to the delivery of CFC/PAS tasks enter them on the Service Plan Schedule.

iii. In the “Comments and Special Instructions” section, list specific member preferences for the delivery of services and other relevant information.

1. When the member elects to implement flexibility parameters, use this section to document pertinent information to ensure member health and safety needs are addressed (refer to CFC/PAS 717).

iv. Use the “Action Plan” section to document any member preferences (as identified on the PCP form and during the PCP meeting) that cannot be met and indicate the member/agency plan and associated time line to address the gap.

v. Upon completion of the Service Plan, the member, Nurse Supervisor, and Plan Facilitator (when present), must sign the Service Plan form and mark the box that indicates that they concur that the information contained on the Service Plan represents the member’s preference for the delivery of CFC/PAS services.

vi. The provider agency must provide the member and Plan Facilitator with a copy of the Service Plan form within 10 working days of completion. If the Plan Facilitator is not present during the visit, the provider agency has 30 working days to obtain a copy of the Plan Facilitator signature.

vii. For more information on the provider agency's intake and annual visit requirements refer to CFC/PAS 702 and 703.

2. "Amendment": The Service Plan must be used to submit an amendment request to MPQH. For instructions on how to submit an amendment request to MPQH refer to CFC/PAS 719.

3. "Temporary Authorization": Anytime the provider agency needs to deliver services without a MPQH Service Profile or needs to implement a change to the current authorization amount on the MPQH Service Profile, the provider agency must complete a Service Plan. For instructions on how to complete a Service Plan for a temporary authorization refer to CFC/PAS 417.

4. "High Risk": Anytime the provider agency needs to implement services for a member immediately, without a MPQH Service Profile, the provider agency must complete a Service Plan. For instructions on how to complete a Service Plan for a high risk intake refer to CFC/PAS 414.

5. "Other": Whenever the provider agency receives an amended or annual MPQH Service Profile and there is a change in the authorized time, task and/or task frequency, the provider agency Nurse Supervisor or Qualified Designee must contact the member to discuss the change in authorization, determine a plan to implement the change in authorization, and document the conversation in the member's case notes.

   a. If the member elects to receive CFC/PAS services at the frequency identified on the amended/annual MPQH Service Profile, the provider agency Nurse Supervisor or Qualified Designee must document the conversation with the member in the case notes and indicate "services delivered according to MPQH Service Profile" in the member's case notes.

   b. If the member elects to implement the flexibility

parameters and receive CFC/PAS services at a frequency that is different from the MPQH Service Profile, the Provider Agency or Nurse Supervisor must complete a new Service Plan, mark the circumstance "Other", and work with the member to enter the following information:

i. Enter the current MPQH Services Profile date span, total bi-weekly profile units (bi-weekly total = two week total), total ADL units, Total IADL units, and total skill acquisition units.

ii. In the "Service Plan Section", list out all of the tasks that will be performed at a frequency, along with the frequency, and provide a comment.

iii. In the "Comments and Special Instructions section" document pertinent information to ensure member health and safety needs are addressed (refer to CFC/PAS 717).

c. The provider agency has ten days from the date they receive the change in authorization on the amended/annual MPQH Service Profile to contact the member, document the conversation in case notes, and complete a new Service Plan, when applicable. For instructions on how to implement changes to service authorization refer to CFC/PAS 719.

d. ➢Upon completion of the Service Plan, the Nurse Supervisor or Qualified Designee must sign and date the Service Plan. When the Qualified Designee completes the Service Plan, the Nurse Supervisor has ten days to sign-off on the Service Plan.

e. The provider agency must provide the member and Plan Facilitator with a copy of the "Other" Service Plan within 30 days of completion.

NOTE: The member and Plan Facilitator signature is not required.

SERVICE PLAN ASSURANCES

The Service Plan should be reviewed regularly by the provider to assure program compliance. The Service Plan is required to be reviewed every six months during the agency re-certification visit.

The Service Plan review should include a review of the member's MPQH Service Profile, PCP form and service delivery records (a sample of at least two months should be used) to ensure that the Service Plan meets the following assurances:

1. Member preferences are documented on the Service Plan as detailed on the PCP form;
2. Service Plan Schedule addresses member ADL, and IADL needs as specified on the MPQH Overview and Service Profile;
3. Services (as documented on the service delivery record) are delivered according to the Service Plan Schedule;
4. Flexibility parameters have been utilized according to policy which enable member choice and control of service schedule;
5. ➢Intake and annual Service Plan is signed by the Nurse Supervisor, member, and Plan Facilitator and all other Service Plans contain Nurse Supervisor sign-off;
6. Service Plan is amended, as necessary, when there is a change in member's service needs; and
7. Temporary authorizations are used to implement immediate change to the Service Plan and/or for high risk intakes.