SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

HOME AND COMMUNITY BASED WAIVER Policy Manual	Section: CASE MANAGEMENT SYSTEM
	Subject: Service Plan Development

Reference: ARM 37.40.1420

DEFINITION

A service plan is a written plan for services developed by the Case Management Team (CMT) and members to assess and determine the member's status and needs. The service plan also outlines the services that will be provided to the member's to meet their identified needs. Refer to Appendix HCBS 899-11 for a copy of the HCBS Service Plan (DPHHS-SLTC- 135). Each service plan must be completed following the instructions in 899-11.

Refer to 899-11B for the Service Plan short form for members who are enrolled for short-term temporary placement.

REQUIREMENT

An initial Service Plan must be created at the time the member is admitted to waiver. Subsequent service plans must be completed at least annually (Refer to HCBS 809-7) or when the member's condition warrants it. Initial Care Category (CC3) service plans must be prior authorized by the Regional Program Officer (RPO) and Community Services Bureau. Subsequent CC3 Service Plans are reviewed only when budget changes are made. See the Home and Community Based Services (HCBS) policy 402 for the process.

The Service Plan shall be created in compliance with requirements specified in HCBS 608 (Quality Assurance) and include the following:

1. Standard One requires evidence of a legally responsible person as applicable;

2. Standard Two requires that the Service Plan will be complete; and

    a. Documented evidence that the member directed the development and/or modification of the

Service Plan;

b. At least one measurable goal must be included in the Service Plan;

c. At least one measurable objective will be included in the Service Plan;

d. Format of the Service Plan must follow HCBS requirements; and

e. Required signatures must be present on the Service Plan (e.g. Self/member, case manager, legal representative);

3. Evidence of risk assessment and mitigation if appropriate;

4. Standard Three requires timetables for re-evaluation of the following:

   a. 180 days;

   b. Amendments as appropriate;

   c. Documentation of goals and objectives, progress, failure to progress towards goals and objectives; and

   d. Evidence of collaboration documented on goals/objectives by Social Workers and Nurses;

5. Standard Five which describes CSB expectations for principles of charting for providers of HCBS services including:

   a. Each page must have the member's name on it;

   b. The full date of each entry must be recorded;

   c. Each entry must end with the signature or initial of the person making the entry; and

d. Entries must be made in sequence; and

6. Documentation should contain the following:

   a. Pertinent observations, psychosocial and physical manifestations, incidents, any unusual occurrences or abnormal behavior;

   b. Document facts, what is seen, heard, felt, and smelled and the type of contact; e.g., telephone call, home visit etc.;

   c. Document approaches to correcting problems identified in the member's service plan; and

   d. Document all instruction given to member and/or member's family;

CONSULTATION

The CMT shall consult with the member and/or the member's legal guardian and conservator if applicable. The CMT may consult with the primary care provider and other representatives such as a Power Of Attorney (POA), as needed. Other contacts may include family members, relatives, psychologists, medical personnel and other consultants as necessary, with the member's approval.

DISTRIBUTION

The CMT shall provide a copy of the service plan to the member or legal representative and, if applicable, to the primary care provider.