Person-Centered Support Plan

Instruction Manual

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Person-Centered Support Plan Instructions

Introduction to the Person-Centered Support Plan

This support plan was developed with feedback from Waiver Support Coordinators (WSCs), self-advocates, and other stakeholders. This support plan format fosters the WSC and Consumer-Directed Care Plus (CDC+) Consultant in engaging in person-centered conversations with the individuals they serve.

The support plan is a written tool that contains information provided by the consumer and those that know the consumer the best regarding future goals and supports needed. The support plan is the guiding document from which services are authorized and provided.

The role of the WSC and CDC+ Consultant in the support planning process is to help the consumer identify key information about themselves and to develop a vision for the 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 consumer. It identifies informed choices made by the consumer 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 the community
- The personal goals, accomplishments, or experiences the consumer would like to achieve
- How to meet health, behavioral, medical, or environmental needs; and
- How to address risks and follow up on incidents

The support plan form is intended to guide the conversation between the WSC or CDC+ Consultant, the consumer, and those involved in the support planning process.

Compliance with State and Federal Requirements

The federal Centers for Medicare & Medicaid Services (CMS) authorized the iBudget Home and Community-Based Services (HCBS) waiver program under 1915c of the Social Security Act. It also provides rules and requirements for waiver programs to operate. Federal regulations require every consumer on the iBudget waiver have a current support plan.

CMS published updated HCBS regulations in 2014. These federal rules were designed to enhance the quality of HCBS by establishing a more outcome-oriented definition of the services, based on the nature and quality of the individual's experience. CMS identified additional protections to group home residents to ensure full access to the benefits of community living.

Federal rules require service planning for participants in Medicaid HCBS programs to 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 rules include six standards that all HCBS programs 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

Information about the HCBS regulations can be found by clicking here or by visiting the website www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html

The support plan template can be divided into four major types of information:

- **Identifying information and demographics**, including who is currently involved in supporting the consumer and any funding sources for each paid service;
- **Person-Centered Information**, a complete picture of the individual's daily life from their perspective, including strengths and capacities, preferences, and daily routines;
- **Significant Needs and Risks**, which includes information taken from the most current Questionnaire for Situational Information (QSI) assessment, incident reports, medical documentation, and other records. Based on identified needs and risks, the support plan identifies strategies, specific plans, and follow-up steps that will be taken to address these needs and who is responsible; and
- **Past Accomplishments and Future Goals**, describing what the person worked on last year and any progress toward reaching those goals, what the consumer wants to accomplish in the next five years, and the goals they want to focus on during the upcoming year.

Overview of Person-Centered Planning

Person-centered planning refers to a way of coordinating services that places the individual at the center of the support planning process. It differs from a traditional medical model, which relies on assessments or input from professionals to describe the individual's problems and what needs to be done to fix those problems.

Person-centered planning starts with the individual's preferences and goals, which are supplemented by input from assessments performed by professionals 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, it may be important to an individual to choose their morning routine or to have access to a park, whereas, taking a necessary medication is important for the individual.

Characteristics of person-centered planning

1. The consumer is present at the meeting and chooses the time, location, and who will participate in the meeting (such as family, a guardian, staff).
2. The consumer directs the process and is in control of what is decided and the direction for his or her life.
3. It is more of a conversation with the consumer rather than professionals talking about all the things that need to be done for the consumer.
4. It focuses on the positive aspects of a consumer's life rather than a discussion of past problems or failures.
5. The goals written in the support plan are based on what is important to the consumer, not those serving them.
6. Person-centered planning often involves using drawn pictures or other images intended to visually reflect important aspects of the person's life, dreams, goals for the future, how to help the person self-advocate, as well as how to make progress toward goals.

Risks and Needs

Another important aspect of person-centered planning is that it clearly identifies needs and any significant risks present in the consumer's life. While it is important to encourage the consumer to pursue dreams and goals, it is critical to address needs and risks. When health and safety needs are not addressed, serious consequences to the consumer or others can occur. Information about needs and risks may come from the consumer, his or her legal representative, caregivers, the QSI, incident reports, medical case manager reports, doctor recommendations, behavior analysis reports, and other documentation from licensed practitioners, such as care plans and annual reports.

Planning Methods

The person-centered planning process involves more than just filling out a form. The process includes getting a complete picture of the consumer's life, what he or she wants for the future and how to get there. Person-centered planning is not a one-time event but should be ongoing, as the consumer's preferences, needs, and goals will change over time.

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

- Include people chosen by the individual;
- Provide necessary information and support to ensure that the individual directs the process as much as possible and that they are enabled to make informed choices and decisions and have help, where needed, to make these choices;
- Be timely and occur at times and locations that are convenient for the individual;
- Reflect cultural considerations of the individual and provide information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited in English proficiency;
- Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
- Offer the individual informed choices regarding the services and supports they receive and from whom;
- Include a method for the individual to request updates to the plan as needed;
- Record the alternative home settings that were considered by the individual.

For some consumers, it is useful to begin the person-centered planning process in a way that is structured and visually records information communicated. There are many methods that the WSC or CDC+ Consultant can use to facilitate a person-centered planning process. Each uses techniques to help the person communicate his or her story and desires. Some person-centered planning is facilitated using charts, pre-made worksheets, collages, or drawings to paint a picture. It is important to choose a method that meets the needs of the consumer.

The following are some options. However, this list does not include all possible methods.

Using chart paper or whiteboards to record ideas and as a visual aid for communication

Whiteboards or large paper are an easy way to help the consumer and the support planning team to:

- Brainstorm ideas and goals
- Develop a vision for the future
- Record choices
- Assign tasks
- Agree on timelines

Picture boards are also a tool for communicating with individuals who do not verbally express desires. Some individuals may not verbally communicate but can point at pictures or use gestures to convey choices.

Dream Boards

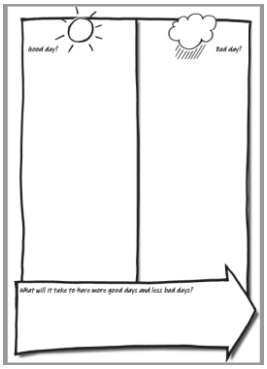
Dream Boards engage consumers in a process of choosing images and words from magazines or other sources and using these to create a collage that expresses dreams, goals, and what is truly important to them. The collage is a springboard for a person-centered conversation.

PATH (Planning Alternative Tomorrows with Hope)

The PATH approach uses a graphic process to help the consumer develop a vision for the future. Working backward, a step-by-step path is created that provides a clear visual timeframe for how the individual can reach personal goals. A benefit of the PATH process is that it engages the whole support team and helps to commit them to specific tasks.

Worksheets

There are many different pre-made, printable worksheets that can be used to help the consumer develop a vision for the future and goals. “Good Day/Bad Day” (shown below) provides a simple way to sort out what is important to the individual and what needs to happen for them to have good days and avoid bad days.



Other worksheets include:

"What is working/not working"

"Sorting important to and for"

"Start Chart"

Free Template: http://helensandersonassociates.co.uk/person-centred-practice/person-centred-thinking-tools/good-daybad-day/

MAP (Making Action Plans)

The MAP process focuses on the consumer's story. It is another graphical planning tool. MAP uses a series of questions and answers that are recorded graphically to construct a personal life story for the individual and to build a plan with action steps to move toward dreams. MAPs are a good tool to engage the whole team and get commitments.

The Roles of the Support Plan Team Members

The Consumer

The support plan process is focused on the consumer. With support planning, the consumer must have the opportunity to direct the process as much as possible. This includes, but is not limited to:

- Choosing who the person would like to participate in the planning process and who is invited to the meeting
- Participating in the support planning meeting in a way the person chooses
- Communicating desires, hopes, and dreams for the future, including what is working now, what is not working, and what they would like to see change
- Signing the support plan to indicate agreement. If there are areas of disagreement, these concerns are conveyed to the team.
- Requesting changes and approving changes or revisions to the support plan throughout the year as desired or needed
- Communicating any concerns or feedback to the WSC or CDC+ Consultant throughout the year. If disagreements are not resolved, consumers may request that these are noted on the support plan before they sign it.

Legal Representatives, Family, and Friends

Legal representatives must be involved in the support planning process. The consumer 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 consumer may choose to have others participate in the planning process. However, any designated legal representative must be included. Participation may include:

- Contributing to the person-centered information based on knowledge of the individual
- Helping to identify and address known risks
- Helping the individual plan for the future and providing support if requested
- 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 or CDC+ Consultant

- Reviewing and approving changes to the support plan throughout the year if needed
- Sharing any concerns or feedback with the WSC or CDC+ Consultant throughout the year

WSC or CDC+ Consultant

WSCs and CDC+ Consultants are crucial in facilitating person-centered planning and helping the consumer achieve desired outcomes. A WSC/CDC+ Consultant:

- Engages in an ongoing conversation with the consumer regarding what he or she wants for the future, assists the person in making changes to the support plan as necessary, and documents any changes in the support plan
- 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 or funded by other sources such as natural supports or volunteers
- Ensures that the plan meets the consumer's current service needs and complies with requirements for the chosen service setting(s) and associated funding
- Signs the support plan
- Provides to the consumer, the legal representative, or both, via secure email, U.S. mail, or hand-delivery, a copy of the support plan and the APD-approved cost plan
- Documents in the progress notes the date and method by which the support plan was provided to the consumer or legal representative
- Files a copy of the support plan and cost plan signature pages in the consumer's central record
- Monitors service provision, progress on goals, and the consumer's satisfaction with services and providers
- Addresses and resolves issues, which are identified by meeting with the consumer and pertinent providers
- Helps the consumer communicate with providers to help the consumer achieve his or her desired goals and outcomes
- Reviews incidents and follows up on needs to prevent future occurrences.

Service Providers (paid and unpaid)

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

- Helps the consumer participate in the planning process as fully as possible
- Contributes to the planning process as requested by the consumer
- Gathers information and shares it with the WSC prior to the meeting

- Helps identify serious risks by providing medical or other historical information
- Notifies the WSC or other team members if the consumer's desired outcomes or support needs must be readdressed or updated
- Carries out activities that assist the individual in achieving goals

Getting Ready for the Support Plan Meeting

WSCs and CDC+ Consultants 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/CDC+ Consultant to gather all the necessary information. The consumer (or legal representative) chooses the time, day, the topics to discuss, who can contribute to the planning process, and who is invited to the actual meeting.

Prior to the formal support plan meeting, the WSC/CDC+ Consultant should conduct pre-support planning activities to gather information to facilitate the process. These activities include:

1. Talking to the consumer and others involved in his or her life, with the consumer's permission. Have the consumer start thinking of personal goals, needs, and services before the meeting.

2. Visiting the consumer at home or spending time with them at other locations of the consumer's choice to gather the information.

3. Reviewing written documentation, including clinical reports, incident reports, evaluations, the current QSI, and provider documentation from service providers.

Keys to successful support planning:

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

Support Plan Submission Timelines

Upon an initial enrollment to the waiver and then on an annual ongoing basis, the WSC/CDC+ Consultant will follow established time frames and guidelines for submitting the support plan to APD, the consumer, and all other participants in the support planning meeting.

Initial Support Plans

- For newly enrolled consumers or those new to a WSC/CDC+ Consultant caseload, the WSC/CDC+ Consultant must complete the support plan within 45 days of the consumer's selection of the WSC/CDC+ Consultant.
- For consumers 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 consumers 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/CDC+ Consultant must provide copies of the support plan to the consumer or legal representative within 10 calendar days, and to providers within 30 calendar days of the effective date. In APD iConnect, the WSC/CDC+ Consultant can send the support plan to the provider by using a note within the system.

Support Plan Updates

- The WSC/CDC+ Consultant works with the consumer to revise the support plan as necessary.
- The support plan must always be up to date.
- If the desired change is related to a change in the individual's needs or circumstances, the WSC/CDC+ Consultant should notify the Region to determine whether a new QSI is needed.
- The WSC/CDC+ Consultant must provide a copy of the updated support plan within 10 calendar days of the effective date of the support plan.
- The WSC/CDC+ Consultant should follow up on any service needs and referrals that result from an updated support plan.

APD iConnect Requirements

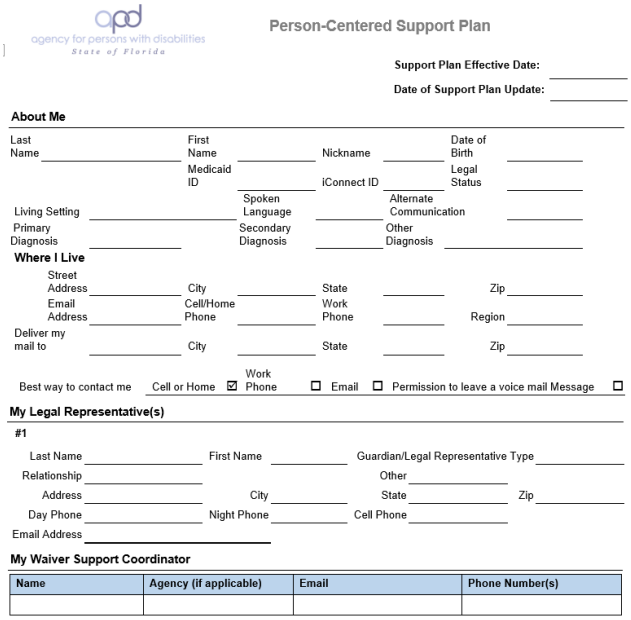
WSCs and CDC+ Consultants complete the Person-Centered Support Plan in APD iConnect. WSCs and CDC+ Consultants may refer to APD iConnect training materials for instructions on how to navigate the form by clicking here or visiting www.apd.myflorida.com/waiver/iconnect/wsc.htm.

The WSC or CDC+ Consultant will print the support plan that they created in APD iConnect and provide a copy to the consumer and legal representative to sign. The WSC or CDC+ Consultant will attach the signed support plan to a note in APD iConnect.

In the future, APD iConnect will allow WSCs and CDC+ Consultants to transmit the support plan as a note to providers who are responsible for carrying out services in accordance with the support plan.

Reminder! When creating the support plan in APD iConnect, keep the support plan in an "open" status so that updates can be made as needed throughout the year.

The first section of the support plan identifies the consumer, where they live, the best way to contact them, and those involved in the person's life. WSCs and CDC+ Consultants must ensure that this information is current in the APD iConnect demographics tab. WSCs and CDC+ Consultants are required to update this information any time there is a change.



agency for persons with disabilities
State of Florida

Person-Centered Support Plan

Support Plan Effective Date: _____
Date of Support Plan Update: _____

About Me

Last Name _____ First Name _____ Nickname _____ Date of Birth _____
Medicaid ID _____ iConnect ID _____ Legal Status _____
Living Setting _____ Spoken Language _____ Alternate Communication _____
Primary Diagnosis _____ Secondary Diagnosis _____ Other Diagnosis _____

Where I Live

Street Address _____ City _____ State _____ Zip _____
Email Address _____ Cell/Home Phone _____ Work Phone _____ Region _____
Deliver my mail to _____ City _____ State _____ Zip _____

Best way to contact me Cell or Home ☑ Work Phone ☐ Email ☐ Permission to leave a voice mail Message ☐

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 _____

My Waiver Support Coordinator

Name	Agency (if applicable)	Email	Phone Number(s)

About Me and Where I Live

This section records demographic information that the circle of supports will need to better serve the individual, such as where they live, the best way to contact them, legal status, etc. Much of this information is pulled directly from APD iConnect, but WSCs and CDC+ Consultants must verify that it is accurate.

My Legal Representatives(s)

If the individual is a minor, or if legal documentation identifies a legal representative, then that legal representative must be included in the support planning process. If more than one legal representative is identified, the WSC/CDC+ Consultant must identify them.

Legal Representatives include the following:

(a) For clients under the age of 18, the legal representative or health care surrogate appointed by the Florida court to represent the child or anyone designated by the parent(s) of the child to act on the parent(s)' behalf (e.g., due to military absence).

(b) For consumers age 18 years or older, the legal representative could be the client, anyone designated by the client through a Power of Attorney or Durable Power of

Attorney, a medical proxy under chapter 765, F.S., or anyone appointed by a Florida court as a guardian or guardian advocate under chapter 393 or 744, F.S.

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 keep these documents in the individual's central record.

WSCs are always required to maintain this information in APD iConnect and to keep it current.

My Waiver Support Coordinator

Name	Agency (if applicable)	Email	Phone Number(s)

My Family, Friends, and Support System

Name	Relationship	Email	Phone	

Other People Who Support Me or Work for Me (Teachers, Providers, Doctors, CDC+ Representative)

Name	Relationship	Email	Phone	

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 of an individual's quality of life. In this section, identify those who are closest to the consumer. This does not include paid supports who would not be in the consumer's life if that paid relationship were discontinued.

Other People Who Support Me or Work for Me

List any additional people, paid or unpaid, who provide support to the consumer. Supports listed here may receive payment through the waiver or other funding source. This may also include the CDC+ Representative.

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 Funding Sources for Supports

Identify any non-waiver funding sources that address critical needs. List the need or specific support that they provide and indicate the funding source from the following list that appears as a drop-menu on the form:

- Adult Protective Services
- Behavioral Health
- Brain and Spinal Cord Injury Program
- Children's Medical Services
- Child Protective Services
- Department of Elder Affairs
- Department of Corrections
- Department of Juvenile Justice
- Medicaid State Plan
- Medicare
- Military Benefits
- Natural Supports
- Private Insurance
- Public or Private school
- Section 8 Housing
- Supplemental Nutritional Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF)
- Vocational Rehabilitation
- Woman, Infant, and Children's Program (WIC)
- Workforce Programs and Services
- Other

People Who Can Provide Information for My Support Plan

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

The following sections contain person-centered information and provide a “snapshot” into the consumer’s life, where they have been, where they are now, and where they would like to be in the future. The support plan is intended to help the consumer make informed choices about his or her life and to give the consumer control over his or her life and services.

To accomplish this, record information in a way that captures the consumer’s true desires and goals and informs others about how to support the person in both maintaining health and safety and achieving goals

If first-person statements are included, they should be indicated with quotations.

My Current Day-to-Day Life

This first part of the My Life section provides an overview of the consumer’s daily life and routine, such as where they live, if they live with others, if they have a private bedroom, and the type of living setting. The information in this field also includes a summary of daily activities and any supports or services delivered during the day or night. If the consumer lives in a licensed facility or Supported Living, identify whether they have their own room or share a room. Does the person attend school, work, or another activity on a regular basis? Does the person receive other services or natural supports? This is not intended to be a schedule to justify a service, but a “day in the life” description of the consumer.

The 2014 HCBS regulations require that the Person-Centered Support Plan reflect that the “setting in which the individual resides is chosen by the individual.” Based on this regulation, the WSC/CDC+ Consultant must list the material they provided to help the consumer make an informed choice about where to live. For example, this section may include a list of brochures for other group homes or Supported Living apartments or an account of the other environments you visited with the individual and the discussion you had with them about 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.

Also, document what the consumer likes to do as a daily routine, such as waking up early, having coffee every morning, going out to lunch at a specific restaurant, or enjoying evening sports news.

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

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 home 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 consumer gets around in the community from day to day. The inability to access safe and convenient transportation often prevents individuals with developmental disabilities from being fully integrated into the community. Review the person's QSI assessment to see how involved they are in community activities and to identify their means of transportation. If they have limited access to the community, the WSC/CDC+ Consultant should find out why to determine whether they would like to make a change. When choosing the options for how the consumer gets around the community, think about what method is used on a day-to-day basis most of the time, not just to access waiver service providers. Transportation can be both paid, such as through the waiver Transportation Services, or unpaid, such as community transit. If the person has multiple forms of transportation, choose "Other" from the drop-down menu, and enter the types of transportation in the box provided.

Drop-down list:

- Licensed driver with my own car
- Licensed driving using another individual's car
- Family/Friend transit
- Transit from a faith-based organization
- 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

- Hired Driver (Taxi, Uber, Lyft)
- Bicycle; Walking
- Share-A-Ride
- Mobilizing via wheelchair
- Other (explain below)

My Interests, Talents, Abilities, Preferences, and Skills

This section provides an overview of what the consumer considers to be his or her unique interests, abilities, strengths, and daily activities. This information is important, as it provides an understanding of how consumers view themselves and what is important to them. WSCs/CDC+ Consultants should use the information in this section to develop support plan goals that are meaningful to the consumer.

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.

Person-centered examples of statements for this section might include:

- Shawn is outgoing and always makes people laugh and have a good time. Shawn is also very athletic and loves “football all the time.”
- Daryl is an excellent dancer. He has participated in the local talent show and has won three years in a row!
- Louise is an excellent cook; all her housemates agree that she makes the best pancakes.
- Gloria’s aunt said that Gloria is a wonderful singer.
- Michael 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.

Things I would like to change

Information here is not just about services but also the person's life. 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 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."

Person-centered examples for this section might include:

- Jonathan would like to have his own room due to medical needs at night.
- Michael said, "I want to start showering at night so that I can sleep later in the morning."
- Thomas's mom indicated that Thomas is sometimes unhappy at his group home and would like to look at other living arrangements.
- Evette expressed wanting to talk to her family at least once a week.
- Louis stated that he wanted to "change jobs" this year and do something working with tools.
- John said what is important to him is to spend time independently with his girlfriend. He said, "I only see Stacey at workshop, but I want to take her to the movies."

Things I Want to Stay the same

What does the individual indicate they need on a daily or weekly basis to be happy? This can include items, activities, routines, the way people approach them, etc. Input from others can be included here as well.

Things I want to stay the same:
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 can get to work 5 minutes early.

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 ‘n’ roll or country music played in my house.”
- Jane stated that she wants to watch her favorite “Mickey” movies each night before going to bed.
- It is important to Louis to keep his morning routine. He does best when he has at least an hour. He said, “I don’t like to be rushed.”
- Michael stated, “I love watching car races and want to watch it on the big screen at my brother’s house.” He wants to be able to keep doing this each weekend.
- Gloria said that what makes her happy is being able to watch FSU football. She said, “I love football. I want to watch all games.” Gloria’s aunt indicated that this includes all preseason and regular season games.
- Ben stated that all individuals must take off their shoes before coming into his apartment.

Important Aspects from My Personal History

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

- **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.” Or “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 that 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 like to be independent and enjoys making friends outside of his group home on social media. This has resulted to exploitation in the past as John tends to be too trusting of others and they tried to take advance of him financially.

Date: 3/15/2019

How I Communicate and Make Choices and Decisions

Identify how the person makes and communicates personal choices and decisions. This should include decisions the person makes themselves and those 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 do I express what I 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?

WSCs and CDC+ Consultants should determine how the consumer communicates so that the circle of supports can use the person's communication style as much as possible. It is important to consult not only the consumer, but also the family, legal representative, or other providers to get a full picture of the individual's communication style and decision-making skills.

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 bedtime, 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 decisions:
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

Employment is appropriate to consider for adults and provides consumers with a chance to grow financially, contribute to society in a meaningful way, and build self-esteem. When brainstorming about future plans, have a conversation about the benefits of working, long-term employment support, and resources like Vocational Rehabilitation (VR) that are available to help them obtain a job or the skills necessary for employment.

For individuals 18 and older, ask whether they want to work and discuss how they can achieve 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 about 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 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?

Many people with developmental disabilities are not working. Individuals report barriers to finding work, including lack of training or transportation, the need for special accommodations on the job, and specific limitations related to the person's developmental disability such as cognitive or behavioral limitations.

Many barriers can be overcome when a person's supports understand what type of work would match the skills that the person has, how the person's developmental disability impacts work performance, and the level of support needed and available to the person to make employment a viable option.

Identify paid and unpaid supports that would help the individual accomplish employment goals. Information in this section must be both meaningful and specific enough that it is clear to the consumer's circle of supports how the individual wants to be supported to gain employment or a volunteer position.

Job(s) I Have: Identify all jobs that the consumer holds. If the consumer chooses not to work, state N/A.

Hire Date(s): Identify the dates the consumer started jobs listed.

Type of Job(s) I Have: Choose the type of job from the drop-down menu. If Other is chosen, provide an explanation.

I am interested in getting a job: Identify whether the consumer is interested in working or choose N/A.

I am interested in changing jobs: If the consumer is already working but wants to change jobs or is looking for a new volunteer opportunity, state this here.

Type of Job I Want: Include the specific type of job or volunteer opportunity that the individual would like to have. For example, if the individual expresses the desire to work at a grocery store, include that specific information as opposed to just stating that they want a job in general.

Supports needed to reach my employment goals: Include any steps or resources that are necessary to make the individual's future employment goal a reality.

I was referred to Vocational Rehabilitation and **Date of Referral to Vocational Rehabilitation:** Indicate whether the person has tried to access services through Vocational Rehabilitation (VR) in the past and the date of the referral. If they have received services previously, help them determine if are eligible to reapply for services. If the individual has never received VR services, help them explore this option. If the person has not been referred to VR, this should be done. The WSC or CDC+ Consultant should help the person apply if needed and actively participate in the first meeting with the VR counselor to advocate on the individual's behalf.

Outcome of Referral to Vocational Rehabilitation: Identify the outcome of the referral to VR.

Date Phase 1 Job Stabilization was Completed, if applicable: If the individual accessed Phase 1 services through VR, identify the date this was completed. If not applicable, this can be left blank or write "N/A."

Employment

Job(s) I Have (for those who choose not to work, state N/A)	Hire Date(s)	Type of Job(s) I Have
Bob's Air Conditioning	3/12/2020	Full Time - Competitive Employment
Our Town Food Pantry	07/13/2021	Volunteer Work

I am interested in getting a job						I am interested in changing jobs						Type of Job I Want	Supports Needed to Succeed at Work
Yes	☐	No	☐	N/A	☑	Yes	☑	No	☐	N/A	☐	Ben said he wants to keep working at Bob's air but wants to make more money.	Supported Employment Coach and Ben talked to Bob's boss about helping Ben learn to use the computer system so that he can apply for a promotion in the office when it becomes available.

I was referred to Vocational Rehabilitation						Date of Referral to Vocational Rehabilitation	Outcome of Referral to Vocational Rehabilitation
Yes	☑	No	☐	N/A	☐	1/5/2019	Started working at Bob's Air Conditioning
							Date Phase 1 Job Stabilization Completed: 4/12/2020

Other Services Needed for Health and Safety

> *Per 42 CFR 441.301, the support plan must "[r]eflect 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 Other Services Needed for Health and Safety section contains most of the information about significant needs and risks. The information in this table under the **Functional**, **Behavioral**, and **Physical** portions are directly related to the individual's most current QSI. Specifically, the WSC/CDC+ Consultant pulls in the scores from the QSI onto the support plan form within APD iConnect.

The **Other Risks/Needs Related to Me** and **Needs/Risks Related to My Caregiver** portion should be completed during the person-centered planning process to plan and mitigate existing or potential risks that the individual may experience.

Complete the following steps:

1) Pull the consumer's QSI assessment scores into the **Functional**, **Behavioral**, and **Physical** portion of the table using the *copied-shared response* feature within APD iConnect. Pay attention to the specific concern and the level of support needed to address the concerns.

TIP! For directions on how to use the copy-shared response feature in APD iConnect, please visit the WSC iConnect Library online at www.apd.myflorida.com/waiver/iconnect/wsc.htm

2) Review any other documentation related to health and safety issues such as doctor reports, Medical Case Manager reports, behavior analysis information, abuse reports, and incident reports for the past 12 months.

3) Discuss potential risks and situations that the consumer may experience that are not part of the QSI. Include the in the **Other Risks/Needs Related to Me** and **Needs/Risks Related to My Caregiver**.

4) For all scored items (where the QSI score is 1 or above) or additional risks identified in the **Other Risks/Needs Related to Me** and **Needs/Risks Related to My Caregiver**, complete the table to describe:

   - The specific concern or risk;
   - The strategies in place to address the need or risk;
   - Who is responsible to address the need or minimize the risk; and
   - The source of funding for this service or support.

The QSI helps to identify needs and potential health and safety risks. Other supports should also be consulted: day programs, residential staff, or family. Significant risks are needs that, if not addressed, could result in institutionalization, medical attention, legal action, or could place the person or others in danger. The **Needs/Risks Related to My Caregiver** portion is only completed for consumers who live in the family home.

Specific issue and measures in place to address/minimize risk:

In this column, provide a **specific description of the need or risk** and what will be done to address the risk. Since the items listed on the support plan are broad categories of risks rather than specific concerns, it is important to describe exactly what is going on with the individual that can lead to a significant risk. One-word answers, vague descriptions, or simple restatements of the QSI results will not be enough to give readers a full understanding of the specific issues being addressed.

For example, if ambulation is checked on an individual's support plan but the WSC/CDC+ Consultant does not add further details or a includes vague statement such as, "requires assistance," the exact concern will still not be clear. Does the individual walk, but falls sometimes? If they fall, under what circumstances do they fall? Do they need to use a wheelchair with assistance, or can they propel the wheelchair themselves?

When filling in this section, always ask: Is this information clear? Does it provide a good understanding of the individual's actual needs and potential risks?

Identify **procedures or strategies to address and minimize the risk**. Strategies or procedures can be verbal agreements between members of the person's circle of supports. Strategies often include formal documentation such as a Safety Plan, Behavior Implementation Plan, or Nursing Care Plan. In this case, make a note of the document name so that it is clear where to find the specific steps or strategies that staff is to follow.

Keep in mind that a person most likely requires the same type of support in any setting that is part of their daily routine. For example, someone who requires frequent blood glucose monitoring at home will also require it at a day program or if they go to visit family. Therefore, nursing services will most likely need to be available in all settings.

If a person does not require the same supports in a different setting, that should be clearly stated. These details are important so that providers are clear about their responsibilities.

Service/Support:

Identify who (or what entity) is responsible for addressing the need. This could be a paid or unpaid support. If more than one person or entity is responsible, you can add additional choices. The supports listed here should tie back to the specific strategies described in the previous box.

Source of Support:

Identify how this support is funded. This is a drop-down menu, and multiple choices can be selected if needed.

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.

Review the example from the support plan below and pay attention to how the risks were identified and note that there is a plan that includes measures to address these 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)			
Vision			
Hearing			
☑ Eating	Requires total assistance 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
☑ Ambulation	Requires total assistance with a manual wheelchair. Has a backup plan for Personal Supports.	Personal Supports	iBudget Waiver Natural Supports
☑ Transfers	Requires two staff to transfer or a lift. Has a backup plan for Personal Supports and	Personal Supports	iBudget Waiver Natural Supports

		funding to fix lift if needed.		
	Toileting			
☑	Hygiene	Requires total assistance for hygiene. There is a backup plan for Personal Supports. Due to choking on liquids, provide accommodations with toothbrushing.	Personal Supports	iBudget Waiver Natural Supports
	Dressing			
	Communications			
☑	Self-protection	Can request assistance can call for help. However, would need physical assistance for self-protection.	Personal Supports Companion	iBudget Waiver Natural Supports
☑	Ability to Evacuate (Home)	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

Steven's Scenario

Steven is 45 years old and lives with his parents, who are in their 70s. Steven's parents are unable to provide consistent physical assistance and supervision throughout the day due to their ages and abilities. Steven is somewhat independent and can be left home alone for short periods of time. He enjoys playing games on his computer and watching the evening news. Although he can make simple meals, he needs help with staying safe in the kitchen and cleaning up after cooking. Steven is learning about money management, medication management, and home safety. He still requires substantial education and opportunities to try what he is learning.

Review the example from the support plan below and pay attention to how the risks related to caregivers were identified. Note that there is a strategy that includes measures to address these risks across different settings.

Other Risks/Needs Related to Me (Choose all that apply)

Identified Need/Risk Area	Specific issue and measures in place to address/minimize risk	Service/Support	Source of Support
☑ Requesting and Getting Help, if needed	Steven needs help with multistep tasks, such as putting groceries away or doing laundry. He needs verbal prompts to finish tasks. Sometimes he uses a timer to keep focused because he will stop in the middle of chores to start watching TV.	Personal Supports to give verbal prompts and some guidance to complete tasks throughout the day	iBudget Waiver
☑ Medication Management	Steven remembers to take his medication if it is organized in his weekly pill box. If this is not done, he will not take his medication. Father will sit with Steven and help him review and organize his medication on Sunday nights.	Natural Supports	Natural Supports

☐ Refusing Eating, Hygiene, or Supports			
☐ Substance Abuse			
☑ Handling Money/Finances	Steven has limited experience with financial management. He is unable to buy items at the store and is not aware of bills or long-term saving. Steven works with his parents to learn about money and making safe financial choices, he practices counting money before going on a shopping trip.	Parents and Personal Supports provide education on finances, shopping, and saving	iBudget Waiver Natural Supports
☐ Interactions with Strangers			
☐ Child/Adult Protective Services			
☐ Relating with Others			
☑ Home Safety	Steven does not remember to turn off kitchen appliances. Steven also leaves the front door open after retrieving the mail. He has signs and notes posted around the house to remind him to turn things off and close doors behind him.	Personal Supports	iBudget Waiver
☐ Community Safety			
☐ Internet Safety			
☐ Need for information or training on how			

	to prevent abuse, neglect, and exploitation			
☐	Insufficient or Unstable Housing			
Needs/Risks Related to My Caregiver (For those living in the family home. Choose all that apply)				
☑	Caregiver Health Needs	Father has had two knee replacements surgeries in the past 5 years. Steven requires physical assistance and supervision while using the kitchen.	Personal Supports for Steven training and assistance with household chores	iBudget Waiver
☐	Limited Relief for Caregiver			
☑	Caregiver Needing Additional Assistance	Steve's father will need to provide additional help to his mother.	Personal Supports is currently helping when parents are unavailable.	iBudget Waiver
☑	Aging Caregiver	Mother has dementia. She also uses a walker for long distances and bathroom is ADA accessible. Steven does not grocery shop or manage finances independently. Steven's parents are unable to provide physical assistance throughout his day, but they can offer words of encouragement and prompts to keep him on track with chores.	Extended family assists with grocery shopping and light housework	Natural Supports

Back-Up Plans for My Critical Needs/Risks

After identifying all needs and strategies to address those needs, the next step is to ensure that the consumer has resources available to meet these critical needs in case something goes wrong.

A back-up plan is a set of actions or additional supports that are agreed to ahead of time to keep the consumer safe and healthy. The back-up plan is used when the consumer'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 available community resources.

The WSC/CDC+ Consultant's role in developing a back-up plan:

1. Have a conversation with the individual or the legal representative to discuss what his or her back-up plan should be for each critical service provider.
2. Find out if there are family or friends already in the individual's life that could provide care if the primary worker is not available.
3. If the consumer does not have someone else available to provide care, work with the consumer to identify community resources that will be contacted to provide emergency support while a caregiver is being located.

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

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 provide care in case personal supports does not come to work. Gloria also has a medical alert pendant.	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 has been trained to address and will call 911.

Risk Management Strategies to Consider *(To Help Provide Back-Up)**:***

- Paid or unpaid/natural supports
- Assistive technology or devices such as medical alerts and 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 or CDC+ Consultant'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 and includes a description of progress toward meeting individually determined goals, an explanation of how services and supports helped them achieve 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. Input from family, friends, or other supports can also be included.

Significant events may include incidents or events in the person's life and the follow-up measures taken to mitigate risks to the individual.

Important Points Regarding the Annual Report

- Providers must submit the 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 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 Year

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 theater 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 coworker 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 on how to talk 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 in the corresponding field.

Goals I worked on last year	Progress on each goal
Get a paid job.	Accomplished goal and works at a movie theatre.
Get along better with housemates.	Michael did not meet his short-term goals. He continues to engage in physical aggression when disagreements occur.
Go to a car race.	Michael did not save enough money for a ticket this year due to working less hours.
Get ready on my own for work.	Michael needs less prompts and reminders to complete hygiene tasks now.
Take medications without help.	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 consumer would like to see in his or her life in the next few years. This information is from the perspective of the consumer based on what is important to them.

The information included in this section 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 consumer 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 to do it. Michal said, "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 document the accomplishments, supports, dreams, hopes, desires, and activities that the individual would like to see in his or her life. Meaningful goals are based on the information gathered earlier in the support planning process and they guide the action of everyone who will help the individual achieve them. The ultimate purpose of personal goals is to help the support team work together with the individual to achieve independence and live a meaningful life.

Personal goals are the pathway to:

- Being able to decide where to live and to have access to the community
- Remaining connected to family and friends
- Obtaining employment, and

- Having meaningful relationships

Defining goals on the support plan is not a task that WSCs should complete independently. Defining the specific goals that the individual will focus on for the year is part of the conversation that occurs during the support planning meeting.

Questions to Develop Clear Personal Goals

The following questions can be used to guide the person, family, or legal representative in choosing meaningful goals:

- 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 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 is the best place for you to meet friends? Would you like to join a social club or establish friends at school, a day program, 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.
- I want to continue to learn about my medications and how to manage them independently.
- I want 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 the consumer decide what service or support will help achieve each goal. Identify if they are paid or unpaid, and if the support is not paid, include the relationship of the unpaid support to the individual.

All people are unique and have specific wants and needs. It is wrong to assume that one individual with a developmental disability will have the same wants and needs another individual with that same developmental disability. Support plan goals must be individualized and specific to the consumer. A common error in support plan development is including goals that are vague and generic. This way of writing leads to "cookie-cutter" support plans that have no meaning to the person and does not represent true needs or desires.

The following are ways to make sure that the goals written in the support plan are specific:

- Ask questions such as, "What does this goal mean?" Does the goal statement say something specific, or can it be interpreted in several ways?
- Repeat the goal statement back to the consumer and the legal guardian during the support planning meeting. Repeating the goal will help to make sure that it is exactly what the consumer wants and that it means something to them.
- Make sure that the goal is not simply a statement of the need for a specific service. services. Services are NOT goals but a means to achieve the goal. For example, Adult Day Training is a service used to reach specific goals such as gaining work skills, making friends outside of the home, increasing communication skills, etc.
- Make sure that the goal statement represents the outcome that the person wants to achieve, not actions that must be taken along the way. For example, stating, "Michael wants to pour his laundry detergent into the washing machine independently seven out of 10 trials" is not a goal, but a means to a goal. Instead, the goal could be phrased as: "Michael wants to do his laundry independently."

Natural Supports and Community Resources:

Natural supports are the relationships and networks that occur naturally in a person's life, and they are key to living a truly integrated life in the community. A natural support is not a

paid provider, but someone in the individual's life that has formed a connection with the individual based on a natural life experience. Everyone needs the support of people who care about them. It is the role of the WSC or CDC+ Consultant to find ways to help the individual make connections and build a network of family, friends, neighbors, and other community connections.

There is no single method or checklist for developing a network of natural supports. The WSC/CDC+ Consultant and other providers must support and help the person develop associations and relationships.

When generating community and natural resources, it is important to consider organizations and resources already available in the community. These can include nonprofits, other state agencies, and public service organizations. In addition, family connections and friends who are involved in the individual's life can be a vital source of daily natural support or can step in during an emergency. Last, no matter where the source of support is coming from, it is necessary to match the person's interests and strengths with what the support or organization can offer.

Remember to consider natural supports and community resources when developing goals. WSCs and CDC+ Consultants are required to work with individuals, families, other providers, and APD staff to identify and develop community-based resources.

Before using a waiver service, The WSC/CDC+ Consultant must ensure that the same service 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 a Resource Directory as an informational service to help individuals with disabilities learn about available resources and organizations in their respective areas. WSCs and CDC+ Consultants 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. WSCs and CDC+ Consultants 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.
Getting a new job with lumber and tools.	Supported Employment	Paid
Going to a car race.	Residential Habilitation in coordination with his brother.	Paid
Increase ability to do my own self-care and medications.	Residential habilitation initially. Supported Living Coaching possibly in the future.	Paid
Getting along with my roommates and learn how to have less problems.	Behavior Therapy. Also, attending free Communication Savvy class offered at the local disability resource center next month.	Paid
Meet more friends besides my housemates. Join the local chapter for the racecar fan club and attend monthly meetings.	Life Skills Development Level 1-Companion	Paid

Personal Rights

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

- Individuals have a right to be free from abuse, neglect, and exploitation.
- Individuals have a right to privacy where they sleep and live.
- Individuals can lock the door to private spaces and restrict key access to only appropriate individuals.
- Individuals have a choice in roommates.
- Individuals have the freedom to furnish and decorate their living spaces.
- Individuals have the freedom and support to control their schedules and activities and to access food at any time.
- Individuals can have visitors that they choose at any time.
- Individuals have the right to live somewhere that is physically accessible to them.

Florida Statutes, Chapter 393.13 requires that services for individuals with developmental disabilities be designed to meet the individual's needs and protect the integrity of 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 the legal representative. The individual's signature on the last page of the 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 understand what this means for them. Additionally, for individuals who live in licensed facilities, the WSC should review the *Resident Rights for Individuals Living in APD Licensed Facilities.*

When reviewing the Bill of Rights, the WSC or CDC+ Consultant should verify the consumer's understanding of abuse, neglect, and exploitation. Make sure that the consumer understands what this is and how to report it. Since each consumer receives and processes information differently, it is important for the WSC/CDC+ Consultant to communicate this information in a way that is best understood by the individual. WSCs/CDC+ Consultants must also document the individualized efforts to educate consumers about abuse, neglect, and exploitation in the case notes in APD iConnect. Additionally, it is important that the WSC or CDC+ Consultant explains to the person/legal representative that they also have an obligation to report allegations of abuse, neglect, or exploitation to the Florida Abuse Hotline, even if the allegation involves another consumer.

During this conversation, or if at any time the WSC or CDC+ Consultant knows or has reasonable cause to suspect that a person with a developmental disability is being abused, neglected, or exploited, they are required to report such knowledge or suspicion to the Florida Abuse Hotline. The toll-free number is 1-800-96-ABUSE. Failure to report known or suspected cases of abuse, neglect, or exploitation is a criminal offense.

Such knowledge also requires WSCs and CDC+ Consultants to alert APD when an allegation is suspected.

Personal Rights: (not related to guardianship)

Signatures on the last page indicate that the individual or their Legal Representative are aware of the individual's personal rights and the Bill of Rights for Persons with Developmental Disabilities.				
Is there a right I would like to learn more about?	**Yes**	☐	**No**	☐
My WSC provided information about abuse, neglect, and exploitation to me this year, and I know the reporting process and requirements.	**Yes**	☐	**No**	☐
Do I have restrictions on my rights? This might include limited restrictions such as not being able to lock my bedroom door with a key, restricted visitation, inflexible schedule, limited food or environmental access, etc. If yes, complete the table.	**Yes**	☐	**No**	☐

Copies of the *Bill of Rights* and *Resident Rights* can be found in Appendices A and B.

> *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 or more rights, such as limited access to food (locked cabinet doors or fridge), not being able to lock the bedroom door, etc., fill out the table:

1. Explain the specific right being limited.
2. List the reason for the limitation and what less intrusive methods were tried previously.
3. Explain what is being done to help obtain full rights.
4. Input 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 been called in the past.	Staff following Behavior Plan, working with Jonathan to communicate using iPad/board. Working with behavior assistant to extinguish behavior.	2/20/2022 – LRC will review Behavior Plan and restrictions.

WSC, initial as assurance that the interventions and supports cited above will not be harmful	XX
Safety Plan Required and Attached (if applicable) **Yes** ☐ **No** ☑	

The WSC/CDC+ Consultant is responsible for ensuring 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 a 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 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 to facilitate successful community living.

The Safety Plan should include the following:

- A summary of historical behavior and any related criminal charges, court order, and probationary or registration requirements
- Information related to preventing the reoccurrence of offenses
- Explanation of preventative measures, including triggers and high-risk situations for the individual
- Documentation of 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 personal rights, the Local Review Committee (LRC) must provide oversight. This Safety Plan must be developed and in place before a person moves to a new setting, and the WSC should also make sure the service providers are fully trained on the Safety Plan.

Within the Person-Centered Support Plan form in APD iConnect, if the WSC or CDC+ Consultant identifies that a Safety Plan is needed, additional fields will appear.

Safety Plan:

Summary of Historical Events:

Special Considerations:

a) If there is a court order, indicate what it requires:

b) If there is a Probation Officer, identify who, their location, contact numbers and any other court requirements:

c) If required, identify where the person must register locally as a "sex offender":

General Precautions and Preventative Measures

a) Identify any triggers, high-risk situations, environmental and personal stressors that might lead to re-offending:

b) What predatory "grooming" behaviors are known:

c) Limitations on access to media (TV, movies, printed material, video games, internet or cell phone) if any and why:

d) Identify "avoidance" or preventative behaviors that need to be trained or be prompted in risky situations:

e) The level or type of routine supervision required is:

f) Staff assignments, including size, gender or other critical attributes:

g) Risk sites to be avoided near home location:

h) Bedroom assignments (roommates and location within the home):

i) Community limitations (allowable activities, van routes, supervision):

j) Day program or work environment supervision:

k) Alarms and monitoring devices needed:

Additional Notes/Comments/Considerations

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. The sources for this information include the most recent QSI, current Medical Case Manager reports (if applicable), past support plans, nursing or physician care plans, incident reports, and progress notes. When there are gaps in information, or if anything does not seem clear, conversations or face-to-face meetings may be required to get an accurate picture of the individual's health.

Important Health History About Me

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

- Is her or she still experiencing any medical concerns?
- Are there 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 underweight and continues to lack arm strength and is unable complete activities of daily living and transfer. Gloria requires close supervision when eating to avoid aspiration. She requires Thick-It for all liquids.

Hospitalizations

If the consumer was hospitalized or had to go to the emergency room for any reason during the last 12 months, indicate "yes" and include specific information about the situation.

Hospitalizations in the past year	**Yes**	☑	**No**	☐
Emergency Room Visits in the past year	**Yes**	☐	**No**	☑

If yes, why did I go to the hospital or emergency room?
Gloria has 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 result of the pneumonia.

My Medication Information

Include all current prescriptions, over-the-counter drugs, and homeopathic/natural remedies. This information is collected on the Medications tab in APD iConnect and can be pulled into the support plan electronically.

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., EpiPen), this must be identified here.

Medications	**Dosage/Frequency**	**Purpose of Medication**	**Side Effects/Problems Experienced**
Advair	2 puff per day/morning and night	Asthma	Nose bleeds possible, but none noted.

Allergies: (Including any reactions to any medications, substances, chemicals, etc.)
Seasonal allergies occur mostly in the Spring. Michael's brother reported that Michael had an allergic reaction to seafood in the past.

My Critical Health Follow-Up Areas and Preventive Health Plan

These are areas defined by a health care practitioner, legal representative, or others in the person's life as needing specific monitoring, follow-up steps, or preventative measures. In this section, identify areas where the individual's health would be at risk without a plan in place to address it. This could include current or chronic health-related issues that require ongoing monitoring and intervention. Significant medical needs that are identified in the individual's current QSI and/or Medical Case Manager report and current doctor's recommendations should always be included here.

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

Health Care Contact Information/ Health Care Decisions Maker

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

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

Identify who this health decision maker is, the specific role 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	9/1/2021	Health stable	None-Continued Annual Checkup
Dr. Smith	7/16/2021	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 needs any specialized equipment or adaptations to his or her 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.**
Uses a power wheelchair, transfer board, and adaptive utensils. Needs 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/CDC+ Consultant must obtain the signature of the individual or legal representative on the worksheet during the support plan meeting. The signature will document that the individual has chosen to receive home and community services and the decisions made in the support plan, including any restriction on 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.

Updating the Support Plan

The support plan must be updated any time there is a change related to the person's desires, needs, and circumstances. A support plan update can be initiated by the individual, legal representative, service providers, or the WSC/CDC+ Consultant.

The following are some basic steps for WSCs/CDC+ Consultants to take when updating a support plan:

1. Make sure that the individual understands the nature of the change to the plan, what the change means for them, and that they agree to the change.
2. Create a note in the support plan in the section where the change is being made.

Charlie's Scenario

Charlie recently experienced a decline in his health that has led to falling at home. He is no longer able to feed himself, dress, or walk on his own. Charlie, his WSC, and his family agree that he would benefit from an increase in Personal Supports during the day, while the family can assist more at night. Charlie and his supports also agreed that Physical Therapy was necessary to help Charlie regain his strength. In this example, updates would be entered in the Other Services Needed for Health and Safety section for ambulation, eating, and hygiene, as well as the My Health section.

The note should begin with the word "Update" and the effective date of the change, followed by a description of what is changing and why. An example is shown here.

My critical health follow-up areas and preventative health plan: (How will I maintain my Health and Health Stability?)
Update 4/19/2021: Charles has experienced two falls in the past month and required stitches. He has lost strength in his legs and is currently not able to feed himself or complete hygiene tasks without one-one assistance. Requesting an increase in Personal Supports to help. Family will provide additional supports on evening and weekends. Requesting a new Physical Therapy assessment.

☑ Eating	Update 4/19/2021: Now requires hand-over-hand assistance and supervision during meals to prevent choking. Has one-on-one assistance during all meals.	Personal Supports	iBudget Waiver

☑ Ambulation	Update 4/19/2021: Has fallen twice in one month. Requires use of a manual wheelchair at home and in community. Requesting Physical Therapy.	Personal Supports Physical Therapy	iBudget Waiver

3. Once the support plan has been updated, provide a copy to the individual and request that they sign the new plan. Once the individual has signed and returned the copy of the plan to the WSC/CDC+ Consultant, the WSC/CDC+ Consultant must also sign the plan.
4. Distribute copies of the signed plan to the individual. The APD Regional Office can view the support plan within APD iConnect. The WSC is required to transmit the support plan to the provider by a note in APD iConnect.
5. Last, if the support plan update requires a change to the cost plan, the WSC/CDC+ Consultant will initiate that change and request additional funding if needed.

And remember….

When a provider's service is affected by a support plan update, agreement to a change in the job description cannot be assumed. Before completing the support plan update, talk with the provider to make sure they understand the change and how it impacts their work with the individual and ensure that they agree to the change.

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 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.