

Person Centered Planning Stakeholders Feedback

HCBS Requirements (excerpts from rule)	What We Do Now?	What We Need To Do?	Comments/Barriers/Concerns
PERSON CENTERED PLANNING PROCESS			
The individual will lead the person centered planning process where possible. The individual's representative should have a participatory role, as needed and as 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			
Includes people chosen by the individual.			
Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.			
Is timely and occurs at times and locations of convenience to the individual.			
Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient			
Includes strategies for solving conflict or disagreement within the process, including clear conflict-of interest guidelines for all planning participants.			
Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person	Rules require that WSCs be legally and financially independent from and free-standing of persons or organizations providing direct services within the state of Florida, other than support coordination.	No Change – Already Implemented	

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centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.			
Offers informed choices to the individual regarding the services and supports they receive and from whom.			
Includes a method for the individual to request updates to the plan as needed.			
Records the alternative home and community-based settings that were considered by the individual			
PERSON CENTERED SERVICE PLAN			
The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State's 1915(c) HCBS waiver,			
Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and			

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work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.			
Reflect the individual's strengths and preferences.			
Reflect clinical and support needs as identified through an assessment of functional need.			
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			
Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.			
Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient, consistent with § 435.905(b) of this chapter.			
Identify the individual and/or entity responsible for monitoring the plan.			

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Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.			
Be distributed to the individual and other people involved in the plan.			
Include those services, the purpose or control of which the individual elects to self-direct.			
Prevent the provision of unnecessary or inappropriate services and supports			
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			
Identify a specific and individualized assessed need.			
Document the positive interventions and supports used prior to any modifications to the person centered service plan.			
Document less intrusive methods of meeting the need that have been tried but did not work.			
Include a clear description of the condition that is directly proportionate to the specific assessed need.			
Include a regular collection and review of data to measure the ongoing effectiveness of the modification.			
Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.			
Include informed consent of the individual.			

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Include an assurance that interventions and supports will cause no harm to the individual.			
REVIEW OF THE PERSON CENTERED SERVICE PLAN			
The person-centered service plan must be reviewed, and revised upon reassessment of functional need as required by § 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.			