Person-Centered Planning
for Individuals using the ID and DS Waivers
Frequently Asked Questions
10/01/09

Introduction

Person-centered practices promise ongoing listening and learning. Over the past few years, Virginia has traveled well down this road, listening and learning from the questions and comments we've received from individuals, family members and other advocates, support coordinators and providers about ways to improve our new person-centered planning process and ISP. The following is a compilation of a number of questions we received, along with answers to promote a clearer understanding by all stakeholders of the new person-centered planning process and ISP. This process (and paperwork) was developed through the support of many voices representing many players. Feedback and good ideas continue to be collected in the effort to find the best blend of everything that's needed to help the individual get a better life in the community.

For ease of locating specific concerns, these Frequently Asked Questions are arranged around the 5 parts of the ISP as seen in the table below. An additional section: *Learning, Updates (Supporting Documentation) and Process* explains the supporting documentation and ongoing learning process. If you continue to have questions after reviewing these answers, please contact your Community Resource Consultant with ODS.

All the Person-Centered Planning forms referenced can be found at: http://www.dmhmrsas.virginia.gov/ODS-PersonCenteredPractices.htm.

PART	NAME	FORMS ASSOCIATED WITH THIS PART:
I	ESSENTIAL INFORMATION	• Essential Information Long Form (Word) • Essential Information Update Form (Word) NEW 07/01/09 • Annual Risk Assessment (SIS Section 4) (Word)
II	PERSONAL PROFILE	• Personal Profile version for handwriting (Word) • Personal Profile version for computer (Word)
III	SHARED PLANNING	• Shared Planning (Word)
IV	AGREEMENTS	• Agreements (Word)
V	PLAN FOR SUPPORTS	• Virginia ISP Part V (Word) Revised 07/01/09

Part I: Essential Information

1. Q. What information is provided by the support coordinator (SC) to providers who are selected by an individual?

A. The SC is responsible for sending the same information as always and in any format to waiver providers who are newly selected by the individual. All required essential information has been captured on the Essential Information Long Form. Providers of individuals who were receiving services under the ID and DS Waivers prior to April 2009 already have the essential information needed to provide services, so only annual or as needed updates of changes are sent.

2. Q. Does the SC send a new set of Essential Information annually?

A. No. Once the SC has sent the essential information needed for the provider to begin services, only changes to the information need to be sent to the provider. An update form is available on the website for that purpose. Essential information is reviewed to assure all changes have been made in the record and that these changes are distributed to providers as needed.

3. Q. Is the SC still required to send the social assessment to providers each year?

A. No. After April 1, 2009. there is no longer a requirement for the social assessment as previously used, although the information contained in it is still important and will be captured somewhere in the new person-centered record. Information found in the Essential Information was previously found in the Social Assessment. Those CSBs that continue to use the old social assessment format for distributing the essential information to the provider are also only required to share updates annually and when changes are made (rather than recreate a new document).

4. Q. If we're no longer using the social assessment, why does the Jack sample include "social assessment" as the location in the record?

A. Some CSBs may continue to use their existing social assessment format to record and share certain of the essential information with providers.

5. Q. The Essential Information long form indicates that all individuals need a "back-up plan." Is this true?

A. No. The only services that require the individual to have a back-up plan are agency-directed Personal Assistance or any of the 3 CD services (Respite, PA and Companion). The reformatted version effective 7/1/09 provides clarification.

6. Q. The Essential Information long form indicates that a "discharge plan" is not always applicable. Is this true?

A. Yes. Not all waiver services require a plan for discharge, such as those expected to continue throughout an individual's life. Do not confuse this with a licensed waiver provider's requirement to maintain discharge procedures and policies and to complete an individual's discharge plan where applicable.

7. Q. Do providers still complete their functional assessments each year?

A. Providers are required to continue completing their approved assessments for individuals who do not have a Supports Intensity Scale. After the three year phase-in of the SIS, providers will no longer be required to complete functional assessments.

Part II: Personal Profile

1. Q. Should all providers have input toward an individual's Personal Profile?

A. Yes. The individual and/or SC may ask one or more partners to support the individual with completing the profile prior to the meeting. At a minimum, providers are required to offer input toward the personal profile at the annual meeting. The SC will share the final copy (typed or handwritten) will all partners after the meeting.

2. Q. Should there be a meeting to complete the profile?

A. No. This is not required, but is an option based on the individual's preference. The profile information can be gathered in a number of ways, but should be close to final prior to the annual meeting. The individual and/or SC may select a "planning partner" to assist the individual with gathering the information from those who know him or her best (see Q1).

3. Q. Can other person-centered tools assist in completing the profile?

A. Absolutely. Other tools can help guide the individual and family to identify the good life and facilitate conversation about what's working and not in each life area.

4. Q. How is the profile completed when an individual does not speak?

A. For people who do not speak in traditional ways, the answers to the profile become our best guess from what we know about the person. There are person-centered thinking tools that are especially helpful with people who don't speak for themselves.

5. Q. How can I get more information on Person-Centered Thinking tools?

A. Person-Centered Thinking (PCT) skills and tools are being taught in training sessions across the state. For more information, contact Dawn Machonis at the Partnership for people with disabilities at 804-828-1335 or dmmachonis@vcu.edu.

6. Q. What if providers and families are reluctant to identify things that aren't working, thinking it reflects on their ability to support the individual?

A. It is important to remind providers and families that the Personal Profile is not a tool to evaluate the skills of support providers, but rather help discover where improvements can be made for the individual to have a better life in the community. The Personal Profile is intended to help us look beyond the current situation in a person's life to see what's possible and to help them connect with others who are not paid providers.

7. Q. Does every section in the profile need to be completed?

A. It is expected that the individual (first with the support of chosen partners and then the planning team at the annual meeting) complete the profile in a thorough manner considering all subcategories under each life area. No life area may go unaddressed. When there is insufficient information in any life area, it is an indication that more information is needed and the planning team should have further conversation with each other and others who know the individual well.

8. Q. What if changes need to be made in the Profile following the annual meeting? How are these made/distributed?

A. It is not necessary to update the profile. The profile is a planning tool that is used to plan for the coming year. As new and important information is learned, it should be shared with other partners as applicable and through the person-centered review process. The profile is not redistributed as a single document again until after the next annual meeting. When new providers are selected by the individual, the SC can add a note to the profile explaining the reason for the additional service or can share recent SC person-centered reviews to describe the changes that have occurred since the last annual meeting.

Part III: Shared Planning

1. Q. Do outcomes have to be written as if they are happening?

A. Person-centered outcomes are written in the present tense and in active terms, as if what's hoped for is actually happening right now. Agreeing on what success would look like when achieved gets everyone on the same "person-centered page." If you're in the habit of writing them as "Sarah will" or "Jack wants to," go ahead and then strike-though the "will" or "wants" (and correct the tense) for a person-centered outcome. There is a guidance document on the web called Outcomes and Support Examples.

2. Q. On the Shared Plan, there is a column marked "how often." Is this column related to the frequency of the outcome and do all providers have to provide supports for that outcome at that frequency?

A. The "how often" column on the shared plan reflects the desired frequency that the individual would like the outcome to occur. The team should explore options to work toward this frequency. If this frequency cannot be met among existing partners, those that can provide some support toward the outcome agree to help to the extent that they can (as documented on each plan for supports) and the SC continues to explore and offer other supports that may eventually help the individual reach his or her desired frequency. Friends, family and other natural supports may also help an individual reach a desired frequency.

3. Q. I think some people's desired outcomes are unrealistic. How can I say that I will help with something that I know can't be achieved?

A. A person-centered plan is a promise. Those supporting the person commit to help that individual move toward his or her good life, which may sometimes include what others think is impossible. It is important to recognize that an initial request may eventually be satisfied in other ways. Someone who wants to be a doctor may find that volunteering at the local hospital meets her needs. Offering to help an individual achieve an outcome is not guaranteeing to make it happen, but respecting a person's desires and providing preferred supports that lead someone closer or in a different, more possible direction. Knowing what a person really wants takes skill and knowing the person. When what someone wants goes into his plan, something that addresses his request is more likely to happen.

4. Q. Is Part III: Shared Planning required for all individuals?

A. Yes. Part III: Shared Planning is a central part of the new person-centered planning process. It is required as of 5/1/09 for all individuals receiving waiver. Part III may be developed in a different format as long as all of the elements are present. The desired outcomes listed on Shared Planning are the basis for the support activities that are developed in each Part V.

5. Q. When is the shared plan developed for individuals new to waiver?

A. An initial shared plan is developed by the SC and the individual (with family/others) before beginning waiver services. Newly selected providers identify the outcomes they will address on this initial shared plan and spend up to 60 days learning about the individual's preferences and support needs (as described in their Part V: Plan for Supports). There is a guidance document online that details the 60 day process.

6. Q. When is the person-centered plan developed for someone leaving a training center?

A. Prior to leaving the training center, the individual with others as needed/required and the SC meet with community partners to update the Profile and develop a Shared Plan that reflects the individuals desired life in the community. The new community providers may choose to complete a 60-day Plan for Supports. See online guidance on completing a 60-day PFS.

7. Q. Is the SC solely responsible for writing the shared plan?

A. Absolutely not. The shared plan is a team process, where all providers and other partners participate. It should be completed by a volunteer recorder at the annual meeting, so the SC can focus on facilitating the planning process. The SC is responsible for assuring all partners receive a complete and accurate copy of the shared plan after the annual meeting so that they may proceed with developing the Plan for Supports.

8. Q. What is the process when an existing provider does not attend the annual meeting?

A. A Medicaid provider is required to have an approved Plan for Supports. The SC should speak with the individual and others as needed/required to determine if continued services are desired from the absent provider. If continued services are chosen, the provider will:
1. Receive from the SC a copy of the Shared Plan developed by the team.
2. Indicate on the Shared Plan the outcomes that will be addressed in the plan for supports.
3. Submit the Shared Plan with provider commitments identified, a copy of the PFS and a copy of the existing agreement page signed by the provider with the current date to the SC for review and approval prior to beginning services.

A Medicaid waiver provider is required to have an approved Plan for Supports in order to bill for services provided.

9. Q. Where do we obtain the important TOs and important FORs listed in column 2 in Shared Planning?

A. The personal profile helps to focus on what's most important in each critical aspect of one's life. What's most important will be uncovered as what's working and what's not working in that aspect of living are identified. For example, in Jack's Personal Profile, under "Home," we learn it's important for Jack to live with Joe and Jerry. We also learn from what's not working under "Home," that it's important to Jack to have time alone and listening to his music. The team identifies that having privacy (while continuing to live with Joe and Jack) is what's most important to Jack at this time.

Important FORs are identified in the same manner, mostly under "Health and Safety," but they can be discovered at other places in the profile. For example, being with the guys at the Krispy Kreme is important to Jack, but it is important for Jack that he not go alone at night and not eat the donuts.

If the individual has a SIS and/or another person-centered tool, these should be reviewed to assure that no important items (TO or FOR) are missing from the shared plan.

10. Q. Do all important TO and important FOR items in the Profile, Essential Information and SIS have to be included in the plan?

A. Important FOR issues related to health, safety and value in community must be addressed in the Shared Plan and subsequent plans for supports. Important TO items may be selected by the individual with his/her partners to address over the next 12 months. Any items that are identified as important TO an individual in any of these areas that do not appear on the Shared Plan are explained on the Agreements page in the spaces provided.

11. Q. Will waiver providers still use their own functional assessment in order to identify goals and objectives?

A. Functional assessments are only required of ID and DS waiver providers until the individual has a SIS completed. Functional assessments are used for identifying supports that are needed for an individual to accomplish his or her desire outcomes, not for identifying goals and objectives. The use of goals and objectives has been replaced with "desired outcomes" and "support activities." Please see the language changes document PCP Language Changes online.

12. Q. Is the Shared Plan modified/edited throughout the year?

A. No, except in the case of new providers selected after the plan meeting, who will put their name by **existing** outcomes on the Shared Plan that they will address in the plan for supports. If the individual wants to change outcomes during the year, providers will complete a quick PCR update explaining the change and submit along with a revised PFS to the SC.

13. Q. Can the support coordinator refuse to add an outcome that the day support program feels is necessary?

A. Outcomes must be either important to the individual or important for the individual's health, safety and value in the community (as identified in the SIS or other assessment). If the outcome does not meet one of these two conditions, it is not considered appropriate for planning. For example, if a day support provider is seeking to add an outcome for the development of "fine motor skills," an individual preference like an interactive video game or scrap booking could address "motor skills" and would focus the supports towards a good life for the individual.

14. Q. Individuals in congregate settings will have similar schedules due to the fact that some activities are group activities and staff are shared. Case managers do not seem to understand these constraints and expect agreement to outcomes that we cannot provide. What do you suggest?

A. The suggestion is that you explain your abilities to accommodate the desires and needs of the individual in a group setting. You will have to be honest with the individual about what is possible given these constraints. Don't agree to help with an outcome if you don't believe there are any supports you can provide. Creative team exploration may reveal some new possibilities and ideas for developing new relationships and natural supports.

15. Q. How are daily routine supports included in the shared plan?

A. Routine supports are typically identified under important FOR in the Shared Plan.
A few simple outcomes can accommodate many routine supports. For example, "John is clean each day and lives in a clean, organized home" becomes the outcome for many residential supports related to personal care and home maintenance like bathing, cleaning the kitchen, washing the dog, getting the mail, etc.

16. Q. We are worried that we won't accommodate all of a person's needs during shared planning. How can we assure that all issues are covered?

A. The team will need to help the individual to prioritize what can be addressed in the coming ISP year. Several things that are important TO an individual can be addressed through the same outcome rather than through multiple outcomes - for example, "Cindy meets new people through a variety of her favorite community activities (such as neighborhood walks, church socials and volunteering with Meals-On-Wheels. All important FOR items must be addressed in the ISP to assure the individual is healthy and safe while receiving services in the waiver.

Part IV: Agreements

1. Q. Is it acceptable to have some of the agreement questions unmarked if they don't apply?

A. No. All agreement questions need to be considered and answered. There are spaces available for describing unresolved issues or items that don't apply.

2. Q. Does Part IV: Agreements replace the previous Documentation of Agreement for recording signatures at the annual meeting?

A. Yes. The new PC ISP requires signatures on Part IV and on the individual Plan for Supports developed with the individual after the annual meeting. The Documentation of Agreements is no longer used.

3. Q. What if the guardian is not present at the team meeting and cannot sign the agreement when others sign it? Can the plan be put into action without this signature?

A. There needs to be a guardian signature or verbal consent (if unable to be present) on the plan prior to the start date. When verbal consent is used, it should be documented and followed by obtaining the guardian's signature. If the guardian is unavailable/not responding, all efforts to obtain the guardian's signature should be well documented and communicated to the SC by providers before beginning the new ISP year.

4. Q. If the individual has a guardian, does the individual sign the Agreement page or his/her Part V: Plan for Supports, too?

A. While the guardian may sign in place of the individual, it is recommended that the individual sign as well to maximize their participation in the development of their own plan. Even if an individual is unable to sign, the plan should be reviewed with them and their consent and understanding should be obtained to the extent possible.

5. Q. If changes are made in any part of Parts I-III, is a new Part IV needed?

A. No. Changes to Part I: Essential Information are communicated on the update form that is signed by the person providing the changes in information. There is no requirement for the individual to sign the updates to EI.

Part II: Profile is completed by the individual once each plan year by the person with someone he or she chooses to help. Part II does not require a separate signature beyond that provided at the end of the planning meeting (Part IV Agreements).

Part III: Shared Planning is modified only when new providers are introduced after the annual meeting. The new provider reviews the Shared Plan and identifies desired outcomes they agree to help the individual achieve. They record their provider information under "who's going to support me" and sign a copy of the existing Part IV with the current date. Other changes in outcomes during the year are explained on the Person-Centered Review.

6. Q. Do all waiver providers need Part IV Agreements in their records?

A. Yes. Part IV is signed by all partners and sent by the SC to all partners following the annual meeting. The answers to the agreement questions including any unresolved issues, as well as signatures must be available in each record. If you have not received Part IV from the SC, be certain to record any attempts to obtain it.

7. Q. If a CSB/provider has an electronic record, how will Part IV be handled? Can it be scanned in and how would it be shared with others?

A. Part IV: Agreements can be handled in the same manner as the previous Documentation of Agreement/signature page. Providers with electronic records may find that scanning, securely emailing or faxing is an appropriate way to distribute the document. Recent advances in electronic recording include the use of signature devices, which may accommodate the completion of this form (speak with an IT specialist for additional information).

Part V: Plan for Supports (PFS)

1. Q. Does the SC write each provider's Plan for Supports or does each provider write their own?

A. After the PC ISP meeting, each provider develops their plan for supporting the individual (Plan for Supports) to accomplish the outcomes they agreed to help with at the meeting. A plan for supports is sent to the SC for review and included as a part of the ISP if approved. If it cannot be approved because of questions or discrepancies between the shared plan and the PFS, the support coordinator is expected to contact the provider for resolution.

2. Q. What documentation related to Part V: Plan for Supports do providers give to the SC?

A. Annually, the Plan for Supports is developed with the individual after the meeting and sent to the SC prior to the start of services. Quarterly, the Person-Centered Review reports progress on each outcome and is also used for mid-quarter changes in outcomes. Anytime the outcomes change, the PFS is updated with the new outcome and support activities and signed with the individual and others as needed/requested and submitted to the SC with the revision date noted.

3. Q. PA, Companion and Respite providers don't have "training goals," does this impact implementing the PC ISP?

A. No. Services that currently require training goals must have supports that indicate that the individual is learning new skills or abilities. Skill-building supports are not provided by PA, Companion and Respite providers, but the routine supports they provide would still address the individual's outcomes and personal preferences. Personal Preferences is a supplemental document that captures individual's preferences and may be used with the CMS-485 or the DMAS 97 A/B, when those forms are used in place of the PFS. See samples of documentation online at http://www.dbhds.virginia.gov/ODS-PersonCenteredPractices.htm.

4. Q. How do unlicensed providers, mental health providers, non-waiver funded services and family participate in Shared Planning?

A. Waiver providers, non-waiver providers and natural supports are all included on Shared Planning in the "Who's going to support me" column, even if they may not have made it to the planning meeting. Unlicensed providers who offer waiver services are still required to participate in the PC process as licensed providers under the ID and DS Waivers. If no current partner can provide supports for a desired outcome, the SC may be the partner designated to help the individual to locate other providers or supports.

5. Q. Where are SC goals recorded?

A. The SC shares outcomes, just like any provider when SC support is needed. The SC will also have one outcome under important FOR that addresses the required monitoring and review of all services.

6. Q. The licensing regs ask us to incorporate strategies for addressing behaviors, communication and risk for falls. If it is identified as a need, will we put these issues as an "important for" if the person does not claim it as "important to?"

A. Yes, risks of falling, behavioral and communication issues will always be addressed in a person-centered plan. If they are not identified in what's important to the person, they'll be considered under what's important for the person. Remember that supports that are important FOR an individual's health and safety are also to be provided according to personal preferences and what's important TO him or her. PC practices strive to obtain a balance between what's important to a person and what's important for the person. The annual risk assessment (SIS Section 4) does not replace the assessment of fall risk as required by the Office of Licensing.

7. Q. Would communication or behavioral support needs always have an outcome?

A. No. If an individual's Essential Information includes communication or behavioral support needs and no active planning is needed, it would be acceptable to **detail the supports in the support instructions** across outcomes. If an individual needs speech therapy, a communication device or a positive behavioral supports consult an outcome under Shared Planning would be appropriate.

8. Q. Right now we break our plan into sections, one for training objectives and one for assistance activities. Will all of these supports now be grouped together on the Plan for Supports?

A. There are many ways to learn something new and a number of different instructional methods, and all services that require skill-building (RS, DS, SE, etc.) will include supports and activities that the DSP is doing to help the person learn something new. Sometimes that will happen through consistent and ongoing modeling. Other times, it will be an activity with a carefully followed instructional plan. Deliberate skill-building activities should readily present themselves to a reviewer, but it is fine to label them in the plan.

9. Q. Since "support activities" are replacing what used to be "objectives" on the PFS, do we also need a start date and a target date for completion of each of the supports?

A. No. The PCP is planning for one year - so all outcomes and supports are targeted for 12 months unless indicated sooner. The sample PCP has the end date of the ISP on every page. Some end dates will be less than 12 months and should be noted as such. If there is a specific support that is time-related, that needs to be noted on the plan, e.g. – register for knitting class.

10. Q. I thought this was supposed to be one plan, but now I hear all providers and the SC do their own plans?

A. The individual has one ISP, which amounts to 1) one set of essential information, 2) one personal profile that's used to assist the team in planning for the year, 3) one set of outcomes whose supports are shared across all partners/providers, 4) agreements that all partners sign to help with the shared plan and 5) the providers' plans for supporting the individual to achieve the outcomes agreed to in the shared plan.

As always all providers who bill Medicaid must have their own plan for supports that describes what they will be billing Medicaid. They may use either Part V Plan for Supports on the ODS website or their own format that must include the same elements: the individual's shared outcomes, support activities with corresponding support instructions that address the individual's preferences, the frequency of support and a general schedule of when supports will be provided.

11. Q. What criteria will the SC be using to review the Plan for Supports?

A. The SC will be reviewing each plan for basic assurances including: the PFS matches the shared plan, there are no new outcomes (unless there is a Person-Centered Review explaining the reason the individual decided upon an additional outcome), Support activities focus on and relate to the individual's outcomes, all health and safety needs are addressed, support instructions reflect the individual's personal preferences, support needs and participation in the activity, the PFS is signed by the provider and individual (or other, as applicable), and that the general schedule matches the Plan for Supports and does not exceed requested hours.

12. Q. What should an SC do when a provider's Part V: Plan for Supports does not include the outcomes from shared planning or includes new outcomes that were not discussed at the meeting?

A. There is a PFS Review letter available online to assist support coordinators with the PFS review. The SC should return the provider's Plan for Supports with a request that it be revised to match the Shared Plan which was agreed upon at the meeting. Disagreements should be handled through the supervisory process when possible before contacting ODS staff.

13. Q. Do all providers need copies of all Plans for Supports?

A. No. Each provider should retain their own copy after submitting to the SC for review.

14. Q. Can the Plan for Supports be ready before annual planning?

A. No. it's not until the Shared Plan is completed that the Plan for Support can be developed. For people you've been supporting, you will know ahead of the meeting some of the supports you'll need to provide, especially those related to the individual's ongoing health and safety needs. You also may have a close partnership with the person and know the outcomes that he or she will select and have already talked some about supports. In those cases, some of the plan can be drafted in advance of the meeting (such as writing support instructions for diabetes or ideas about important TO/important FOR).

15. Q. How do we update the Plan for Supports?

A. When changes in outcomes are desired by the individual, a PCR update on affected outcomes is completed by the provider to explain the reason for the changes. The PFS is updated with the outcome(s), support activities and support instructions.

16. Q. My agency doesn't use the PCR how do we update the Plan for Supports?

A. Your agency can send a revised plan for supports that describes changed outcomes, along with an explanation of the reason for the changes. The new PFS must be signed by the individual (and representative if needed). Include a space for the support coordinator's signature. The support coordinator will review and confirm changes with the individual as needed and then sign and return the signature page to your agency.

Learning, Updates (Supporting Documentation) and Process

1. Q. Does the SC write all the Person-Centered Reviews (PCR), or does each provider write their own?

A. Each provider writes their own PCR. The SC will review these and summarize any changes and significant information in his/her reviews as they have in the past.

2. Q. Does the general schedule of supports take the place of the previous schedule (or "master activity schedule") and should the outcomes (goals) be included in this section?

A. Yes, it can be used in place of any previous schedule. The Schedule of Supports should reflect the supports described in each waiver provider's Part V and Supports Checklist (if being used). There needs to be enough information on the schedule that would enable the individual and staff to know when supports will be provided.

3. Q. Do we still need to record data (the old training objective data sheets) or is that information now incorporated into the progress notes.

A. Many previous methods of "data collection" that we've used in Virginia to demonstrate "training" and progress are now obsolete. For all Waiver providers, there must be documentation confirming that supports were provided at described in the Plan for Supports. This can be done with the use of the "Supports Checklist" accompanied by a Support Log that explains why support activities did not happen as agreed. For services requiring skill-building, the support log should include observable evidence that new learning has occurred or when not, changes that might be needed in the support activities.

4. Q. How often do providers have to report on each outcome in the Support Log (formerly progress notes)?

A. The ongoing use of the Support Checklist and Support Log confirm that supports are provided as agreed, document what the individual learns and what we learn about the individual and assist us in making adjustments to our supports that aren't working. These documents support billing Medicaid for services and supports that are provided under the ID Waiver. The status of each outcome should be reported on in the Support Log at least once monthly in preparation for regulatory visits and the quarterly Person-Centered Review. If your agency does not record Support Log entries every day, there should be weekly or monthly summaries that describe successes, barriers and relate new learning about the individual.

5. Q. If an individual's schedule shows shopping on Tuesdays each week, can they change their minds and go another day?

A. Of course. The General Schedule of Supports provides an overall picture of the individual's schedule. If the Plan for Supports states that shopping will occur "weekly" another day is fine based on individual preferences. It is documented on the Checklist and explained in the Support Log when shopping doesn't occur as plan. The Supports Checklist would then be initialed on the day that shopping occurs.

6. Q. Are quarterly meetings required?

A. Quarterly meetings are not required. Multiple meetings may be needed through the year to complete the SIS and PCP. The SIS can be completed in segments with respondents at different quarters and individuals can begin their profile at any point during the year in preparation for planning. The more complete the profile is in advance of the annual meeting, the more expedient planning will be.

7. Q. In the sample PCP for Jack, are all Licensure/CMS/DMAS requirements met?

A. Yes. The sample has been developed in cooperation with Licensing, DMAS and approved by CMS for implementation in Virginia. Please remember that it is the content of any form that must meet requirements.

8. Q. What is the best way to handle when an individual has a guardian and the guardian has opposing views to the individual?

A. The guardian should receive information on PCP and human rights from the SC as needed. If a conflict is unable to be negotiated, you may discuss with the human rights advocate. There is a workbook created by a team of self-advocates called "I want a Good Life" that may help the individual and guardian discuss the individual's life. It is available online at: http://www.dbhds.virginia.gov/ODS-Self-AdvocateResources.htm or through the Partnership for People with Disabilities at http://www.vcu.edu/partnership/.

9. Q. Regarding implementation of PCP, when do all individuals need to have a person-centered plan?

A. Please remember that as each individual's annual plan is due between May 2009 and April 2010, the new person-centered individual support plan (ISP) process should be utilized. That is the case whether a SIS is administered this year or not. All individuals' plans are not required to change to the new process/ISP all at once, but over the course of the year when their annual planning is due.

10. Q. Can annual planning take place at the 9 month meeting and then providers get together at the annual for signatures?

A. This is an acceptable process. It is important to realize that in this case individuals may be waiting from 9 month planning to the new ISP year for new plans to be implemented, which may create concerns for some individuals.

11. Q. What process should be followed when a legal guardian cannot attend the annual meeting?

A. The same process should be followed under PCP that has been followed in the past. Every effort should be made to both inform the guardian and obtain information from him or her in preparation for planning. The final plan should be provided to the guardian after the planning meeting and the guardian's signature should be obtained on Part IV Agreements and each Plan for Supports.

12. Q. How do Person-Centered Thinking tools fit with the PCP process?

A. There are a variety of PCT tools available through the PCT training that help to develop a better understanding of the individual. These tools may be used day-to-day to record new learning about the individual, to develop the profile and to find better ways to support individuals. Information gathered from these tools is used during the person-centered planning process, and the PC ISP uses many of the concepts. PCT Training can be arranged by contacting Dawn Machonis at dmmachonis@vcu.edu.

13. Q. Can the SC refuse to accept wording from the provider that the SC does not feel the individuals will understand such as "socialization" and "comprehension?" If so what about for individuals who do not communicate?

A. Person-centered language is a priority in the transformation of Virginia's system of services to individuals of all ages and abilities. A SC can educate and enlighten providers by modeling and making suggestions for better ways of saying things, both during the meeting and in follow-up to the provider's plan for supports. An SC may refuse to accept a plan in which the desired outcomes agreed to during shared planning are not addressed, when the supports being provided do not appear to lead to outcomes or when they do not reflect the person's routines and preferences. Failure to use person-centered language in the plan should not delay the start of the ISP year, but will require additional immediate revisions that better reflect the desired outcomes expressed by the individual.