EPSDT CPOC Instructions

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Comprehensive Plan of Care (CPOC) General Purpose

The Comprehensive Plan of Care (CPOC) reflects information shared by the individual requesting/receiving services, as well as by those who know him/her best. The primary goal of the CPOC process is to learn as much as possible directly from the individual and those who support him/her. This individual perspective assists those who provide supports and services to identify the individual's expectations, desired outcomes and guide service activities.

An individual support plan should be a statement of the individual's vision for the future and the services designed to assist the individual to move towards that future. The CPOC is a tool used to document specific information about individualized supports for each individual. It also communicates priorities to all support individual and provides a point of reference for reviewing progress and change.

The CPOC is developed through a **flexible, on-going collaborative process** involving the individual, family, friends or other support systems, the support coordinator and appropriate service providers. Plans are based on information from the individual, the individual's primary support network and other service individual who know and interact with the individual. It reflects discussion and decisions about services and supports during planning sessions. The plan provides a road map for the achievement of individual outcomes.

Learning about the individual does not stop when the planning session is completed. Interacting with people as they experience new opportunities and situations provides new information that can be used to initiate, and/or enhance the effectiveness of supports and services (both formal and informal) that can be combined to enable people to live the lifestyle they want to live.

The information contained in this instruction manual identifies and explains how to complete various sections/components of the CPOC. For detailed information and guidance regarding the discovery, planning, and review process review OCDD's Guidelines for Planning. This manual is not to be considered a stand-alone document in the development of an individual's plan of care, but rather used as a guide in the collection, planning, execution, evaluation and on-going documentation of valuable, key information. Significant movement toward the lifestyle an individual prefers and is satisfied with can only happen through the development of a network of people (paid and unpaid) who are committed, willing and able to listen to the individual's desired outcomes, and then build supports to achieve those outcomes.

Most importantly, keep in mind the purpose of the planning session. The planning session should create a shared understanding of the individual's priorities and a sense of excitement and possibility for the individual's future.

The service provider and individual are to be given a copy of the most current CPOC and any updates.

The Support Coordinator is responsible for requesting and coordinating all services identified in the CPOC immediately upon completion of the CPOC and prior to approval from BHSF/SRI. Since approval of Medicaid state plan services is through the prior authorization unit, there is no reason for the Support

Coordinator to await BHSF/SRI approval of the CPOC before making referrals for necessary services. Again, the CPOC does not control the services. This process only controls the payment to Support Coordination Agencies.

Section I. Contact Information / Demographic Information

Contact Information

This initial portion of the CPOC is self-explanatory and requires the Support Coordinator to develop current contact information on the individual, including name, mailing and physical address, and good contact numbers. Nothing should be left blank.

Name: Last, First MI	Indicate the individual's full **legal** name, last name first. If the individual's name is spelled or listed incorrectly, there may be a problem with billing. Support Coordination PAs are issued to the name that is on file at Medicaid. If there is a discrepancy in the name provided by the individual and Medicaid, the individual may need assistance in obtaining a correction. If SRI needs to correct the name on file, please send a copy of the e-MEVS to the EPSDT SC Contract Administrator.
Physical MCO Agency **Behavioral MCO Agency**	Select the individual's physical and behavioral Managed Care Organization from the picklist as applicable. If the individual has Fee-for-Service Medicaid for physical health, select the blank option for physical. If the individual is enrolled in the Coordinated System of Care (CSoC), select the blank option for behavioral. If the fields are pink, Statistical Resources, Inc. (SRI) is populating the Physical MCO Agency and/or the Behavioral MCO Agency based on the datafile SRI receives from Gainwell Technologies and you may not edit the fields.
Address	List the individual's physical address (place of residence), including zip code. If the individual's mailing address is different from their physical address, note that information under "Mailing (if different)" section.
Legal Guardian **Name and Relationship**	List the name of the person (if any) who has legal guardianship. Indicate the relationship of the person listed beside their name. If someone other than a parent is the guardian, you must obtain the legal guardianship papers from Medicaid, OCDD, or the guardian for the case file. If the child or youth is in the custody of the state, indicate the Department of Children and Family Services guardian; not the foster parent.

Demographic Information

This initial portion of the CPOC is self-explanatory and requires the Support Coordinator to develop current demographic information on the individual including SSN, Medicaid ID, ICD-10, etc. Nothing should be left blank.

Client SSN	Indicate the individual's social security number.
Medicaid ID	Indicate the individual's 13-digit Medicaid number. Do not use the card control number (i.e. 7770000……..)
Date of Birth	Indicate the individual's date of birth.
Case Open	Indicate the date of referral to Support Coordination (stamped date on the Support Coordination Choice and Release of Information EPSDT Target Population form).
Sex	Indicate the individual's sex .
Race	Indicate the individual's race.
Legal Status	Indicate the individual's "legal status" as far as his/her "legal" ability to make his/her own decisions regarding medical, financial and other areas of care. For an individual whose legal status is identified as "Interdicted" or "Power of Attorney" attach a copy of the legal document denoting that status. Legal document must be submitted with initial POC or upon change in legal status. Continuing tutorship should also be noted (attach legal documentation). Once an individual turns 18, they are a competent major unless they have legally been declared incompetent / interdicted. A legal document must be on file if the individual is 18 years of age or older and is not a competent major.
Is able to direct his/her own care?	You will only be able to answer if the individual is a competent major. If the answer is "no", you must have an Authorized Representative form on file.
ID	Indicate the individual's level of Intellectual Developmental Disability as identified on formal information documents (psychological evaluation, 1508-school evaluation form, etc.). Not ID is an option on the pick list. Review the IEP and other formal information documents for changes in the status.
Adaptive Functioning	Indicate the individual's level of adaptive functioning as identified on formal information documents. Review the IEP and other formal information documents for change in the status.
Residential Placement	Indicate their current living situation. **01 Homeless:** Children and youth who lack a fixed, regular, and adequate nighttime residence and includes the following: 1. children and youth who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;

	2. children and youth who have a primary nighttime residence that is a private or public place not designed for or ordinarily used as a regular sleeping accommodation for human beings; 3. children and youth who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; 4. migratory children who qualify as homeless because they are living in circumstances described above. **11 OCS Foster Care:** Children and youth who are in foster care pursuant to placement through the Louisiana Department of Children and Family Services. If they are living with family/friends but in the custody of the state, use this code. **12 Living with Family/Friends**
Number of ID/DD/Special Needs in Home (excluding recipient) **Names**	Enter the number and list the names of any other household members with Intellectual Developmental Disability diagnoses or special needs. Do not count the individual.
Current Education/ Employment	Indicate their current education or employment status. **01 Early Intervention:** Special education services for children birth to 3 years of age. Early Interventionists may also reference a certified early childhood special education teacher in a preschool setting. If the child has not yet been referred to Child Find complete a referral. School systems provide services to families with children ages three to five (IDEA Part B) and the child may be eligible to receive special education services. Services should be provided in the Least Restrictive Environment (LRE). **04 Regular Education only:** The student does not have a current Individualized Education Plan (IEP) or district approved services plan. **05 Regular and Special Education or 06 Special Education only:** The student has a current Individualized Education Plan (IEP) or district approved services plan. **07 Homebound:** The student has a current Individualized Education Plan (IEP) or district approved services plan to receive homebound instruction. Note: students receiving school virtually through a public school are not receiving homebound instruction. **08 Graduated**: The student received a diploma or certification of completion.

	16 Homeschool: The student is independently educated by the family. Families may enroll in a BESE Approved Home Study Program (HSP) or a Nonpublic School Not Seeking State Approval (NPNSB). Applications are valid for one year and must be renewed annually. Visit Approved Home Study Programs and Nonpublic Schools Not Seeking State Approval for more information. A student who is not registered through the Louisiana Department of Education (LDOE) may be out of compliance with Louisiana's compulsory attendance laws. https://www.legis.la.gov/legis/Law.aspx?d=80276
Non-Chisholm Reason	SRI will complete this section and label the individual as Non-Chisholm across LSCIS screens.
ICD10 Diagnosis	Indicate the individual's primary Intellectual Developmental Disability. The ICD-10 code for the diagnosis may have changed since the last submitted CPOC. Make sure the code continues to match the current formal documents. Refer to https://www.icd10data.com/.

Section II - Medical/Social/Family History

An individual's health profile is a collection of health and medical information obtained from the individual himself/herself, persons who know the individual best, other sources such as the individual's physicians, other health care providers, and medical and/or psychological records. Individuals with disabilities that interfere with cognition or communication may not be able to either recognize or tell anyone about significant changes in their health status. In these cases, people who know the individual best can provide an invaluable source of information.

A thorough collection of information concerning an individual's health profile and current health status can be an invaluable tool in early identification and monitoring of potential health and welfare concerns when working with populations of individuals with intellectual / developmental disabilities, especially those individuals who may have a history of unstable health conditions.

Information documented in this section will guide the individual's support team in assuring that appropriate, adequate and person-centered supports are addressed in the support planning process.

If any information is unknown, document that it is unknown.

Past

A brief, narrative description of the individual's significant health history and provides a means of sharing social/family history.

Prenatal health and birth	Provide any significant details regarding the prenatal health and the birth of the individual.
Nature and cause of individual's disability	Include date, age at time of onset, and cause of disability (if known).
Diagnosis	Information on how diagnoses were obtained. Must include when and by whom. • What documentation do you have on file to support the diagnoses? • If "family states" a diagnosis, has documentation been requested? Each agency is required to have a nurse consultant who may be able to assist in obtaining the documentation.
Early intervention	Include any early intervention services that were received from birth to age 3 such as services provided through EarlySteps or special education services.
Placement history	Briefly document any significant details regarding placement history and recurring situations that impact care. • Has the individual been in custody of the state, had psychiatric hospitalizations, placements with other family members/friends, etc.?

<table>
<tr><td>Past medical history, surgeries, etc.</td><td>Anything significant that occurred over a year ago. Include relevant historical information regarding school, family, hospital admits, etc.

• Were there any major events in your family's life? What events made a difference in your life?
• Are there situations that have caused you to need support outside of your family and friends? If so, could you describe?
• Did you have any serious illnesses, hospitalizations or surgeries?</td></tr>
<tr><td>Events that lead to the request for services at this time</td><td>Document what led the individual to request EPSDT Support Coordination.

• What has led you to request EPSDT SC at this time?</td></tr>
<tr><td>Legal Guardianship documents on file</td><td>Document any legal guardianships documents that you obtained and have on file. If you are working to obtain legal guardianships, document this; the CPOC will be denied but the approvable CPOC submit date will be honored when the CPOC is resubmitted with the required legal guardianship documents.

➢ For minors, if the caregiver is not the parent you must have legal guardianship documents on file and this must be noted in the CPOC. A non-legal custodian affidavit (Appendix V) can be obtained by the caregiver. This affidavit does not require a parent signature. It must be notarized and renewed each year.

➢ Document if authorized representative documents on file. If the competent major is unable to sign the CPOC documents, is unable to direct his/her own care, or requests an authorized representative, Authorized Representative Form (Appendix U) must be on file.

➢ Document if a supported decision-making agreement is on file. Supported decision-making (SDM) allows individuals with disabilities to make choices about their own lives with support from a team of people they choose.

➢ If in DCFS custody, you must have a letter on file from the DCFS guardian authorizing the foster parent to make medical and educational decisions, sign the documents and be the EPSDT SC contact. If you do not, all monthly contacts must be made with the DCFS guardian, they must sign all documents and they must be present at assessment and reassessment meetings.</td></tr>
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Present

A brief, narrative description of the individual's current living situation. Natural supports should be explored to determine who is involved in the individual's social support network (i.e., what friends/family and community resources are involved in supporting the individual on a daily basis).

Information included in this section is relevant to the individual's life today. Include information that is important to share and relevant to supporting and achieving the goals determined by the individual.

Current Living Situation	Describe current family situation including level of education attainment, family's understanding of the individual's situation/condition, knowledge of the disability, and consequences of non-compliance with POC, economic status, relevant social environment and health factors that impact individual (i.e., health of care givers, home in rural/urban area, accessibly to resources), and residential status (i.e., own home/rental/living with relatives/ extended family or single-family dwelling). Significant life events may include family issues, issues with social/law enforcement agencies, etc. Include if a social services case worker or Probation Officer is assigned and if you will have to interact with that agency/individual. • Who do you live with? • Does the family have an understanding of the individual's diagnoses and knowledge of the disability? • What is the source of household income? • Do you worry about having enough money to buy the things you need? • Is there a need for referral to financial resources such as family flexible fund, SSI, etc.? If so, was the service offered and response received? • Does the individual have access to transportation and their community? • Is the home in an urban or rural area? • Is there a need for NEMT or Gas Reimbursement program? If so, was the service offered and response received? • Do you own you rent or own your home? Do you participate in any housing program to help you with your rent? • Does your home meet your physical needs? If not, why? • Do you feel safe in your home and neighborhood? If not, why?
Natural Supports	Include list of family members (names and ages) and how they are involved/not involved. Description of complete social support network including list of friends and other community resources involved in supporting the individual on a daily basis. • How are family members involved or not involved? Must address both parents and if they provide natural or financial support. • Who is the primary care giver (PCG)? • Is the PCG employed?

	• What is the diagnosis of other household members that have special needs? Do they receive any service in the home? Do the needs of other special needs household members affect the individual's needs from being met? • Who is important to the individual? What does the individual like to do with that individual and how often? • Who do you spend time with when you are not with your family?
Current Community Supports or Other Agency Supports	Include the individual's significant life events, which may include family issues or issues with social/law enforcement agencies. • Does the individual have social services caseworker or probation officer assigned? Will you have to interact with that agency/individual? • Who supports you besides your family?
Personal Preferences	Preferences, likes and dislikes. The purpose of this section is to get to know the individual, his or her personality traits, interests, capabilities, preferences and support needs to gain a better understanding of how to support him or her. Information is to be obtained in a positive and respectful manner that allows you to paint a full picture of the individual. Through this approach, the circle of support will strive to build services and supports that are individualized and responsive to the individual's personal preferences, interests and choices. • What are the individual's gifts and talents? What are some things people like about you? • What are things that work? Include people, places, things and activities that create motivation, enjoyment, excitement, happiness and engagement. Information will provide insight to the individual's personality and help support staff and significant others really know the individual. This is a very powerful tool in the development of individualized supports. • What are things that don't work? Include people, places, things and activities that create frustration, anger, upset, worry, boredom and depression. Information will provide insight to the individual's personality and help support staff and significant others really get to know the individual, such as understanding what to avoid or when not possible, what support will be needed. This is a very powerful tool in the development of individualized supports. • What is important to know and do in order to support the individual? • What do you want for your future? Address school, employment, leisure, living situation, etc. How do you see

<table>
<tr><td></td><td>your life in the next 3-5 years? Where will you be living, what will you be doing, and who will be in your life?</td></tr>
<tr><td>Education/Employment</td><td>Address the individual's current education or employment situation.

Ages 3-5: Contact Child Search if the individual has not had a Special Education Evaluation. A Special Education Evaluation is needed before an IEP can be done to receive school services. Special Education Evaluations should be completed every three years.

Ages 7-18: School or education should be an identified need unless they have a doctor's statement that it is not appropriate or they have completed an educational program.

Review the IEP for information. Discuss the IEP with the parent/guardian.

If receiving IEP services, contact the parent after Easter to see if the individual qualified for Extended School Year Program (ESYP) and if they will be attending, and if not, what additional needs might need to be met in the summer.
Do you attend school? If so, where? What do you like about school? What would you like to change?
Are they aware of what services their child is or is not receiving and the frequency of the services?
Does the parent need to request another IEP meeting to have the IEP services corrected? The School Board is legally obligated to provide the services on the IEP.
If they are receiving homeschooling, is it registered with the Department of Education to be renewed annually?
If the child is not in school, is the parent aware of the educational law for school attendance when the child is 7 years old? Does the parent plan to enroll the child next school year or obtain an exemption?
If the individual is not attending school, do they have interaction with friends, participate in leisure and social activities, and get out of the home?</td></tr>
<tr><td>Transition needs</td><td>If the individual will be 20.5 years old this CPOC year, EPSDT transition strategy must be addressed.

The individual must be informed of LT-PCS, OCDD services, how to obtain the services he now receives, link to resources to receive those services, change in Medicaid services on 21st birthday- encourage to obtain exams, glasses, DME, etc. prior to aging out.
When will the individual graduate?</td></tr>
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<tr><td></td><td>Will they receive a diploma, Certificate of Achievement, or GED?
If they are leaving school prior to age 21, do they need to be transitioned to LRS, higher education, etc.?</td></tr>
<tr><td>Documentation for Competent Majors</td><td>If the individual is a competent major and someone else is being contacted and followed up with instead of the individual or is signing documents on behalf of the individual, there must be documentation that an Authorized Representative form (Appendix U) or a supported decision-making agreement is on file. There must also be documentation to support the beneficiaries request to have the authorized representative contacted <u>or</u> documentation of the individual's inability to self-direct their care.

The SC must attempt to ask all the beneficiaries, regardless of their ability to self-direct, about their preferences.

During each Quarterly Review ask and document if they still want representation.

The CPOC and Quarterly Reviews are to be signed by competent majors that are able to self-direct their own care.
Are they able to self-direct their care? Must match response in demographic information. Are they able to communicate in any form, engage in their life and make choices of what is important to them and what they want in their life? Can they self-direct and have other family members or concerned individuals assist?
If they are able to self-direct, did they request that the SC contact someone else to assist and communicate on their behalf?
If they are able to self-direct, did they request that SC speak with someone if they are not available at the time of the SC contact?
If unable to self-direct, explain the basis for this (individual observation during the face-to-face meeting, a specific psychological evaluation, IEP, etc.) It should not be based only on the parent states they are unable to self-direct. Physical disability does not prevent the ability to self-direct. Who has agreed or is responsible for assisting the individual in obtaining needed services?</td></tr>
</table>

HEALTH STATUS

Summarize important aspects of the individual's health, behavioral and/or psychological concerns. Any pertinent information about the individual that can be provided by the family or gathered from formal information documents should be documented. If there is only sketchy information available in any

health status area, remember the individual is eligible for screenings, which can help to determine his/her health needs. It is the Support Coordinator's responsibility to help the individual access those screening services.

In addition, it is important to remember that psychological and behavioral services are available for the individual and should be offered. If it seems a behavioral support plan would benefit the individual, but there is not one in place, refer the individual for this service. Information gathered from the psychologist's assessment could prove invaluable in the development of the CPOC.

This portion of the Plan of Care must be addressed initially, and updated as significant change occurs in the individual's life. When significant new information is obtained from a medical appointment or assessment, including a psychological and behavioral services assessment, the CPOC should be updated by adding and/or revising the goals and objectives according to the most recent information available.

Physician and Last Appointment Date	List the name of their primary care provider and the date of their last appointment.
Immunization Current	All information on immunizations should be current. This is extremely important. If immunizations are not up to date, this will need to be addressed in the Medical Diagnoses section.

Medical Diagnosis and Concerns/ Significant Medical History

A brief narrative description of the individual's current medical condition, including medical diagnoses, hospitalizations, and continuing health concerns and medical needs should be included. This section summarizes important aspects of the individual's physical and mental health status, medication needs, adaptive functioning capabilities/needs, frequency and reason for doctor visits, preventive medical/dental checkup schedules, and/or specialized medical follow-up, such as monitoring of medications, blood pressure, lab values, and other needs.

Medical Diagnoses/ Concerns/Significant Medical History	Describe the individual's medical diagnosis and what current formal documentation you have to support their intellectual developmental disability. Medical concerns should be listed in this section. Diagnoses can change over time. Update with the most current information. Use your nurse consultant as a resource for medical information that is not understood or use the internet for information. • Does the individual want a referral for an evaluation to obtain a formal diagnosis? It can be documented that a parent states a diagnosis, but also document that you do not have documentation to support this and what you are doing to obtain the documentation. Each agency is required to have a nurse consultant who may be able to assist in obtaining the diagnosis.

<table>
<tr><td>Individual Doctors/Medical Providers</td><td>List the individual’s primary care provider and any specialty providers the individual may see for routine and/or specialized care. Include the full name or the provider, his/her specialty (area of practice), how often the individual sees, and last and/or upcoming visit dates.

• Are they obtaining physicals at the recommended EPSDT screening exam interval? If not, are you encouraging that they do so?
• Are they receiving the recommended annual dental checkups? If not, are you encouraging that they do so? Also explain to adults that dental is not covered when they turn 21.
• Are referrals needed?
• Are they overdue for any appointments?
• Was scheduling assistance offered?</td></tr>
<tr><td>List of Medications</td><td>List prescription and over-the-counter medications and what it’s prescribed/used for. Medication name must be listed.

Important Note: Awareness and proper management of an individual’s medications, especially those used to stabilize, keep a medical condition from worsening, and/or avoid hospitalization should be of prime importance when discussing an individual’s use of medications.</td></tr>
<tr><td>List of Medical Procedures</td><td>Identify any medical equipment or special procedures such as gastrostomy tube, tracheostomy tube, urinary catheter, or other medical equipment.

• How often is the special procedure administered?
• Home Health - Clarify if EHH (three or more hours of skilled nursing per day) or basic home health visits were offered/requested/received. Document what skilled service is needed that cannot be provided by PCS.</td></tr>
<tr><td>Physical</td><td>This section describes the individual’s functional and sensory abilities in the areas of vision, hearing, physical mobility, use of arms/hands, need for assistive devices, and overall health status.

Vision
• How is their vision?
• Need for any screenings, physician referrals or assistive devices?

Hearing
• How is their hearing?
• Need for any screenings, physician referrals or assistive devices?

Physical Mobility
• How do they ambulate?
• Use of arms, hands and legs?
• Concerns with fine or gross motor skills?
• Need for any screenings, physician referrals or assistive devices?</td></tr>
</table>

	• If physical or occupational therapy is an identified need, was it offered and response received? Assistive Devices • Need for assistive devices or durable medical equipment?
Communication	Identify how the individual communicates and primary language used at home. • How do you communicate? Examples: gestures, body movements, speech, sign language, communication devices, pictures, written words, behave a certain way. • If speech therapy is an identified need, was it offered and response received?
Toileting needs	• Can you use the toilet? What assistance is needed? • If diapers are needed, is it due to incontinence of bowel or bladder, bedwetting, occasional soiling, working on potty training, etc.? • If incontinence supplies are an identified need, was it offered and response received? (Note: Diapers are provided by Medicaid beginning at 4 years old and ending on their 21st birthday. PA tracking can begin 60 days prior to the individual's 4th birthday. Instruct the provider to list her 4th birthday as the PA service begin date)
Dietary needs	Describe any dietary needs such as formula or nutritional supplements, special diet needs like allergies, pureed food, etc. or funds received for a special diet. • If formula or nutritional supplements are an identified need, was it offered and response received?
Therapies	Document any therapies that are offered/requested/received. • If receiving therapies at school through an IEP, did SC explain that Medicaid will provide medically necessary therapies in addition to the therapies received at school through the IEP? Response received?
Activities of Daily Living	Describe activities of daily living that must be completed by others. If an individual meets the criteria for PCS and declines the service, document this. If the individual is capable of doing Activities of Daily Living or Instrumental Activities of Daily Living, document this. • What skills can the individual complete independently? With assistance? Require total assistance? • If PCS is received or requested, what two or more Activities of Daily Living (ADL) do they need PCS to assist with? • Do they need mentoring, supervision, respite, assistance with homework, etc., which are not provided by PCS? What is the service needed to provide this?
Evaluations	Current formal information must be reviewed to identify needs while developing the CPOC. Information from the documents must be incorporated into the CPOC.

	• Were additional assessments or services recommended? What services are they to receive at school?

Psychiatric/Behavioral Concerns

A narrative description of the individual's psychiatric status, diagnoses and behavioral problem which may impact his/her health status and/or ability to function. Any relevant history that poses a potential risk for the individual or others should be provided. Also, information on effective behavior interventions, support plan and skills training should be detailed in accompanying information. This information can be obtained from the psychological.

Describe the behaviors	List problem behaviors with a description of what it looks like for that person. Address both behaviors at both home and at school. What is reported on the IEP? Home and school may have different concerns. List what is observed by the SC. Ask the individual, not just the guardian, about behaviors and need for services. • What exactly does the behavior look like?
Frequency	Be specific (i.e., 4 times a day, 2-3 times a week, a few times a month, etc.). Don't use words like frequently or rarely. The CPOC covers a year and documenting "recently" or "a couple of months ago" is not helpful in determining a time frame. SC will need to know if there has been improvement in behavior or frequency of the events. • How often do the behaviors occur? • Have they improved or gotten worse?
Significant behavioral incidents	Document month and year of significant behavioral incidents and what exactly occurred. Clarify any placements. Is the facility a detention center, psychiatric hospital, etc.?
Triggers	List the things that can cause the person to exhibit the problem behavior. Significant social, affective, cognitive, and/or environmental factors that may trigger an inappropriate response (e.g., threat or injury to self and/or others, etc.) should be noted. • Is there something that caused the behavior such as the effect of a medication, beginning of illness, change in routine, individuality clash, antagonized by someone, toy taken away, unknown, etc.?
Strategies	Describe successful interventions and what those around can do when they actually exhibit the problem behavior. History regarding skills training in dealing with: suicidal or homicidal ideation, intent or attempts, history of elopement, aggression, and inappropriate sexual behavior should also be detailed in accompanying documentation. If restraints (physical and/or chemical) are used, provide explanation. • How are the behaviors managed/ what strategies are used such as redirection, positive reinforcement, etc.?

	• Were significant behavior concerns or incidents discussed with or reported to their physician? • Does the individual harm himself or others during behavioral episodes, destroy property, etc.? How are siblings protected?
Services	Document offer of services and response received. Be clear on what service is received or offered. See Handbook pages 21-26 for more information on specialized behavioral health services. If formal information documents, interviews with caretakers, information in the case record, or SC observations identify the need for Psychological and/or Behavioral Services it must be addressed on the CPOC. Any individual with psychological or behavioral concerns (victim of child abuse, loss of parent or close family member, school suspension or expulsion, recent catastrophic injury, acting withdrawn, etc.) should be offered services. Document offer of services and response received. If there is an identified need for a psychological/behavioral health service and the family/individual declines the offer of the service it should be placed in the Service Needs Section of the CPOC. • What behavioral health services were offered and which are received/requested? If a service was discontinued, clarify why. • Are they taking medications for behavioral or psychiatric issues? If behavior medications are prescribed, they should be listed in the service needs and supports section. • Do they have a school behavior plan? List as service need as applicable. • Do they belong to an Autism support group or want linkage? • If the individual's inability to communicate is causing the frustration, was community ST offered?
Autism Services	**For every Chisholm Class Member that has an Autism diagnosis (or related disorder) or has even been labeled, even informally, as having Autism (or related disorder), please make sure you are either:** • **connecting the class member with Applied Behavioral Analysis (ABA), or** • **referring for testing to assess the need, or** • **documenting that the family declined these services. If declined, please revisit ABA with the family at least annually.** **As you know, autism services can be most effective when delivered as early as possible in a child's life. Services usually should begin at ages 2 to 6. The needed early connection is thwarted if support coordinators fail to identify ABA as a possible therapy and arrange it unless declined.**
Evaluations	Review formal information documents and document if there are any behavioral issues that were not identified or mentioned by the family.

Evaluations/Documentation

Dates of formal information documents used in the development of the CPOC are to be listed. **At least one current formal information document is required in the development of an annual CPOC.** Current

means that the formal information document was less than a year old at the time of the plan of care meeting.

Social Evaluation	
Psychological Evaluation	
Psychiatric Evaluation	
Special Education Evaluation	
IEP*	*If receiving Special Education, current IEP is required to be on file. IEPs should be requested from the parent on intake. If the parent does not have a copy, the SC should request a copy from the school or school board office. Obtain the current annual IEP, not just the progress report or Extended School Year Program (ESYP) which do not have all of the assessment information. IEPs are valid for one year. If the IEP is more than a year old, the SC may need to confirm the date of the last IEP with the school board. Sometimes parents do not attend the IEP meetings, forget it was renewed, or misplace the IEPs. Obtain the annual IEP as it is renewed and update services with an interim CPOC as needed. If the IEP is obtained as it is renewed, the CPOC submit and approval will not be delayed while the SC tries to obtain the document. School services should be current. If the child has special health needs, an Individualized Healthcare Plan (IHP) should be attached to the IEP. You can look on the current IEP under Supporting Documentation to see what documents are included with the IEP such as IHP, Behavior Intervention Plan, etc. If the recipient does not have an IEP, do they have a 504 education plan and/or a school health care plan? If so, obtain that document to identify their needs and services.
Behavior Management Plan	
Home Health Plan of Care*	*If receiving EHH, current EHH POC is required to be on file to receive approval on an initial or annual CPOC. EHH Plans of Care must be signed by the Physician every 90 days.
Form 90 or Medical Records	**EPSDT-PCS Form 90:** If the individual is receiving PCS, an EPSDT-PCS Form 90 can be obtained from the provider or physician. **EPSDT Screening Records:** The PCP or the PCP's contracted provider is required to do yearly EPSDT Screenings (physicals and assessments) for children age 3-6, and every other year after age 6. These records can be obtained by the individual/guardian, or support coordinator with a signed release of information.

	Progress Notes or Medical Records: Progress notes or a copy of a physical can be obtained from the physician's office. Mental Health records require a special release of information form. Contact the provider to obtain the release form that is required or obtain one from the LDH website using the following link, http://LDH.louisiana.gov/assets/medicaid/MedicaidEligibilityForms/HIPAA402PEng.pdf. The school nurse gathers medical information for the IHP and can be contacted to see if the individual other medical documentation in the school records that could be used for formal information documents.
Pediatric Day Healthcare (PDHC) Plan of Care*	*If receiving PDHC, current PDHC POC is required to be on file to receive approval on an initial or annual CPOC.
Statement of Approval (SOA)*	Enter the date of the Statement of Approval and enter the expiration date or check the permanent box.
Other	Enter date and describe what kind of document it is.

Section III - CPOC Service Needs and Supports

This section of the CPOC identifies service needs including the service strategy and a description, how the need was determined, if the individual requests to receive the identified need and any reasons why not, the primary goal, who is providing the support, if the service requires PA tracking, and the amount of service approved. This section of the CPOC will identify the unique individual outcomes envisioned, defined and prioritized by the individual and the agreed upon support strategy needed to achieve or maintain their goals using appropriate natural, community, informal, and formal supports. When designing the goals and objectives of the CPOC, it is important to take into account the strengths and weaknesses of the informal/natural supports. For example, if the primary caregiver has no other supports or has a disability, they may not be able to offer much assistance with physical care, and it may prove beneficial for the individual to use more paid care than may otherwise be provided. It is the Support Coordinator's job to look at and respond to the needs of the individual; however, often the family's needs have a direct impact on the individual's needs. It is important that the Support Coordinator give the caregiver assistance that is dependable and that allows the caretaker to continue to meet the individual's needs over the long-term.

The Support Coordinator must identify all of the services, both Medicaid and non-Medicaid, that the individual needs. The Support Coordinator is responsible for providing complete and clear information to assure the individual can make informed choices regarding the supports and services they receive and from whom. The Support Coordinator must use the Medicaid Services Chart (*Appendix C*) to inform the individual of available Medicaid services. The availability of both formal and non-formal services including the services discussed in Part I of this handbook must be discussed with the individual. Refer to the service strategy pick list for a list of some services.

The Support Coordinator will coordinate all services, Medicaid and non-Medicaid, and ensure that the individual receives the services they need to attain or maintain their individual outcomes. When a service is requested, the Support Coordinator should provide the individual with the medical information forms (EPSDT-PCS Form 90, CMS 485, etc.) that are required for the specific service. The Support Coordinator should assist with scheduling the doctor appointment, transportation, etc. as needed.

The CPOC must include timelines in which the individual outcomes can be met or at least reviewed. The CPOC must be reviewed at least quarterly and revised as needed. The Support Coordinator will have phone contact with the individual at least monthly and meet quarterly to assure that that the CPOC continues to address the individual's needs and maintain their health and well-being and to assure that the services are being provided. It is extremely important for all goals and strategies to be adjusted as the needs of the individual change and as new challenges develop in his/her life, including problems that develop regarding receipt of any services. The Support Coordinator must assure that the individual understands that services and goals may be added at a later date if they do not choose to access them when the need is first identified. The Support Coordinator must document the individual chose not to access a service at the time of the CPOC meeting, and that they will be given an opportunity to add that service during the quarterly CPOC reviews or whenever a request is made. Again, if the individual is 18 or older and has not been legally declared incompetent, the support coordinator should contact the

individual unless the support coordinator has documented that the individual is unable to express their preferences or the individual has authorized the support coordinator to contact a family member.

Service Needs

What support is needed for the individual to achieve their individual goals? This may reflect training, needed supports, skill acquisitions, or may regard the individual's maintenance in the home and community with provided supports. Make sure that you address all issues on IEP and learning disabilities.

Service Strategy (pick list)	All identified service needs must be listed. Include those that are currently received and those that are requested including Medicaid and non-Medicaid services.
Description (blank box)	The description box should clarify the service need that is requested. If there is not enough space, clarify the service in Section IV, Additional Information. Do NOT list the name of the provider in the service description box. The CPOC will be locked after approval and won't allow for this identifier to be edited when a new provider is selected. The provider and/or brand can be identified in Section IV (Additional Information). The CPOC can be revised at any time. Do NOT list other terms, such as amounts of service, "applying" or "requested" in the description box. These descriptions may change over time without having a change in the need for the service. There is a separate box for amount approved.
Service Strategy Pick List Options:	
Personal Care Services	Use the PCS drop down for EPSDT-Personal Care Services only. PA tracking is required. OCDD does NOT provide this service. If respite is requested through OCDD family support indicate that need under Other/Respite.
Home Health Services	Indicate Extended Home Health, intermittent nursing, physical therapy, speech-language therapy, occupational therapy, or home health aide services. EHH provides three or more hours per day of skilled nursing care to recipients under 21 years old only. Prior Authorization is required. An EHH Plan of Care (CMS form 485) is required which must be signed by a physician every 90 days. EHH is a Specific Medicaid program. Basic Home Health services are provided in the home under the order of a physician that are necessary for the diagnosis and treatment of the patient's illness or injury, including: skilled nursing, physical therapy, speech-language therapy, occupational therapy, home health aide services. Recipients must have a physician's prescription and signed Plan of Care. PT, OT, and ST require a PA.

Medical Equipment and Supplies	DME products for a specific task can be grouped together if they are all ordered from the same provider with the same PA service dates. Gauze, tape, gloves, and saline for wound care can be identified as DME/Wound Care. DME that the individual has and uses should be listed as separate received service needs (DME/Wheelchair, DME/AFO, DME/Walker, etc.) so that the SC can check on the status and ensure the item remains in good working order. PA tracking would be needed if a repair is needed or if the item needs to be replaced.
OT **Physical Therapy** **Speech Therapy**	Therapies received at school and in the community should be listed separately. Use OT, Physical Therapy, and Speech Therapy for community therapies and School for IEP services.

Specialized Behavioral Health	Indicate in the description box what service need is identified:
	• Psychiatrist visits
	• Behavioral medications
	• Individual, family, and group therapy
	• Licensed Practitioner Outpatient Therapy
	    o Parent-Child Interaction Therapy (PCIT)
	    o Child Parent Psychotherapy (CPP)
	    o Preschool PTSD Treatment (PPT) and Youth PTSD Treatment (YPT)
	    o Triple P Positive Parenting Program (Triple P),
	    o Trauma-Focused Cognitive Behavioral Therapy (TF-CBT),
	    o Eye Movement Desensitization and Processing Therapy (EMDR)
	• Mental Health Rehabilitation Services
	    o Community psychiatric support and treatment (CPST)*,
	        ▪ Multi-Systemic Therapy (MST) (age 0-20)*
	        ▪ Functional Family Therapy (FFT) and Functional Family Therapy-Child Welfare*
	        ▪ Homebuilders®*
	        ▪ Assertive Community Treatment (ages 18-20 years)*
	    o Psychosocial Rehabilitation (PSR)*,
	    o Crisis Intervention (CI),
	• Crisis Stabilization (CS);
	• Therapeutic Group Homes (TGH)
	• Psychiatric Residential Treatment Facilities (PRTF)**
	• Inpatient Hospitalization
	• Outpatient and Residential Substance Use Disorder Services
	• Medication-Assisted Treatment (MAT)
	***The Managed Care Organization's prior authorization unit must pre-approve CPST, PSR, ACT (ages 18-20), FFT/CWFFT, Homebuilders, and MST.** CPST and PSR providers arrange the assessments necessary to obtain prior authorization for rehabilitation services.
	**A certificate of need must be complete prior to admission to a PRTF.

	Note: CSoC enrollees' specialized behavioral health services do not require PA tracking by the SC.
Dental Services	Dental Care – dental checkups are recommended annually.
Eyeglasses	Eyeglasses and/or contact lenses
Transportation Services	NEMT or Gas Reimbursement Program
Diapers	Diapers are provided by Medicaid beginning at 4 years old and ending on their 21st birthday. PA tracking can begin 60 days prior to the individual's 4th birthday. Instruct the provider to list her 4th birthday as the PA service begin date.
School	Identify services that are on the IEP such as School/OT, School/ST, School/Assistive Technology, School/Social Worker, etc. OT/PT/ST consult is not a direct service. They consult with the teacher and parent and may observe the child in the classroom. It may be received only once a semester or once a month. It should be identified as "OT consult," "PT consult," etc. Adaptive Physical Education, A.P.E., is not a therapy. It is provided to a student who is unable to individual in regular physical education (P.E.) and does not need to be listed as a service need.
Vocational	
Employment	
Transition	Must be listed as a service need if the individual is 20 ½ or older during the CPOC service dates. The strategy is to be documented in the Additional Information section. The strategy will be to inform the recipient and family of LT-PCS, OCDD services, how to obtain the services they now receive, link to resources to receive those services, change in Medicaid services on 21st birthday- encourage to obtain dental and eye exams, glasses, DME, etc. prior to aging out.
Pediatric Day H.C.	
Applied Behavioral Analysis	
Home Modifications	
Community Services	
Redetermination	If the SOA will expire during the CPOC year, Redetermination must be added as a service need (example: Redetermination/6.7.22). The SC should refer a individual to OCDD two months prior to the SOA expiration.
OCDD Services	• Family Flexible Funds • Family Support • Respite
CSoC	Coordinated System of Care and Wraparound Facilitation • Wraparound Facilitation • Parent Support and Training • Youth Support and Training • Short Term Respite Care • Independent Living and Skills Building
Evaluation	
EPSDT Screening Exam	

<table>
<tr><td>Hearing Aids</td><td>Hearing aids and supplies needed for them</td></tr>
<tr><td>Hospice Services</td><td></td></tr>
<tr><td>Physician/Professional</td><td>• Doctor's Visits or Referrals
• Appointment Scheduling Assistance
• Lab and x-ray tests
• Family Planning
• Podiatry Services
• Optometrist Services
• Audiological Services
• Chiropractic Services
• Prenatal Care
• Certified Nurse Midwives
• Ambulatory Care Services, Rural Health Clinics, and Federally Qualified Health Centers</td></tr>
<tr><td>Other</td><td>Use for any other service that you cannot find from the drop-down box.</td></tr>
<tr><td>How was the need determined?</td><td>• D&E (Diagnostic and Evaluation)
• Family
• 1508
• ICAP
• IEP
• Other
• Physician
• Psychiatrist
• Psychologist
• Support Coordinator
• Therapist</td></tr>
<tr><td>Requested by individual/family</td><td>This column will document the individual/family's choice to access services relating to the identified needs at the time of the CPOC meeting.</td></tr>
<tr><td>If not why not</td><td>Carried over-resolved: The service is no longer requested or is no longer an identified need. The service was listed in error or incorrectly identified and is locked on the CPOC.
Note: DMEs that need to be maintained or renewed are to remain as Service Needs and should not be marked as carried over – resolved. If it was a one-time PA for a DME you can mark the DME as received and untrack after the item is received and your tracking log is complete. If a new one is needed or repairs are needed, unmark receiving, recheck PA tracking, and bring forward a new tracking log.

Family does not want: The need for the service has been identified but the individual/family declines the service.

Other - explain next page:
The service is an identified need but is placed on hold. This is not appropriate if on a wait list for therapy as they are requesting the service now.</td></tr>
</table>

	Example: Has a PA for PT but had a recent surgery and the PT was placed on hold with the intention of returning. Requesting PT but only want it in the summer. Document why the service need was resolved/no longer wanted/on hold in the Additional Information section.
Primary Goal	• Natural Supports • Safety • Best Possible Health • Security • Where they live • Choose services • Choose goals • Participate in the community • Have friends
Receiving	Use the check box to indicate if the service need is currently being received.
Will the service be provided by Medicaid, School, Community, Family, or OCDD?	Use the check boxes to identify who and how the individual can be supported to achieve his/her individual outcome. This section identifies whether paid staff or natural supports will be utilized to support the strategy. Medicaid - "Medicaid" and "Requires PA Tracked by SC" must be checked in order to generate the required PA Tracking log. Family – if the service is provided by the family or through private insurance check this box.
Requires PA tracked by SC	"Medicaid" and "Requires PA Tracked by SC" must be checked in order to generate the required PA Tracking log. **"Requires PA tracked by SC" must be checked for all requested Medicaid services that require a PA, unless both a valid reason and how the SC will ensure the service is received is documented in the Additional Information section.** Incorrectly removing the PA tracking requirements on EPSDT CPOCs will cause errors on the EPSDT Quarterly Report and PA Tracking Required Action Report.
Reason for Not Tracking	01 PA not required – it is a service provided by Medicaid but, it does not require a PA. It may be provided via reimbursement instead of through prior authorization. Could also be used for one-time DMEs after the item is received. 02 PA issued monthly 03 EHH nurse tracks 04 On a waitlist 05 Receiving service without a PA 06 Enrolled in CSoC
Amount Approved	Describe the frequency of service delivery the provider will use to meet the individual's need (i.e., 4/day to indicate 4 hours of PCS per day.)

Void	Only void a service need if it was created in error. Otherwise uncheck requested and choose an option from the “If not, why not?” pick list.

No Services to Coordinate
If there are no services to coordinate, the Support Coordinator is to inform the family/individual of this and that they can access support coordination at any time until the child’s 21st birthday. Declining EPSDT Support Coordination will not affect their eligibility to receive Medicaid services or their placement on the Waiver Request for Services Registry. The family can choose to continue EPSDT Support Coordinator service, but they must be informed.

Section IV - CPOC Participants

CPOC Signature Page (paper form)

As the Support Coordinator, it is your responsibility to have everyone sign the printed LSCIS CPOC signature page indicating their participation in the meeting.

This section should contain the signatures of all those who participated in the Plan of Care (POC) planning meeting. The signature(s) identify the individual’s Circle of Support, and their signatures indicate participation in the POC planning meeting.

The Support Coordinator’s signature and the Support Coordinator Supervisor’s signature (indicating they have reviewed the POC) are required.

Planning Participants	The individual and the legal guardian must be present for the CPOC meeting. Everyone present at the meeting must sign in the Planning Participants box and indicate their Title and Agency Name as applicable. This includes the individual, the legal guardian, the Support Coordinator. Again, if an individual is present at the meeting, they should SIGN in the Planning Participant’s box. You may also wish to obtain contact information for each individual attending, so they can be invited to future meetings, if the individual/family requests assistance with this.
Medicaid Services	The Participant/Guardian is to indicate their response to the questions: • SC explained that Medicaid will provide medically necessary therapies in addition to the therapies received at school through the IEP. • SC has reviewed the Medicaid Services Chart with me. • SC has provided me with information on Medicaid EPSDT Services. • SC has provided me with information on EPSDT Screening Services. • EPSDT Screening Services requested.

Participant's/Guardian's Signature	The individual/guardian will sign and date the printed LSCIS CPOC signature page indicating they have reviewed and agree with the services in the CPOC. Beneficiaries age 18 or older must sign all documents if they are able to direct their own care. If they are unable to do this, the reason should be documented. If someone other than the parent or the individual (if they are a competent major) is signing the CPOC as the individual/legal guardian, legal documentation or a Non-Legal Custodian Affidavit (*Appendix V*) must be in the case record and this must be documented in the CPOC. To complete monthlies or quarterlies with someone other than the parent if the individual is a minor, legal documentation or a Non-Legal Custodian Affidavit (*Appendix V*) must be in the case record and this must be documented in the CPOC. To complete monthlies with someone other than the individual if the individual is a competent major an Authorized Representative Form or supported decision-making (SDM) agreement must be in the case record and this must be documented in the CPOC.
Support Coordinator's Signature	The SC will sign and date the printed LSCIS CPOC signature page indicating they have reviewed and agree with the services in the CPOC.
Support Coordinator Supervisor's Signature	The SC Supervisor will sign and date the printed LSCIS CPOC signature page indicating they have reviewed and agree with the services in the CPOC.

CPOC Participants (LSCIS)

This must match the paper copy of the CPOC Signature Page that is filed in the individual's case record.

Planning Participants	List everyone that attended the CPOC meeting.
Additional Information about Service Needs and Supports	List any chosen providers. If any Medicaid services do not require PA tracking, document how you will assure they are received. If on waitlist for any Medicaid services: 1) Did SC confirm waitlist placement with provider? 2) Did SC offer the individual alternative providers for who there may not be a waitlist? Response received? 3) Did SC notify MCO (MCO) or LDH PAL (FFS) of waitlist placement? 4) How will SC assure they move up the waitlist? SC must follow up with the provider at least quarterly.

<table>
<tr><td>Medicaid Services</td><td>The Participant/Guardian is to indicate their response to the questions:
SC explained that Medicaid will provide medically necessary therapies in addition to the therapies received at school through the IEP.
SC has reviewed the Medicaid Services Chart with me.
SC has provided me with information on Medicaid EPSDT Services.
SC has provided me with information on EPSDT Screening Services.
EPSDT Screening Services requested.</td></tr>
<tr><td>Participant’s/Guardian’s Signature</td><td>Enter the date of the Participant’s/Guardian’s Signature on the CPOC Signature Page. This should be the date of your CPOC meeting.</td></tr>
<tr><td>Support Coordinator’s Signature</td><td>Signature of Support Coordinator: Select the Support Coordinator’s login ID.

SC Signature Date: Enter the date the Support Coordinator signed the CPOC Signature Page. This should be the date of your CPOC meeting.

Ready for Supervisor Review: check this box when you are ready to submit the CPOC to your Supervisor for review.</td></tr>
</table>

Section V - CPOC Approval

CPOC Approval Information	
Signature of Support Coordinator Supervisor	Signature of Support Coordinator Supervisor: Select the Support Coordinator Supervisor's login ID that is submitting the CPOC for review by LDH. The SC supervisor's signature denotes that they approve and agree with the content of the CPOC being submitted. The Formal Information documents listed under evaluations/documentation used to develop the CPOC, the prior CPOC, Service Logs, and Quarterly Reviews must be reviewed by the Supervisor for identified needs and the status of requested services. The entire CPOC must be reviewed to ensure that all identified needs are addressed, all required information is included, information is edited and updated, and no discrepancies exist.
Submit for review by LDH	SC Supervisor checks this box to submit the CPOC to SRI for review and approval.
See Service Tickets	This button allows you to review all Service Logs from the prior CPOC year which is required as part of the CPOC approval process.
Approval/Denial Information	BHSF/SRI will review the CPOC to assure that all components of the plan have been identified. If any deficiencies exist, SRI will list them in the Approval/Denial Notes box and return the CPOC for resubmittal. If documents required for initial CPOCs (current formal documents and all assessments/evaluations and supporting documents from the regional OCDD office) or Special Needs CPOCs (current formal documents) or documents required for CPOC monitoring (*Appendix X-2*) are not submitted as required, the CPOC will be returned to the SC without a review. Review the Approval/Denial Note box on all returned CPOCs. An approved CPOC may have a note to address something on an interim CPOC or information regarding the PA.

Submitting a CPOC to BHSF/Statistical Resources, Inc.

The EPSDT SC signs off with an electronic signature on the CPOC Participants page and checks the Ready for Supervisor Review box.

SC Supervisors must read all of the required formal information documents during the supervisor's CPOC review. A CPOC should not be submitted to SRI for approval if the SC Supervisor did not review all of the listed evaluations/documentation used to develop the CPOC, the service logs, and quarterly reviews for identified needs and the status of requested services. The SC Supervisor is to review the entire CPOC to ensure that all identified needs are addressed, all required information is included, information is edited and updated, and no discrepancies exist.

The SC Supervisor signs off with an electronic signature on the CPOC Approval Information page and checks the Submit for review by LDH box. Documents required for an initial or monitored CPOC should be submitted immediately after the SC Supervisor submits the CPOC for SRI approval.

BHSF/SRI will review the CPOC to assure that all components of the plan have been identified. If any part of the CPOC is not completed by the Support Coordinator, the plan will be returned to the Support Coordinator without an approval.

Approvable CPOC Submit Date:

The **approvable CPOC submit date** is the date the approvable CPOC was submitted. The approvable CPOC submit date is not the date the CPOC was approved nor is it the date the CPOC was previously submitted if the CPOC was denied. If the CPOC is sent back the date the approvable CPOC is submitted will be the approvable CPOC submit date.

Initials: An **approvable** initial CPOC must be completed and sent to BHSF/SRI within 35 calendar days of the date of referral to the Support Coordination agency. If the approvable CPOC is submitted timely the PA will begin on the CPOC Participant Signature Date. If the approvable CPOC date is late the PA will begin on the approvable CPOC submit date.

Annuals: The annual CPOC meeting should not be held more than 90 calendar days prior to the expiration of the current CPOC. The **approvable** annual CPOC must be completed and submitted to SRI within 35 calendar days of the CPOC expiration date. If the CPOC is submitted late you will not meet the flat rate billing requirement of a Timely CPOC.

CPOC Documents:

For initial CPOCs, *Appendix X-1* and the required documents must be sent to BHSF/SRI including the evaluations and supporting documentation from the regional OCDD office and must be received prior to CPOC approval.

A individual may be identified as “Special Needs” by BHSF/SRI if the individual is not eligible for the waivers or other OCDD services. Special Needs beneficiaries must have *Appendix X-1* submitted to BHSF/SRI with all annual CPOCs and must include current formal information documents to document that they continue to qualify for EPSDT Support Coordination.

If the CPOC is randomly selected for monitoring when it is submitted to BHSF/SRI for approval, *Appendix X-2* and the required documents must be submitted to BHSF/SRI.

Annual CPOCs that are not Special Needs and are not selected for monitoring are to have the documents placed in the case record and submitted to BHSF/SRI immediately upon request.

Section VII - Typical Weekly Schedule

Typical Weekly Schedule (paper form only)

The weekly schedule is a tool that the Support Coordinator uses to assure that services are delivered at appropriate days and times and do not overlap, unless this is medically necessary. This section is for planning purposes only. It is understood that this schedule is flexible and an individual's daily routine may change based on need or preference.

The intent of this schedule is to assist individuals and their families in assessing and planning for services and supports that will help them move closer to their desired personal outcomes. Utilization of this section and subsequent planning will help assure continuity of care and unnecessary service delivery. Services should be provided in accordance with what is requested and needed by the individual, no more, no less. Simply list the source of service provision when applicable.

For each hour indicate how the individual will typically spend his/her time using the codes listed below. Include services that are in place and those that are requested. The weekly schedule should indicate what services are already in place. The schedule should show when the individual is in school, at home or participating in other activities. Desired times of services that are being requested through Medicaid prior authorization or other sources should be indicated.

Code:
F = Family/Friends
S = Self
Sc = School
ST = Speech Therapy
OT = Occupational Therapy
PCS = EPSDT-Personal Care Services
EHH = Extended Home Health
PT = Physical Therapy

The schedule can be forwarded to in-home providers and prospective providers to support and clarify prior authorization requests. If prior authorization is denied and not appealed, or if for any other reason the planned services are not delivered, the schedule should be amended to reflect services actually put in place. If the individual wishes to change any of the times for established services, the Support Coordinator shall give the revised schedule to all appropriate providers informing them of the time changes to facilitate the change.

CPOC Quarterly Review

During the Quarterly Review meeting, the support coordinator facilitates a discussion about the status of services and progress on action steps.

Progress Status of Service/Receiving Amount PA	Provide the current status of each service need.
Health Changes	Document any health changes that have occurred since the last review.

Safety Issues	Document any safety issues that have occurred since the last review.
Changes in living situations	Document any changes in living situation that have occurred since the last review.
Review of the following occurred:	Indicate that a review of the following occurred: ☐ Medicaid Services Chart ☐ Rights and Responsibilities ☐ Grievance Policy ☐ Abuse Policy ☐ Health Standards Provider Complaint Line, Medicaid Managed Care Program Assistance/Complaint Line
Are you requesting any medically necessary therapies now or do you want to receive therapies on the IEP during the school's summer break?	Ask the individual this question and document their response.
Participant Questions:	Ask the individual these questions, document their response, document if a complaint form (Appendix Q - Complaint Form or Appendix R - Managed Care Complaints) was completed, and any comments. ☐ Are you receiving the services you requested? ☐ Are the services at the days/times needed? ☐ Are you pleased with the services you are receiving? ☐ Are there any additional services that you need?
Notes	Include narrative description of Quarterly Review visit, additional explanations as needed, summary of current status, progress for quarter, FOC and information regarding the requirements to obtain a PA for the services requested, and how often goals and support strategies will be reviewed.
Support Coordinator, Date	Select the login ID of the SC that completed the Quarterly Review and enter the date of the Quarterly Review meeting. Must match your paper signature page.
Names of Attendees Relation/Title/Agency Date	Enter the names of attendees of the Quarterly Review meeting, their relationship, title or agency, and the date of the meeting. Must match your paper signature page.
Virtual Visit Attestation	If the quarterly meeting was completed virtually and you need to complete the attestation, select Yes. If the quarterly meeting was completed face-to-face and you do not need to complete the attestation, select No. If Yes, document your response to the Virtual Visit Attestation questions: ☐ The beneficiary/family is in agreement that a virtual visit is in the best interest of the beneficiary.

	☐ The support coordinator is in agreement that a virtual visit is in the best interest of the beneficiary. ☐ The provider agency(s) are in the agreement that a virtual visit is in the best interest of the beneficiary. ☐ The legally responsible individual or family members living in the home are not paid caregivers. ☐ Technology is available to complete the visit with direct observation of the beneficiary and the home. ☐ There is evidence that the requirements for the quarterly visit can be completed virtually.

Approval/Denial Notes History

Displays submit and approval/denial dates a well as a history of Approval/Denial Notes for the selected CPOC.