SDS Harmony Support Plan Details Worksheet

- Use this to format complete responses to questions on the Person Centered Support Plan.
- You can copy the response text in to the matching area of the support plan details page

Health Synopsis

Summarize the health history over the past 12 months:
Ensure the health synopsis contains current information/narrative related to the person's health condition and needs.
Current information examples: Doctor's appointments, expected or unexpected health events, critical incidents, and/or improvements in health from the past year, emergency room visits, hospitalizations, surgeries or treatments. If applicable include description of scheduled or anticipated surgeries and/or treatments. Include information on scheduled health appointments and procedures from last year. Provide information about health even if there was no significant change in health. Quote the recipient's own concerns and viewpoints on his/her health if applicable.

Summary:

Keep this to a precise minimum of what's necessary for SDS to understand about this person's medical/health needs in the previous year. Use plain language, bullet points or lists and separate paragraphs to help the reviewer easily locate information. Or give an answer to each suggested area:

- **Doctor's appointments over the last year**
- **Expected or unexpected health events,**
- **Critical incidents, and/or surgeries or treatments**
- **Information about health even if there was no significant change**
- **Information on scheduled health appointments and procedures from last year**
- **If applicable -scheduled or anticipated surgeries**
- **What are the Participant's concerns for their health?**

Emergency Response Plan

Provide emergency response information. For example if using an Assisted Living home, refer to the emergency and evacuation plan in place through this service. If agency emergency plan is provided, explain how this plan will ensure the recipient's health and safety.

Examples: Indicate safety resources closest to the recipient, how the recipient will access these resources, and how these resources will know how best to assist the recipient.
We often see a cut-n-paste standard paragraph here about CC not being the emergency contact, and the client is to call 911, a reminder that CIR's and APS reports will be filed, etc…. please make sure the emergency response is specific to the person your client.

- **Describe safety resources closest to the recipient, how the recipient will access these resources, and how these resources will know how best to assist the recipient. (examples: Red Cross and local emergency shelters and evacuation procedures**

Even for folks residing in an ALH or Group/Family Hab. Home, tell us HOW the person knows what to do in an emergency or who will be coming to check on them. Think about a natural disaster or a fire, who can the person count on to help them? If it's truly no one let us know that too. Perhaps we can help to locate a resource.

- **Document how the recipient was assisted to understand and establish their own emergency response in the event of a natural disaster or other emergency:**

- **Indicate how this plan will adequately meet the needs of the recipient with specific regard to their living environment and physical ability to self-assist:**

- **Include the person's concerns for his/her own safety and level of risk**

Adaptive Medical Equipment currently in use:

Adaptive Medical Equipment needed:

EMODs that have been completed:

EMODS that will be requested:

The harmony system captures the personal goal in a separate location. There is no need to attempt to enter it here.

Personal Profile:

The individualized service-planning process offers the recipient the opportunity to identify personal goal(s). Recipients request services to meet their identified needs, and achieve expected outcomes. Explain how the recipient prefers those services to be delivered. Include specific reference to functional abilities and needs for support as found in the assessments you identify below.

This area should very plain language but also very complete, realize this is where the reviewer gets to know the person. What matters to them, what they are hoping to avoid or fear might happen. Additionally other service providers will look here to understand the needs as well as the wishes of the person.

- *Many CC's write a small paragraph under each bullet point (this is minimum)*

Include in the summary the recipient's:

- **Overall life situation, home environment & relationships**

- **Progress toward previous goals** *What does SDS need to know to continue or make service authorization decisions? Summarize reports from other Service providers, you made add the reports to a plan note if you believe SDS could benefit from reviewing them.*

- **Desirable future outcomes**

- **Social environment: friends, hobbies, favorite activities, places, spiritual/cultural preferences, etc**

- **Functional abilities and strengths**

- **Situational limitations, and/or obstacles**

- **What works and does not work when providing direct support**

- **Critical behaviors if applicable. If so, what are their interventions?**

- **Any additional information that could impact the level, or type, of requested service(s):**

Assessments Reviewed
List all assessments completed and reviewed in this planning process and include the source:

Section IV ~ Summary of Non-Waiver Supports and Services

List all other services currently utilized by the recipient; regardless of funding source.
Examples include but are not limited to: PCA, other regular Medicaid services, community/social programs, and family supports. **The Plan of Care is an all-inclusive description of the recipient's life.**

Natural/Family Supports

Service	By who	Weekly Average	Description of service

Community Supports

Service	Provider Agency	Weekly Average	Description of service

Regular Medicaid

Service	Provider Agency	Weekly Average	Description of service

Personal Care Service (PCA)

PCA Type (Agency/Consumer Direct)	PCA Agency	Hours weekly	Describe exactly what's being done in the mins./hours they have authorized?

Other Supports

Service	Provider Agency	Weekly Average	Description of service

Non-Habilitative Service *(Example)*

Need Code	Goal Code	Service Service Code	Provider Agency	Weekly Average	Exact # of weeks
Health and Safety (8)	*8044*	*Chore*	***ACME Agency***	*45*	*52 weeks per year*

Goal of service that will meet recipient needs: ***(Describe the service specifically to the person)***

Lisa needs help keeping her kitchen, bathroom and bedroom clean. She is unable to stand without support and cannot reach many areas that need to be cleaned. She expects the chore worker to clean the kitchen, bathroom, vacuum the carpet, sweep the floors, dust, and do weekly loads of laundry specific to her needs. It's very important that her chosen laundry soap and cleaning products are used. The chore worker needs to meet her at the grocery store to her gather items from her list.

The chore worker does not make meals for Lisa. She has requested the kitchen to be cleaned multiple times a week to keep the germs under control.

Do any providers for this service reside with the recipient? **Yes No**
Are any of the providers for this service related to the recipient? **Yes No**
If yes to either question, identify by name & describe relationship:

Non-Habilitative Service

Need Code	Goal Code	Service Service code	Provider Agency	Weekly Average	Exact # of weeks

Goal of service that will meet recipient needs: ***(Describe the service specifically to the person)***

Do any providers for this service reside with the recipient? **Yes No**
Are any of the providers for this service related to the recipient? **Yes No**
If yes to either question, identify by name & describe relationship:

Non-Habilitative Service

Need Code	**Goal Code**	**Service** Service code	**Provider Agency**	**Weekly Average**	**Exact # of weeks**

Goal of service that will meet recipient needs: ***(Describe the service specifically to the person)***

Do any providers for this service reside with the recipient? **Yes** **No**
Are any of the providers for this service related to the recipient? **Yes** **No**
If yes to either question, identify by name & describe relationship:

Non-Habilitative Service

Need Code	**Goal Code**	**Service** Service code	**Provider Agency**	**Weekly Average**	**Exact # of weeks**

Goal of service that will meet recipient needs: ***(Describe the service specifically to the person)***

Do any providers for this service reside with the recipient? **Yes** **No**
Are any of the providers for this service related to the recipient? **Yes** **No**
If yes to either question, identify by name & describe relationship:

Non-Habilitative Service

Need Code	**Goal Code**	**Service** Service code	**Provider Agency**	**Weekly Average**	**Exact # of weeks**

Goal of service that will meet recipient needs: ***(Describe the service specifically to the person)***

Do any providers for this service reside with the recipient? **Yes** **No**
Are any of the providers for this service related to the recipient? **Yes** **No**
If yes to either question, identify by name & describe relationship:

Section IV-B ~ Summary of Habilitative Waiver Services ***(with Goals, Objectives & Interventions)***

The habilitative services provided along with the corresponding skill development should be linked to the needs identified in the profile and assessments. Home and Community Based (HCB) Waiver and Grant Funded habilitative services require specific learning or habilitation skills that are addressed through the goals and objectives in this section. Goals should have distinct methodology/procedures described, including parties responsible for implementation. One goal may be implemented across other services to assure continuity of services. The objectives must be measurable. Data collected, and how objectives will be measured, must be clearly described and made available for review upon request.

NOTE: These services should clearly and concisely communicate the strengths, needs, desires and plans for the recipient in such a manner that a provider could pick up the document and use it as a working tool to provide uninterrupted services.

Refer to the definition of habilitative services when writing narrative.

Definition: Habilitative services support the person to acquire, build or retain skills in the following areas, including but not limited to: Mobility/Motor skills, Self-care/ Personal Living, Communication, Learning, Self direction/Social skills, Living skills/ Community Living, Economic self-sufficiency/ Vocational skills. Habilitative services support self-help, socialization and adaptive skills aimed at raising the level of physical, mental, and social functioning of an individual.

Habilitative Service #1

Need Code	**Goal Code**	**Service** Service code	**Provider Agency**	**Weekly Average**	**Exact # of weeks**

What position(s) within the agency will be responsible for providing the supports for the above objectives?

Do any providers for the service listed reside with the recipient? **Yes** **No**
Are any of the providers for this service related to the recipient? **Yes** **No**
If yes to either question, identify by name & describe:

Goals for this service that will meet recipient needs:

1. Goal related to this service:

Is this goal: **New** **Revised** **Continued**

List Objectives (Code #)	**How will data be measured**	**How will objective be reviewed & evaluated**	**Intervention codes**

2. Goal related to this service:

Is this goal: **New** **Revised** **Continued**

List Objectives (Code #)	**How will data be measured**	**How will objective be reviewed & evaluated**	**Intervention codes**

3. Goal related to this service:

Is this goal: **New** **Revised** **Continued**

List Objectives (Code #)	**How will data be measured**	**How will objective be reviewed & evaluated**	**Intervention codes**

Habilitative Service #2

Need Code	Goal Code	Service Service code	Provider Agency	Weekly Average	Exact # of weeks

What position(s) within the agency will be responsible for providing the supports for the above objectives?

Do any providers for the service listed reside with the recipient? **Yes** **No**
Are any of the providers for this service related to the recipient? **Yes** **No**
If yes to either question, identify by name & describe:

Goals for this service that will meet recipient needs:
1. Goal related to this service:

Is this goal: New Revised Continued

List Objectives (Code #)	How will data be measured	How will objective be reviewed & evaluated	Intervention codes

2. Goal related to this service:

Is this goal: New Revised Continued

List Objectives (Code #)	How will data be measured	How will objective be reviewed & evaluated	Intervention codes

3. Goal related to this service:

Is this goal: New Revised Continued

List Objectives (Code #)	How will data be measured	How will objective be reviewed & evaluated	Intervention codes

Habilitative Service #3

Need Code	Goal Code	Service Service code	Provider Agency	Weekly Average	Exact # of weeks

What position(s) within the agency will be responsible for providing the supports for the above objectives?

Do any providers for the service listed reside with the recipient? **Yes** **No**
Are any of the providers for this service related to the recipient? **Yes** **No**
If yes to either question, identify by name & describe:

Goals for this service that will meet recipient needs:
1. Goal related to this service:

Is this goal: **New** **Revised** **Continued**

List Objectives (Code #)	How will data be measured	How will objective be reviewed & evaluated	Intervention codes

2. Goal related to this service:

Is this goal: **New** **Revised** **Continued**

List Objectives (Code #)	How will data be measured	How will objective be reviewed & evaluated	Intervention codes

3. Goal related to this service:

Is this goal: **New** **Revised** **Continued**

List Objectives (Code #)	How will data be measured	How will objective be reviewed & evaluated	Intervention codes

Habilitative Service #4

Need Code	Goal Code	Service Service code	Provider Agency	Weekly Average	Exact # of weeks

What position(s) within the agency will be responsible for providing the supports for the above objectives?

Do any providers for the service listed reside with the recipient? **Yes** **No**
Are any of the providers for this service related to the recipient? **Yes** **No**
If yes to either question, identify by name & describe:

Goals for this service that will meet recipient needs:

1. Goal related to this service:

Is this goal: New Revised Continued

List Objectives (Code #)	How will data be measured	How will objective be reviewed & evaluated	Intervention codes

2. Goal related to this service:

Is this goal: New Revised Continued

List Objectives (Code #)	How will data be measured	How will objective be reviewed & evaluated	Intervention codes

3. Goal related to this service:

Is this goal: New Revised Continued

List Objectives (Code #)	How will data be measured	How will objective be reviewed & evaluated	Intervention codes

Providing agency certifies that the group home site is not requesting separate reimbursement for day habilitation service or any service provided by another resident of the group home.

Providing family home habilitation site is not requesting reimbursement for any other waiver services.

Providing agency certifies that the services of in home support habilitation or supported living habilitation are provided on a one to one basis.

Providing in home support agency is not requesting reimbursement for any other waiver service provided by another resident of the home or by the primary unpaid caregiver.

Section V ~ Out-of-Home Residential Services

Any recipient receiving waiver or grant funded out-of-home residential services (including residential supported living, group home, or family habilitation) must complete this section. The description of services and expected outcomes must be based on the recipient's needs identified in Section III.

Name of residential facility or family habilitation provider:

Admission Date:

Description of staffing pattern, including how live-in and shift staff are scheduled:

Is this a state licensed home and is the license current as of the POC Start Date? **Yes** **No**

Does this recipient's placement meet regulatory requirements for this licensed home? **Yes** **No**
(i.e.: maximum number of persons in home, receiving care, child versus adult license, waiver type eligible for this service etc.)

Need	**Service Provided by Residential Provider** **Include frequency & duration**	**Expected Outcome** **(If item covered in goal/objective, indicate)**
Nutrition, Eating, Feeding		
Bathing/Hygiene, Grooming		
Toileting/Incontinence		
Skin Care		
Dressing		
Mental Status, orientation, memory, behaviors		
Medication Management/ Supervision/Assistance		
Laundry/Chores		
Mobility/Ambulation, Safety		
Socialization		
Other Needs (e.g.: weight, vital signs, treatments, skin/wound care, etc.)		
Other Needs (e.g.: monitor seizure activity, chest pain, etc.)		
Transportation/Medical Appointments		
Communication with other caregivers		

Section VI ~ Planning Team

List all members of the planning team. The planning team must include the recipient, the recipient's legal representative if applicable, the certified Care Coordinator, and representative of each certified provider that is expected to provide services, excluding transportation, environmental modification and specialized medical equipment providers (per 7 AAC 130.217). Each planning team member must sign the Plan of Care.

Name	**Role/ Agency**	**Phone**	**Consulted by**			
			In-person	**Email**	**Phone**	**Video Conference**
	Recipient					
	Legal Representative					
	Care Coordinator					
	HCB Agency Name: *ACME Agency*					
	HCB Agency Name:					
	HCB Agency Name:					
	HCB Agency Name:					
	HCB Agency Name:					
	HCB Agency Name:					
	Natural Support					
	NOCM Nurse (if applicable)					