# National Center on Advancing Person-Centered Practices and Systems Individualized Technical Assistance Application

The [National Center on Advancing Person-Centered Practices and Systems (NCAPPS)](https://ncapps.acl.gov/home.html) is an initiative from the Administration for Community Living (ACL) and the Centers for Medicare & Medicaid Services (CMS) that helps States, Tribes, and Territories implement person-centered thinking, planning, and practice in line with U.S. Department of Health and Human Services policy.

NCAPPS currently provides **free** **short-term direct technical assistance** to states experiencing significant challenges implementing person-centered planning consistent with the Home and Community-Based Services (HCBS) Final Rule. Preference will be given to states with strong leadership buy-in and established relationships with advocacy organizations. Please note that NCAPPS is no longer offering multi-year, long-term technical assistance as has been provided in the past.

**If you would like to request technical assistance, complete the application below and email it to** **ncapps@hsri.org****. Once received, a member of our team will be in touch with you to schedule a meeting to further discuss your needs.**

1. State/territory/tribe:
2. Lead organization/agency:
3. Primary contact full name:
4. Primary contact email address:
5. Primary contact title:

List the contact for your state Medicaid agency below. As a condition of receiving NCAPPS technical assistance, applicants are required to include a representative from the Medicaid agency.

1. Medicaid agency contact full name:
2. Medicaid agency contact email address:

Provide names, email addresses, and organizational affiliations below for any additional team members or partners who may be involved in this technical assistance request. Example: "John Smith, jsmith@advocacy.org, Regional Self-Advocacy Coalition." Please note that you are encouraged to partner with state and local advocacy groups. NCAPPS can support you with identifying collaborators if needed.

1. Names/email addresses/organizational affiliations of additional partners:
2. List your waiver(s):
3. Check all populations served:
	1. [ ] Physical disability
	2. [ ] Brain injury
	3. [ ] Mental health
	4. [ ] Intellectual and developmental disability
	5. [ ] Substance use disorders
	6. [ ] Adults
	7. [ ] Transition age youth
	8. [ ] Older adults with long-term needs
	9. [ ] Children/youth
	10. [ ] Other population

Provide a brief description of your technical assistance needs, including information about which of the person-centered planning requirements of the HCBS Final Rule you are experiencing challenges with. A list of these requirements can be found on the [third page](#_Reference:_Overview_of) of this application for reference.

1. Brief description of technical assistance needs:
2. Briefly describe what outcomes you anticipate for your system as a result of receiving NCAPPS technical assistance:
3. Have you received any other technical assistance or resources regarding this request? If yes, describe:

List a few dates and times in the next two weeks that the primary contact and additional partners would be available to meet with the NCAPPS team for an initial 30-minute meeting to discuss this application.

1. List available dates and times for follow-up meeting:
2. How did you find out about NCAPPS technical assistance?
	1. [ ] Referred by CMS
	2. [ ] Referred by ACL
	3. [ ] NCAPPS newsletter/social media/website
	4. [ ] Other, please describe:

## Reference: Overview of the HCBS Final Rule Person-Centered Planning Requirements

This resource serves as a quick reference for reviewing the person-centered planning requirements of the [Home and Community-Based Services (HCBS) Final Rule](https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html) including requirements related to the planning process, the person-centered plan, and documentation of modifications.

### Requirements for the Person-Centered Planning Process

The individual will lead the person-centered planning process where possible. The individual's representative should have a participatory role, as needed and as defined by the individual, unless State law confers decision-making authority to the legal representative. All references to individuals include the role of the individual's representative. In addition to being led by the individual receiving services and supports, the person-centered planning process:

* Includes people chosen by the individual.
* Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions.
* Is timely and occurs at times and locations of convenience to the individual.
* Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
* Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.
* Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process.
* Offers informed choices to the individual regarding the services and supports they receive and from whom.
* Includes a method for the individual to request updates to the plan as needed.
* Records the alternative home and community-based settings that were considered by the individual.

### Requirements for the Person-Centered Plan

The person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. Commensurate with the level of need of the individual, and the scope of services and supports available under the State's 1915(c) HCBS waiver, the written plan must:

* Reflect that the setting in which the individual resides is chosen by the individual. The State must ensure that the setting chosen by the individual is integrated in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS.
* Reflect the individual's strengths and preferences.
* Reflect clinical and support needs as identified through an assessment of functional need.
* Include individually identified goals and desired outcomes.
* Reflect the services and supports (paid and unpaid) that will assist the individual to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the individual in lieu of 1915(c) HCBS waiver services and supports.
* Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.
* Be understandable to the individual receiving services and supports, and the individuals important in supporting him or her. At a minimum, for the written plan to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.
* Identify the individual and/or entity responsible for monitoring the plan.
* Be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation.
* Be distributed to the individual and other people involved in the plan.
* Include those services, the purpose or control of which the individual elects to self-direct.
* Prevent the provision of unnecessary or inappropriate services and supports.

### Requirements for Documentation of Modifications in the Person-Centered Plan

Document that any modification of the additional conditions of this section, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

* Identify a specific and individualized assessed need.
* Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
* Document less intrusive methods of meeting the need that have been tried but did not work.
* Include a clear description of the condition that is directly proportionate to the specific assessed need.
* Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
* Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
* Include informed consent of the individual.
* Include an assurance that interventions and supports will cause no harm to the individual.