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|---|---|
| ● | By Other (*specify State agency or entity under contract with the State Medicaid agency*): |
| | DCFS, Clark County Department of Family Services (CCDFS), Washoe County Human Services Agency |

**2. Qualifications of Individuals Performing Evaluation/Reevaluation**. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

The Care Coordinator ~~Manager or Wraparound Facilitator~~ who is responsible for performing evaluation/reevaluation of eligibility must be independent and have one of the following qualifications:

Qualified Mental Health Associate (QMHA) –

A person who meets the following documented minimum qualifications:

1. Licensure as a Registered Nurse (RN) in the State of Nevada or holds a bachelor's degree from an accredited college or university in a human, social services or behavioral field with additional understanding of RMH treatment services and case file documentation requirements; or
2. Holds an associate degree from an accredited college or university in a human, social services or behavioral field with additional understanding of RMH treatment services, and case file documentation and has four years of relevant professional experience of providing direct services to individuals with mental health disorders;
   or
3. An equivalent combination of education and experience as listed in 1-2 above; and
4. Whose education and experience demonstrate the competency under clinical supervision to:
   a. Direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise;
   b. Identify presenting problem(s);
   c. Participate in treatment plan development and implementation;
   d. Coordinate treatment;
   e. Provide parenting skills training;
   f. Facilitate discharge plans; and
   g. Effectively provide verbal and written communication on behalf of the recipient to all involved parties.
5. Has a Federal Bureau of Investigation (FBI) background check in accordance with the Qualified Behavioral Aides (QBA) provider qualifications listed under Section 403.6A of the Nevada MSM.

Qualified Mental Health Professional (QMHP) - A Physician, Physician's Assistant or a person who meets the definition of a QMHA and also meets the following documented minimum qualifications:

1. Holds any of the following educational degrees and licensure:
   a. Doctorate degree in psychology and license;
   b. Bachelor's degree in nursing and Advanced Practitioners of Nursing (APN) (psychiatry);
   c. Independent Nurse Practitioner; Graduate degree in social work and clinical license;
   d. Graduate degree in counseling and licensed as a marriage and family therapist or clinical professional counselor; or

2. Who is employed and determined by a state mental health agency to meet established class specification qualifications of a Mental Health Counselor; and
3. Whose education and experience demonstrate the competency to: identify precipitating events, conduct a comprehensive mental health assessment, diagnose a mental or emotional disorder and document a current ICD diagnosis, determine intensity of service's needs, establish measurable goals, objectives and discharge criteria, write and supervise a treatment plan and provide direct therapeutic treatment within the scope and limits of their expertise.

The following are also considered QMHPs:

a. Licensed Clinical Social Worker (LCSW) Interns meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada, Board of Examiners for Social Workers (Nevada Administrative Code (NAC) 641B).

b. Licensed Marriage and Family Therapist (LMFT) and Licensed Clinical Professional Counselor Interns who meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors.

c. Psychological Assistants who hold a doctorate degree in psychology, is registered with the State of Nevada Board of Psychological Examiners (NAC 641.151) and is an applicant for licensure as a Licensed Clinical Psychologist who has not yet completed the required supervised postdoctoral experience approved by the Board.

d. Psychological Interns registered through the Psychological Board of Examiners defined in NAC 641.165. Interns must be supervised in accordance with state regulations and may only provide services within the scope of their licensure.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

DCFS offers tiered care coordination services to best meet the needs of youth with serious emotional disturbance (SED). Youth with the highest level of need receive High Fidelity Wraparound and their Wraparound Facilitator will direct the process of eligibility for State plan HCBS and development of the Plan of Care (POC). Youth with intermediate level of need are offered FOCUS Care Coordination, an evidence-informed intermediate level care coordination program created by the National Wraparound Implementation Center which also provides training and technical assistance to Nevada in our implementation of High-Fidelity Wraparound. FOCUS Care Coordination is a new, evidence-informed intermediate level care coordination program created by the National Wraparound Implementation Center which also provides training and technical assistance to Nevada in our implementation of High-Fidelity Wraparound. FOCUS care coordination is built around the following elements of service: Families are laughing, i.e. positive relationships are necessary for healing; Outcomes; Coordination; Unconditional positive regard; and Short-term process (FOCUS). Youth receiving FOCUS will have a Care Manager directing the process of eligibility for State Plan HCBS and development of the POC.

While we anticipate that nearly all youth who are eligible for 1915(i) State plan benefit will also qualify for High Fidelity Wraparound due to intensive behavioral healthcare needs, we have included in this application the possibility that youth may be routed to FOCUS and may have a Care Manager leading their Child and Family Team.

The Care Manager/Wraparound Facilitator (CM/WF) and the Child and Family Team (CFT) will evaluate whether an individual meets the needs-based State plan HCBS eligibility criteria and whether the individual is eligible for the 1915(i)-state plan benefit. The CM/WF and the CFT will perform the evaluation based upon Nevada's definition of medically necessary treatment which states: Medical Necessity is a health care service or product that is provided for under the Medicaid State Plan and is necessary and consistent with generally accepted professional standards to:
A. diagnose, treat or prevent illness or disease;
B. regain functional capacity; or
C. reduce or ameliorate effects of an illness, injury or disability.

The determination of medical necessity is made on the basis of the individual case and takes into account:
D. the type, frequency, extent, and duration of treatment with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies.
E. the level of service that can be safely and effectively furnished, and for which no equally effective and more conservative or less costly treatment is available.
F. that services are delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral health care needs of the recipient.
G. that services are provided for medical or mental/behavioral reasons, rather than for the convenience of the recipient, the recipient's caregiver or the health care provider.

Medical necessity shall take into account the ability of the service to allow recipients to remain in a community-based setting, when such a setting is safe, and there is no less costly, more conservative, or more effective setting.

The CM/WF will be familiar with the medical necessity criteria and will use criteria and the individual's clinical history to facilitate the determination of eligibility.

Re-evaluation occurs every 90 days and includes a re-determination of medical necessity on the basis of the individual case and taking into account:

D. the type, frequency, extent, and duration of treatment with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies.
E. the level of service that can be safely and effectively furnished, and for which no equally effective and more conservative or less costly treatment is available.
F. that services are delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral health care needs of the recipient.
G. that services are provided for medical or mental/behavioral reasons, rather than for the convenience of the recipient, the recipient's caregiver or the health care provider.

Medical necessity shall take into account the ability of the service to allow recipients to remain in a community-based setting, when such a setting is safe, and there is no less costly, more conservative, or more effective setting.

When evaluation and re-evaluation is determined by the local county agency, Clark County Department of Family Services (CCDFS) or Washoe County Human Services Agency, the Safety Assessment Family Evaluation (SAFE) model is utilized. This is a strengths-based, family-centered, and trauma-informed model to inform child welfare agency decision-making. Child safety is the primary focus of the SAFE model, and focus is given to children who may be unsafe based on the presence of uncontrolled danger threats. SAFE uses standardized tools and decision-making criteria to assess family behaviors, conditions, and circumstances, including individual child vulnerabilities and caregiver protective capacities, to make well-founded child safety decisions. The practice model's approach to safety assessment and management recognizes that issues concerned with child safety change as the child protective services intervention proceeds.

The Case Worker (CW) and Child and Family Team (CFT) will evaluate whether an individual meets the needs-based State plan HCBS eligibility criteria and whether the individual is eligible for the 1915(i)-state plan benefit. The CW and CFT will perform the evaluation based upon Nevada's definition of medically necessary treatment which states: Medical Necessity is a health care service or product that is provided for under the Medicaid State Plan and is necessary and consistent with generally accepted professional standards to:
A. diagnose, treat or prevent illness or disease;
B. regain functional capacity; or
C. reduce or ameliorate effects of an illness, injury or disability.

The determination of medical necessity is made on the basis of the individual case and takes into account:
A. the type, frequency, extent, and duration of treatment with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies.
B. the level of service that can be safely and effectively furnished, and for which no equally effective and more conservative or less costly treatment is available.
C. that services are delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral health care needs of the recipient.
D. that services are provided for medical or mental/behavioral reasons, rather than for the convenience of the recipient, the recipient's caregiver or the health care provider.

Medical necessity shall take into account the ability of the service to allow recipients to remain in a community-based setting, when such a setting is safe, and there is no less costly, more conservative, or more effective setting.

The CW will be familiar with the medical necessity criteria and will use criteria and the individual's clinical history to facilitate the determination of eligibility.

Re-evaluation occurs every 90 days and includes a re-determination of medical necessity on the basis of the individual case and taking into account:
A. the type, frequency, extent, and duration of treatment with scientifically based guidelines of national medical or health care coverage organizations or governmental agencies.
B. the level of service that can be safely and effectively furnished, and for which no equally effective and more conservative or less costly treatment is available.

C. that services are delivered in the setting that is clinically appropriate to the specific physical and mental/behavioral health care needs of the recipient.
D. that services are provided for medical or mental/behavioral reasons, rather than for the convenience of the recipient, the recipient's caregiver or the health care provider.

Medical necessity shall take into account the ability of the service to allow recipients to remain in a community-based setting, when such a setting is safe, and there is no less costly, more conservative, or more effective setting.

For simplification the term Care Coordinator will be used to encompass either the Child Welfare agency Case Worker or DCFS Care Manager/Wraparound Facilitator.

**4.** ☑ **Reevaluation Schedule**. *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

**5.** ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

Children/youth must need minimum requirements to be considered for 1915(i) services:

1**. Impaired Functioning & Service Intensity**: The ~~CM/WF~~Care Coordinator and CFT will use a comprehensive biopsychosocial assessment and the level of care decision support tools the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0-5 or the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6-18. The Wraparound Facilitator and CFT will review clinical indicators of impaired functioning: Prior psychological assessment records, prior placement history, and prior treatment history. Youth must demonstrate significant levels of behavioral health needs as evidenced by Serious Emotional Disturbance (SED) determination and must demonstrate a minimum CASII or ECSII level of 1.

AND

2. **Other Community Alternatives:** The accessibility and/or intensity of currently available community supports and services are inadequate to meet these needs due to the severity of the impairment without the provision of one or more of the services contained in the HCBS Benefit, as determined by the DCFS or its designee, as evidenced by at least one of the following risk factors:

- At risk of higher level of care placement due to recent placement disruption within the past six months;
- Current placement in emergency shelter or congregate care due to behavioral and mental health needs;
- In need of transition to community-based living arrangement with intensive behavioral supports when returning or stepping down from residential treatment center or other higher level of care placement; and/or
- At risk of higher level of care placement because prior traditional family foster care and/or less restrictive community treatment services have not been successful.

**6.** ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

| **State plan HCBS needs-based eligibility criteria** | **NF (& NF LOC** waivers)** | **ICF/IID (& ICF/IID LOC waivers)** | **Applicable Hospital* (& Hospital LOC waivers)** |
|---|---|---|---|
| Children/youth must need minimum requirements to be considered for 1915(i) services:<br><br>1**. Impaired Functioning & Service Intensity**: The ~~Wraparound~~ | The individual's condition requires services for three of the following:<br><br>1. Medication,<br>2. Treatment/Special Needs,<br>3. ADLs,<br>4. Supervision, or | In order to meet the ICF-IID level of care criteria, the individual must meet all of the following:<br>1. Have substantial functional impairments in three (3) or more of six (6) areas of major life activity (mobility, | The individual has chronic mental illness and has at least three functional deficits:<br><br>1. Imminent risk of self-harm,<br>2. Imminent risk of harm to others, |

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| ~~Facilitator~~Care Coordinator and CFT will use a comprehensive biopsychosocial assessment and the level of care decision support tools the Early Childhood Service Intensity Instrument (ECSII) for youth ages 0-5 or the Child and Adolescent Service Intensity Instrument (CASII) for youth ages 6-18. The ~~Wraparound Facilitator~~Care Coordinator and CFT will review clinical indicators of impaired functioning: Prior psychological assessment records, prior placement history, and prior treatment history. Youth must demonstrate significant levels of behavioral health needs as evidenced by Serious Emotional Disturbance (SED) determination and must demonstrate a minimum CASII or ECSII level of 1.<br><br>AND<br><br>2. **Other Community Alternatives:** The accessibility and/or intensity of currently available community supports and services are inadequate to meet these needs due to the severity of the impairment without the | 5. IADLs. | selfcare, understanding and use of language, learning, self-direction, and capacity for independent living).<br>For children age six years and younger, to have intensive support needs in areas of behavioral skills, general skills training, personal care, medical intervention, etc., beyond those required for children of the same age.<br>2. The individual has a diagnosis of an intellectual disability, or a related condition. The onset of an intellectual disability must have occurred before the age of 18, and the onset of a related condition must have occurred on or before age 22.<br>3. Must require monthly supports by, or under the supervision of, a health care professional or trained support personnel.<br>4. The monthly support may be from one entity or may be a combination of supports provided from various sources.<br>5. The individual cannot be maintained in a less restrictive environment without supports or services. Through the assessment process the team has identified the | 3. Risk of serious medical complications, or<br>4. Need for 24 hour supervision. |

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| provision of one or more of the services contained in the HCBS Benefit, as determined by the DCFS or its designee, as evidenced by at least one of the following risk factors:<br><br>• At risk of higher level of care placement due to recent placement disruption within the past six months;<br>• Current placement in emergency shelter or congregate care due to behavioral and mental health needs;<br>• In need of transition to community-based living arrangement with intensive behavioral supports when returning or stepping down from residential treatment center or other higher level of care placement; and/or<br>• At risk of higher level of care placement because prior traditional family foster care and/or less restrictive community treatment services have not been successful. | | individual as being at risk of needing institutional placement (ICF/IID) without the provision of at least monthly supports. | |

*Long Term Care/Chronic Care Hospital
**LOC= level of care

**7.** ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of five years. At least 90 days prior to the end of this five-year period, the state may request CMS renewal of this benefit for additional five-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

Target Group. Youth must meet all of the following:
- ✓ Youth must be under 19 years of age at the time of enrollment; they may continue in HCBS benefit through age 19
- ✓ and
- ✓ Youth must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-5) or Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC: 0-3) diagnosis.

✓ **Option for Phase-in of Services and Eligibility** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

*(By checking the following box the State assures that):*

**8.** ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i) (1) (D) (ii).

**9**. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

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| **i.** | **Minimum number of services**.<br>The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:*<br>1 | |
| **ii.** | **Frequency of services**. The state requires (select one): | |
| | ● | **The provision of 1915(i) services at least monthly** |
| | ○ | **Monthly monitoring of the individual when services are furnished on a less than monthly basis**<br>If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency: |

# Home and Community-Based Settings

*(By checking the following box the State assures that):*

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a) (1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

*(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)*

The State plan HCBS benefits will be furnished to children and young adults aged 0-18 who reside and receive HCBS in a home in the community, not in an institution. This may include residence in a home or apartment that is a licensed specialized foster care home. These settings are the private homes of foster parents or group homes who must meet a number of standard environmental and physical space dimensions of the home which are geared toward the individual needs of the children who live there. The child in the specialized foster care program will:

- Live in foster homes which are part of the community and close to provider services.
- Have a room(s) which meet the needs of the child from a physical and behavioral health perspective.
- Be free to move around in the home and is not restrained in any way.
- Be allowed to make life choices appropriate for the age of the child.
- If capable, assist in the selection of services and supports.
- Be in settings that can include additional foster care children and members of the foster family.
- Have some services provided directly in the foster home. Other services will occur in provider locations.

# Person-Centered Planning & Service Delivery

*(By checking the following boxes the state assures that):*

**1.** ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

**2.** ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

**3.** ☑ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

**4.** **Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities.** There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

The ~~CM/WF~~Care Coordinator must be independent and ~~both~~ must have one of the following qualifications:

Qualified Mental Health Associate (QMHA) –
A person who meets the following documented minimum qualifications:

1. Licensure as a RN in the State of Nevada or holds a Bachelor's Degree from an accredited college or university in a human, social services or behavioral field with additional understanding of RMH treatment services and case file documentation requirements; or
2. Holds an associate's degree from an accredited college or university in a human, social services or behavioral field with additional understanding of RMH treatment services, and case file documentation and has four years of relevant professional experience of providing direct services to individuals with mental health disorders;
   or
3. An equivalent combination of education and experience as listed in1-2 above; and
4. Whose education and experience demonstrate the competency under clinical supervision to:
   a. Direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise;
   b. Identify presenting problem(s);
   c. Participate in treatment plan development and implementation;
   d. Coordinate treatment;
   e. Provide parenting skills training;
   f. Facilitate discharge plans; and
   g. Effectively provide verbal and written communication on behalf of the recipient to all involved parties.
5. Has a Federal Bureau of Investigation (FBI) background check in accordance with the Qualified Behavioral Aides (QBA) provider qualifications listed under Section 403.6A of the Nevada Medicaid Services Manual (MSM).

Qualified Mental Health Professional (QMHP) - A Physician, Physician's Assistant or a

person who meets the definition of a QMHA and also meets the following documented minimum qualifications:
1. Holds any of the following educational degrees and licensure:
   a. Doctorate degree in psychology and license;
   b. Bachelor's degree in nursing and Advanced Practitioners of Nursing (APN) (psychiatry);
   c. Independent Nurse Practitioner; Graduate degree in social work and clinical license;
   d. Graduate degree in counseling and licensed as a marriage and family therapist or clinical professional counselor; or
2. Who is employed and determined by a state mental health agency to meet established class specification qualifications of a Mental Health Counselor; and
3. Whose education and experience demonstrate the competency to: identify precipitating events, conduct a comprehensive mental health assessment, diagnose a mental or emotional disorder and document a current ICD diagnosis, determine intensity of service's needs, establish measurable goals, objectives and discharge criteria, write and supervise a treatment plan and provide direct therapeutic treatment within the scope and limits of their expertise.

The following are also considered QMHPs:
   a. Licensed Clinical Social Worker (LCSW) Interns meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada, Board of Examiners for Social Workers (Nevada Administrative Code (NAC) 641B).
   b. Licensed Marriage and Family Therapist (LMFT) and Licensed Clinical Professional Counselor Interns who meet the requirements under a program of internship and are licensed as an intern pursuant to the State of Nevada Board of Examiners for Marriage and Family Therapists and Clinical Professional Counselors.
   c. Psychological Assistants who hold a doctorate degree in psychology, are registered with the State of Nevada Board of Psychological Examiners (NAC 641.151) and are an applicant for licensure as a Licensed Clinical Psychologist who has not yet completed the required supervised postdoctoral experience approved by the Board.
   d. Psychological Interns registered through the Psychological Board of Examiners defined in NAC 641.165. Interns must be supervised in accordance with state regulations and may only provide services within the scope of their licensure.

All Wraparound Facilitators will be required to be certified by DCFS as a Wraparound Facilitator utilizing the standards of the National Wraparound Implementation Center. All Care Managers will be required to be trained by DCFS in the FOCUS model utilizing the standards of the National Wraparound Implementation Center.

All Care Coordinators ~~Managers and Wraparound Facilitators~~ will be at least QMHA level or above. All Care Coordinators ~~Managers and Wraparound Facilitators~~ will be required to maintain appropriate certifications including certification on the Nevada Child and Adolescent Needs and Strengths tool (NV-CANS). Recipients will receive either services of CW, CM, or WF based on level of need.

5. **Responsibility for Development of Person-Centered Service Plan**. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

The development of the person-centered service plan will focus on a strengths and needs-driven approach that provides intensive care management in a team setting using a Child and Family Team (CFT) approach. The CFT team includes the ~~CM/WF~~Care Coordinator, child or youth, caregiver(s), support persons identified by the family (paid and unpaid), and service providers, including the youth's treating clinician as available.

The process is designed to promote youth and parent involvement as active members of the CFT. The goals of CFT meetings are to manage care and services to avoid fragmentation, ensure access to appropriate and person-centered care, and provide a team approach to address needs. Youth and parent/guardian involvement is essential in the assessment of: safety; strengths; medical, social, behavioral, educational and cultural needs; skill building; family/caregiver supports and services; and goals.

The ~~CM/WF~~Care Coordinator will utilize assessments to create the individualized POC for children and families. The plan will include needs, outcomes, and strategies that are:
- Specific. The CFT, including the family should know exactly what must be completed or changed and why.
- Measurable. Everyone should know when the needs have been met. Outcomes will be measurable to the extent that they are behaviorally based and written in clear and understandable language.
- Achievable. The CFT and family should be able meet the identified needs in a designated time period given the resources that are accessible and available to support change.

The person-centered POC will include detailed service plans for applicable 1915(i) services. The CFT shall develop the initial POC, which will be documented by the ~~CM/WF~~Care Coordinator. The ~~CM/WF~~Care Coordinator will also be responsible for documenting updates to the POC, including recommendations and decisions made by the CFT, in accordance to timeframes as listed in DCFS policy.

The ~~CM/WF~~Care Coordinator is responsible to submit the developed POC to the QIO-like vendor for approval.

**6. Supporting the Participant in Development of Person-Centered Service Plan**. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The child's/youth's family is informed verbally and in writing about overall services available in the State Plan HCBS benefit at the time they make the choice to receive 1915(i) services. One of the key philosophies in the Wraparound process is family-driven care. This means that parent(s) or legal guardian, youth and family members are the primary decision makers in the care of their family. The ~~CM/WF~~Care Coordinator is responsible for working with the participant, family, and team to develop the Plan of Care through the process outlined below.

Within 72 hours of notification of enrollment, the ~~CM/WF~~Care Coordinator contacts the participant and family to schedule a face-to-face meeting. At the first meeting between the Care Coordinator~~CM/WF~~, participant, and family after enrollment, the Care Coordinator ~~CM/WF~~ will:
(a) Administer the appropriate assessments, as designated by DCFS;
(b) Work with the participant and family to develop an initial crisis plan that includes response to immediate service needs;

(c) Execute signing of releases of information and all necessary consents
(d) Provide an overview of the wraparound process; and
(e) Facilitate the family sharing their story.

The Care Coordinator~~CM/WF~~ will, with the participant and family: identify needs that they will work on in the planning process; determine who will attend team meetings; contact potential team members, provide them with an overview of the care management process, and discuss expectations for the first team meeting; conduct an initial assessment of strengths of the participant, their family members and potential team members; and, establish with the family their vision statement.

The team, which includes the participant and his or her family and informal and formal supports will determine the family vision which will guide the planning process; identify strengths of the entire team; be notified of the needs that the team will be working on; determine outcome statements for meeting identified needs; determine the specific services and supports required in order to achieve the goals identified in the POC; create a mission statement that the team generates and commits to following; identify the responsible person(s) for each of the strategies in the POC;
review and update the crisis plan; and, meet at least every 30 days to coordinate the implementation of the POC and update the POC as necessary.

The plan must also address the methods used to ensure the active participation of the client and/or the legally responsible person and others to develop such goals and to identify the steps or actions each CFT member will take to respond to the assessed service needs of the participant. This will be demonstrated by the CFT members signing and dating the plan and any updates made to the plan during plan updates and reviews language.

The Care Coordinator ~~CM/WF~~ in collaboration with the team shall reevaluate the POC at least every 90 days with re-administration of DCFS-approved assessments as appropriate.

**7. Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

All participants or legal guardians read and sign a "Statement of Understanding" form. The Statement of Understanding reads, “The 1915(i) HCBS are optional Nevada Medicaid services. Assessment of my diagnoses and needs will direct the services to be provided, as determined by the Child and Family Team led by the Care Coordinator~~Manager or Wraparound Facilitator~~. I have the opportunity to participate as an active member of the Child and Family Team. The Child and Family team will support me in selecting providers for medically necessary HCBS services. My family and I, had a voice and choice in the selection of services, providers and interventions, when possible, in the SAFE, FOCUS, or Wraparound process of building my family's Plan of Care. I choose to receive HCBS. I understand that I have to be eligible for Medicaid to remain in this program. I have been offered a choice among applicable services and available providers.” By signing this form participants acknowledge they have chosen from a list of available providers.

Provider enrollment into the program will not be limited; an ongoing enrollment of providers will promote choice and accessibility.