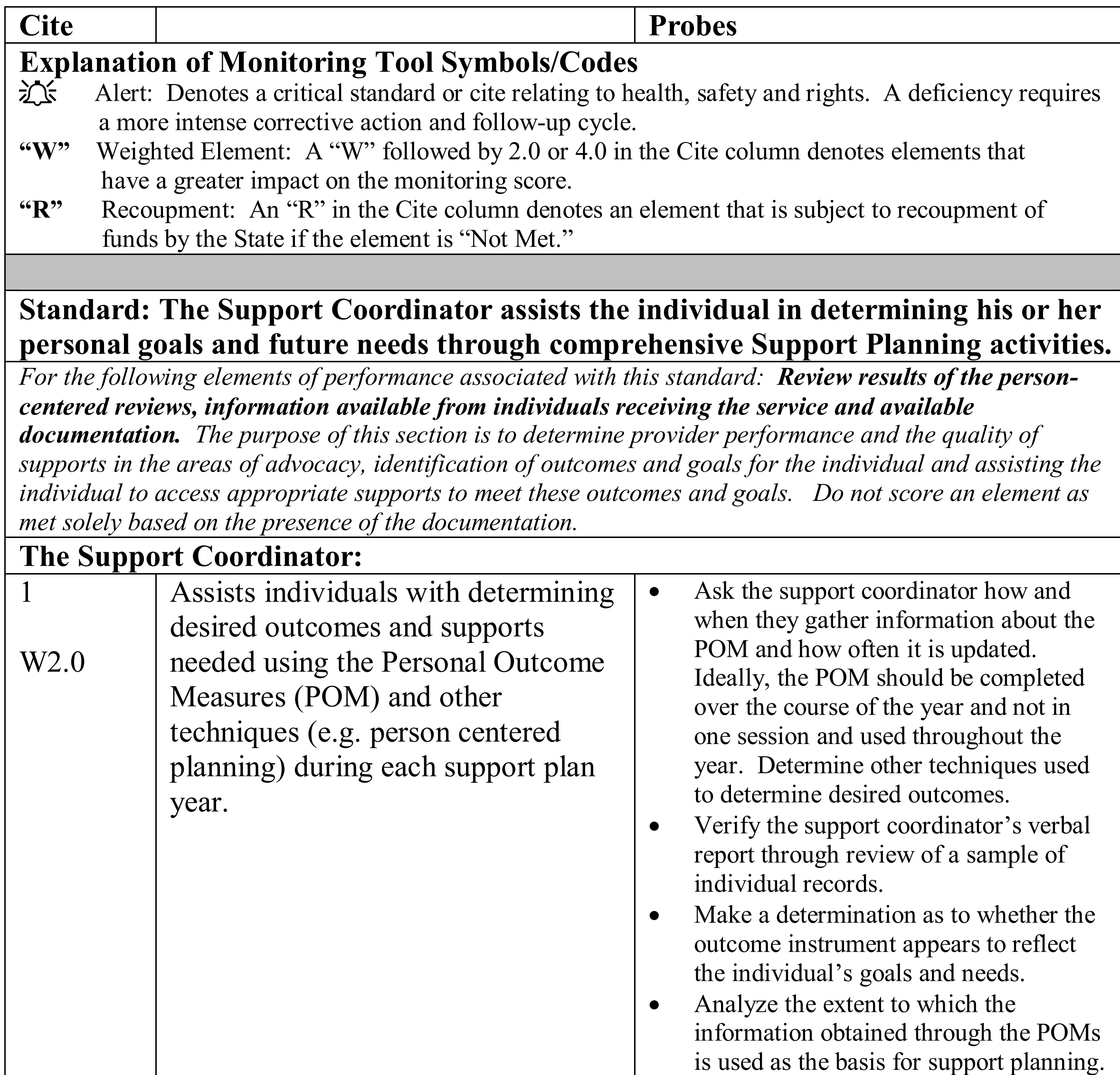
Developmental Services

Support Coordination

Monitoring Protocol

Support Coordination is the service of advocating, identifying, developing, coordinating and accessing supports and services on behalf of an individual, or assisting the individual or family to access supports and services on their own. These services may be provided through waiver and other Medicaid State Plan services, as well as needed medical, social, educational, other appropriate services, and community resources regardless of the funding source through which access is gained. The waiver support coordinator is responsible for assessing the individual's needs, preferences and future goals (outcomes). From that information, the waiver support coordinator assists the individual in developing a support plan and cost plan.



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Explanation of Monitoring Tool Symbols/Codes Alert: Denotes a critical standard or cite relating to health, safety and rights. A deficiency requires a more intense corrective action and follow-up cycle. **"W"** Weighted Element: A "W" followed by 2.0 or 4.0 in the Cite column denotes elements that have a greater impact on the monitoring score. **"R"** Recoupment: An "R" in the Cite column denotes an element that is subject to recoupment of funds by the State if the element is "Not Met."		
Standard: The Support Coordinator assists the individual in determining his or her personal goals and future needs through comprehensive Support Planning activities.		
For the following elements of performance associated with this standard: ***Review results of the person-centered reviews, information available from individuals receiving the service and available documentation.*** *The purpose of this section is to determine provider performance and the quality of supports in the areas of advocacy, identification of outcomes and goals for the individual and assisting the individual to access appropriate supports to meet these outcomes and goals. Do not score an element as met solely based on the presence of the documentation.*		
The Support Coordinator:		
1 W2.0	Assists individuals with determining desired outcomes and supports needed using the Personal Outcome Measures (POM) and other techniques (e.g. person centered planning) during each support plan year.	• Ask the support coordinator how and when they gather information about the POM and how often it is updated. Ideally, the POM should be completed over the course of the year and not in one session and used throughout the year. Determine other techniques used to determine desired outcomes. • Verify the support coordinator's verbal report through review of a sample of individual records. • Make a determination as to whether the outcome instrument appears to reflect the individual's goals and needs. • Analyze the extent to which the information obtained through the POMs is used as the basis for support planning.

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2	Assists individuals to identify needs using the assessment instrument approved by the APD prior to the development of the support plan.	• Ask the support coordinator when they complete the assessment and how often it is updated • Verify the support coordinator's verbal report through review of an individual's record • Make a determination of whether information and scoring appears to legitimately reflect the needs of the individual under review. • Analyze the extent to which the information obtained through the approved assessment is used as the basis for support planning.
3 W2.0	Assists individuals to make decisions and informed choices as indicated by the person's situation throughout the support plan year.	• Ask the provider to provide an example of an individual that they have recently assisted in making decisions and informed choices. Determine if sufficient information was given to the individual for an informed decision or choice to be made. A discussion of the risks, benefits and consequences of decisions should be apparent in discussion with the provider and in the supporting documentation in progress notes. • Review this individual's record with the provider to determine that documentation supports what the provider is supplying verbally. • Review progress notes for the sample selected to determine whether this assistance is provided routinely and appropriately for the situations reviewed.
4 W2.0	Develops the support and cost plan to reflect the individual's desired personal outcomes and individual needs.	• Review the sample: Look for support and cost plans to determine that they are completed annually (at a minimum for the current review period). ➢ Determine whether the support and cost plan appropriately reflects information gathered during the support planning process. Does the plan reflect the goals and outcomes identified by the individual? ➢ Does the plan reflect the needs and current situation of the individual as described in progress notes reviewed? ➢ Determine whether the support and cost plan reflect a decrease in reliance on paid supports and an increase in natural or generic supports of the individual's choice.

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5	Reviews with individuals, at least annually at the time of support plan development, available options for services and supports, (includes both paid and unpaid service options).	*Note: The purpose of the support coordinator's review is to assist the individual in planning for the future, to assist in defining personal goals and to facilitate informed choice. The review should include what the individual can expect from providers of specific services in meeting the individual's goals and needs.* Ask the support coordinator how they help people with knowing options for services. Review records in the sample to determine examples of individuals that they have been assisted in making decisions and informed choices. • Review individual records with the support coordinator to determine that documentation supports what the provider is supplying verbally. • Analyze the results of person-centered reviews involving the support coordinator to identify positive or negative performance trends
6	Annually completes a report of progress for individuals as specified in APD policy.	• Annual report is part of the Support Plan. Look for a report on the individual's progress to determine that requirement is met. • Determine whether unmet goals and needs have been positively addressed in the current plan.
7 W2.0	Assists individuals to meet goals and outcomes through linkages with natural and generic supports.	• Ask the support coordinator about their knowledge of, or how they become knowledgeable about neighborhood and community supports and services. • Review progress notes and other information to determine whether natural and generic supports are pursued. • Determine to what extent the individual is involved in this process. Are choices and interests explored and developed?
8	When natural and generic supports are not available, assist the individual in locating services available through local, state or federal sources, including Medicaid and the DS Medicaid waiver.	• Ask the coordinator how they assist individuals with using Medicaid State Plan and DS Medicaid waiver services, shared funding with the Department of Education, V.R. and other funding sources. • Determine through progress notes how support linkages occur. • Determine to what extent individuals are involved in this process. Are choices and options explored and developed? Is information about options presented as well as opportunities to visit service sites and potential vendors? • Check how and whether the provider

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		determined the most cost beneficial approach for services, and still met the individual's needs.
9	Reviews with service vendors the goals to be achieved for the individual and notes these discussions in progress notes.	• Review attendance at support plan meeting to determine if providers were present, if invited to attend. Is there documentation in the progress notes that indicates the support coordinator worked with the individual on who they wished to attend the support plan meeting? • Review progress notes and/or service authorizations to determine if there was communication with the service vendor to adequately relay the type, intensity, and individualization of the supports the person needs and desired goals. • Review Implementation Plans and other progress information received from service providers. If goals are not consistent with the support plan and individual desired outcomes, review progress notes for evidence that the coordinator took action to correct the discrepancy.
10	Takes actions necessary to coordinate the continuity of supports and services among providers, family and others to achieve the goals and outcomes of the person.	• Ask the support coordinator to provide examples of how communication and coordination is promoted for an individual between paid and unpaid supports. Are actions needed to help the person achieve outcomes being addressed? • Review progress notes and other information to verify that coordination between supports occurs. Look for trends of lack of coordination rather than incidental omissions. Consider the seriousness of the incident(s) and the resulting consequence(s) of the lack of coordination.
11	Documents all support coordination services, activities and contacts in clear and adequate progress notes.	• Progress notes should contain the "who, what, when, where, why and what's next" so that it is clear what action took place and any anticipated actions that should follow. • Notes should detail support coordination activities made on behalf of the individual. • Notes should detail efforts made to assist individuals to achieve outcomes and goals and to become more integrated into communities. • Notes should be complete, legible and contain no unnecessary abbreviations. • Notes should adequately describe

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<tr><th>Cite</th><th></th><th>Probes</th></tr>
<tr><td></td><td></td><td>contacts with the individual, their family and others, identify any issues or concerns and contain adequate follow-up information to determine resolution.
• Use information gathered throughout the review and through examination of progress notes to determine this element.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">Standard: The Support Coordinator assists the individual to achieve personal goals and outcomes.</td></tr>
<tr><td colspan="3">For the following element of performance associated with this standard: Review results of the person-centered reviews, information available from individuals receiving the service and available documentation. The purpose of this section is to determine provider performance and the quality of supports in the areas of advocacy, and assisting the individual to meet outcomes and goals. Do not score an element as met solely based on the presence of the documentation.</td></tr>
<tr><td>12

W2.0</td><td>Has taken action on the results and recommendations reported through the person-centered review process.</td><td>• Determine if any person-centered reviews have been conducted with consumers receiving services and supports from this provider.
• Review records and information for persons participating to determine if there is any documented evidence that the provider has acted on the report.
• Review documentation to determine that other service providers were made aware of report results and any recommendations for service improvement or change. Did the coordinator discuss with the provider possible actions for addressing the report?
• Determine how this information was communicated. Was confidentiality for the individual maintained?
• Review progress notes and other documentation to determine whether the coordinator followed-up with the provider(s) to assure that the report was addressed and appropriate changes made
• Review progress notes and other documentation to determine whether the coordinator follow-up with the individual to determine satisfaction with the service change or outcome status.

Note: If there have been no person-centered reviews, score this element Not Applicable.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">Standard: Support and Cost Planning information is submitted to the Area Office and shared with the individual and other stakeholders within appropriate timeframes.</td></tr>
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13	Support and cost plans are provided to the individual or their guardian within 10 calendar days of the effective date, and at any time they are requested.	• Ask the support coordinator about their process and the timing for supplying support and cost plans to individuals or their guardians • Check for support coordinator documentation in individual records that support and cost plan information was supplied to the individual or guardian, at a minimum, within timeframes stated. • For the Cost Plan Only: Determine the receipt date from the Area Office; calculate 10 days out to identify when the individual should have received the approved plan.
14	Cost plans are signed by the individual or guardian.	• Review cost plans to determine that cost plans contain the appropriate signature(s).
15	Copies of the support and cost plans are submitted to the Area Office no later than 20 calendar days prior to the effective date. Cost plans, amendments or addendums meeting exceptional cost review guidelines must be submitted to the Area Office within 90 calendar days prior to the effective date.	• Interactively, with the support coordinator, review procedures for submitting support and cost plans to the Area Office. • Look for evidence in a sample of records to determine that there is documentation of the date that these plans are submitted to the Area Office (plans should be date stamped) • Cost plans, or amendments to cost plans, that exceed the average ICF/DD cost for services require special review and require more time for review and approval. Refer to Policy Directive 99-05 REV02.
16 W2.0	Service authorizations that accurately reflect the Area Office's approved service level on the cost plan, as well as copies of pertinent support plan information is given to other providers of services to authorize and initiate service delivery within ten calendar days of the effective date of the support plan.	• Ask the support coordinator about their process and the timing for supplying approved service authorization to other supports and services vendors ➢ Review record sample: Look for documentation of when the support coordinator supplied service authorization to the service vendor. ➢ Look for evidence of when the service vendor began supports and services for the individual ➢ Interview by phone or in person, a sample of service vendors who are supplying supports and services to the individual ➢ Determine if the service vendor received authorization within ten days of the effective date of the support plan. ➢ Determine what information was sent relating to goals for the

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		individual. *Note: The support coordinator is not responsible for meeting timeframes in this element if there is documented evidence that the delay was caused by circumstances outside of the coordinator's control, such as the Area Office not meeting review timelines.*
Standard: The Support Coordinator advocates for the individual and assists the individual to increase or maintain the capacity to direct formal and informal resources.		
For the following elements of performance associated with this standard: ***Review results of the person-centered reviews, information available from individuals receiving the service and available documentation.*** *The purpose of this section is to determine provider performance and the quality and intensity of supports in the areas of advocacy, assistance with informed choice and problem resolution.*		
The Support Coordinator:		
17 W2.0	Assists the individual in evaluating whether the purchased services meet the individual's expectations.	• Seek indications that the support coordinator is evaluating services and providing feedback to providers and the individual. • Review progress notes and other documentation to determine if the coordinator is gathering information about whether service delivery is meeting expectations from the individual, provider information and records; family and other interested parties. • Review a sample of records to determine if the support coordinator is documenting discussions with the individual or their family about satisfaction with services • During record review determine if any changes in service vendors are documented as a result of the individual's or family's dissatisfaction • When available, analyze the results of person-centered reviews to identify the individual's satisfaction with support coordinator and service vendors. • Review records to determine assistance and support in this area. A formal
18	Assists the individual in determining whether services are age and culturally appropriate.	
19 W2.0	Assists the individual in determining whether services address the desired goal(s) and/or need for which they are intended.	
20 W2.0	Assists the individual in determining whether services provide appropriate challenges, motivation and experiences to meet the individual's goals and expectations.	
21 W2.0	Reviews with individuals available options for places to live.	
22 W2.0	Reviews and assists individuals in ADTs with information and/or referral to rehabilitation, vocational habilitation, and other employment services and employment opportunities available in their community.	

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23 W2.0	Provides service counseling for individuals currently in sheltered workshops or segregated work environments to apprise them of the options available to them for meaningful work activities and training.	presentation of information and options should occur annually. • Review progress notes and other documentation to determine if individual choices and desired changes in service direction were addressed.
24	Discusses with the individual their concerns related to dissatisfaction, quality of service delivery, health and safety, or other issues in order to resolve differences.	
25 NEW	Provides information to recipients on residential options available to them including owning or renting their own home, with supports.	• This should occur at a minimum of once a year during support planning, but should also occur when anticipating a change in the residential situation.
26 W2.0	Discusses with providers concerns relating to individual dissatisfaction, the quality of service delivery, individual health and safety, or other issues in order to resolve differences, including recommendations and results from person-centered reviews.	• Ask the support coordinator about their process for communicating and discussing issues with service vendors • Look for evidence that the support coordinator documents discussions and resolutions to issues of dissatisfaction or health and safety concerns of an individual. • Look for evidence that the support coordinator discusses results and recommendations from applicable Person Centered Reviews with other providers, and follows-up to assure changes are addressed. • Look for evidence that the support coordinator monitors the service vendor’s response.
27 W2.0	Follows-up to provide closure on issues and resolution of problems or situations.	• If findings indicate there are issues or concerns, look for evidence that further demonstrates the support coordinator facilitated a resolution or other follow-up with the individual and the service vendor. • Review progress notes to determine actions taken and indications that timely follow-up activities were initiated and, where possible, closure achieved.

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28	Initiates contact with the Area Office to request assistance in resolving concerns that cannot be resolved through discussion or the normal grievance process.	• Ask the support coordinator if they know that the Area Office is available to assist in the resolution process when necessary. • Ask the support coordinator if they ever had occasion to contact the Area Office for assistance in resolving issues. • Contact is initiated when the coordinator is unable to resolve a concern.
Standard: Changes in the individual's service and support needs are dealt with appropriately and timely by the Support Coordinator.		
29	Progress notes include sufficient information concerning any changes in an individual's service and support needs that require an update to the cost plan.	Review a sample of records for individuals, specifically focusing on the content of progress notes. Review results of person-centered reviews for information about whether changes were requested and the responsiveness of the coordinator. Talk with individuals to determine whether requested service or needs changes were acted upon. *Note: Effective 7/01/01 changes in an individual's service needs that result in an update to the cost plan do not have to have a corresponding update to the support plan. Reason for the changes must be supported in the progress notes.*
30	Cost plan updates are initiated when support coordinators become aware of the need for change.	• Interactively, with the support coordinator, review a sample of records for individuals, specifically focusing on the cost plan and when updates have occurred. • Discuss with the support coordinator when and what prompted them to update the cost plan. • Determine whether progress notes support that cost plan changes were made within acceptable timeframes. • Cost Plans are submitted to the Area Office within five days of the support coordinator becoming aware of the need for change. (Area Offices have 10 days of their receipt of the update to respond.)

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31 W2.0	Service authorizations and adequate information concerning the individuals' goals and needs are sent to providers, as appropriate to the cost plan change, within 5 working days of receipt of Area Office approval.	• Review records to compare timeframes for submission of the authorization and Area Office approval. • Review information provided to alter services. • Talk with a sample of providers to determine timeframes for notice of change.
Standard: The Support Coordinator assists the individual to build linkages to natural and generic supports and, when necessary, appropriate paid services.		
The Support Coordinator:		
32	Recruits and locates potential service vendors who are acceptable to the individual, are qualified to meet the individual's needs in the most cost-efficient manner possible, and assists them with waiver enrollment procedures.	Ask the support coordinator for examples of how they work with the Area Office to identify service vendors for individuals. ➢ What influences these individuals? ➢ What consideration is given to cost in these decisions? • Describe the interaction that occurs with the Area Office in these cases? • Determine if the support coordinator: ➢ contacted appropriate service vendors; ➢ sought out potential service vendors to render the service; ➢ sought assistance from the Area Office to identify, train and process eligibility documents for new service vendors; ➢ assisted with the submission of documents for new vendors if appropriate; ➢ notified the Area Office of service vendors needed for the area. • If a needed service was not available in the community, ask the support coordinator how they handle this information (response should be related to data entry in the ABC system.) • Review Area Office policy related to rate negotiations, and cost approval and documentation from the support coordinator to determine: ➢ How families and consumers are included in the decision process. ➢ If rates were compared for vendors of the needed service. ➢ If there is a shortage of a service vendor that results in a rise in rates, is there evidence of a collaborative effort to develop or attract additional service vendors in the area? • Review results and recommendations of person-centered reviews. • Talk with individuals about access and availability of services they may need. Are they satisfied with current vendors?

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33 W2.0	Notifies other paid service providers when it is determined that an individual receiving services is no longer Medicaid eligible.	Ask the support coordinator about their process for communicating and discussing issues with service vendors. Verify description through available documentation that notification is given when information is known.
34	Works with providers and Area Office to plan for possible continuation of services and funding options when an individual's eligibility is in jeopardy.	• Ask support coordinator about how they plan for continuation of services for individuals when they are no longer Medicaid eligible. ➢ Review documentation of their efforts in the individual's record.
35	Assures that purchased supports and services are not billed in excess of the annual limits of current approved cost plan(s) for individuals.	Review policy and current practices with support coordinator to ensure that overspending does not occur • If possible, compare billing information from the Allocation, Budgeting, and Contract Control (ABC) system against the approved cost plan. Review ABC screen AINBCL and compare to cost plan to ensure expenditures have not exceeded overall annual authorized amount in the cost plan. • If supports and services are exceeding the limits of the approved cost plan, determine if an amendment was submitted and approved? • Review documentation of last full year of services in the sample of records. • Score as met unless there is actual overspending on an annual basis. The approved annual amount does not have to be divided equally between the 12 months
For individuals residing in supported living arrangements or licensed residential facilities who are taking any psychiatric or anti-epileptic medications review cites 36-40. Refer to Medication Review Criteria.		
Standard: The Support Coordinator assures that individuals will be free of risks associated with prescribed medication.		
36 W2.0	Provider assures a comprehensive psychiatric (for psychiatric medication) review is completed annually by a licensed psychiatrist/neurologist or an A.R.N.P., who acts pursuant to a protocol with the psychiatrist/neurologist.	• Ask support coordinator about procedures for obtaining information on individuals residing in supported living arrangements or licensed residential facilities. • Ask support coordinator about the types of information that they request from providers and their follow-up process when information is not received.

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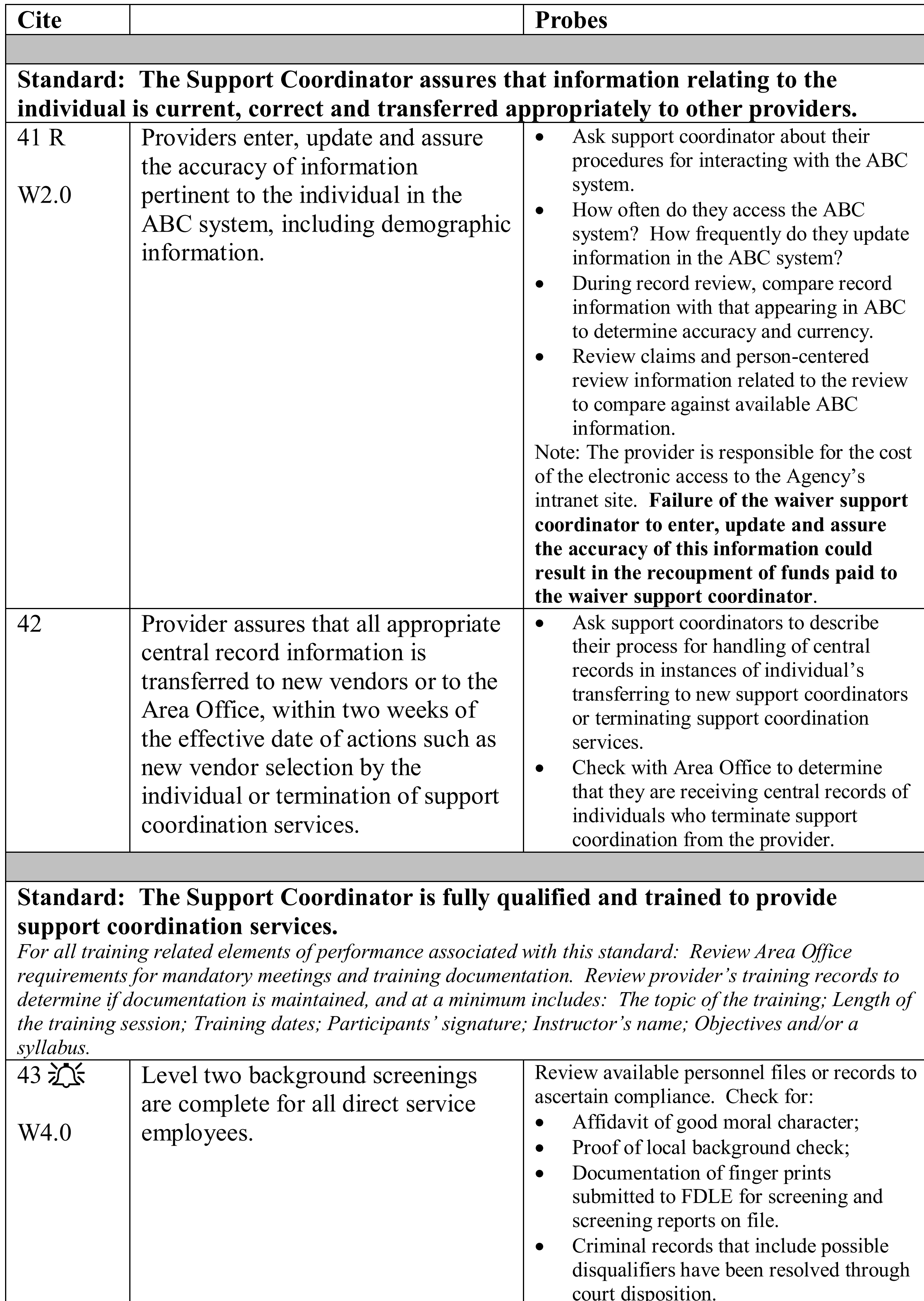
37 W2.0	Provider assures a medication review by a Licensed Consultant Pharmacist is conducted at least annually when individual is on two or more medications or meets the criteria for medication review as defined in the handbook.	• Interactively, with the support coordinator, review the record of an individual that is residing in supported living or in a residential facility who is taking psychiatric or anti-epileptic medications. ➢ Look for evidence in progress notes of attempts and efforts to arrange for the services noted in elements 36-40. The Support Coordinator should ensure that individuals living in their own or family home are aware of the need to obtain a medication review and should pursue this service if requested by the individual or family. Request to see evidence of this discussion. Review results and recommendations of person-centered reviews. Talk with individuals about the health care they are receiving.
38	Provider assures the individual receives follow-up reviews by the psychiatrist, neurologist or A.R.N.P. at a frequency established by these practitioners.	
39	Provider works with Area Office Health Care coordinators to obtain documentation from psychiatric or neurological practitioners if frequency of the follow up review is less frequent than every 90 days.	
40	Provider maintains documentation of medical practitioner rationale regarding frequency of follow-up visits in the individual's central record.	



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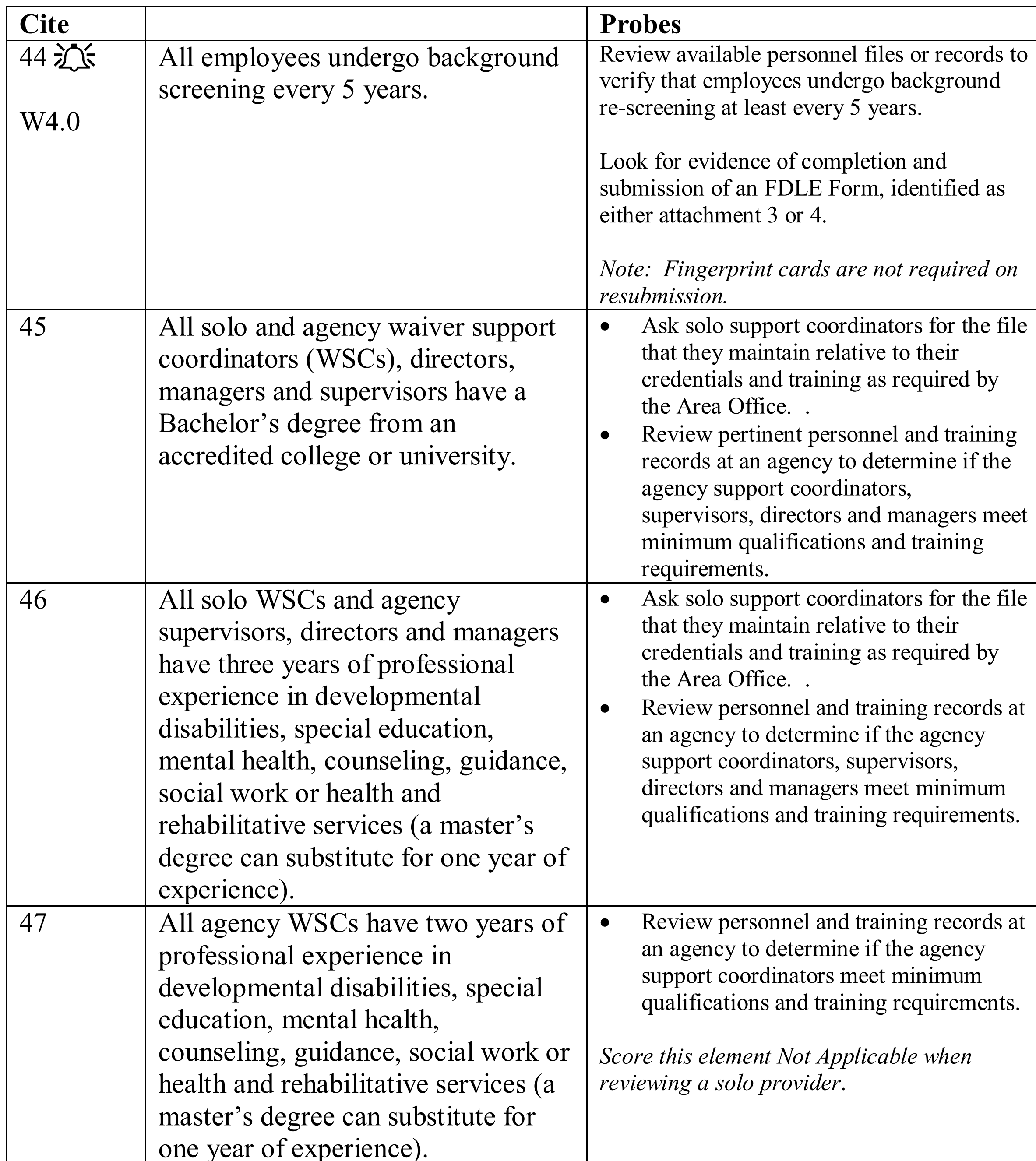
Standard: The Support Coordinator assures that information relating to the individual is current, correct and transferred appropriately to other providers.		
41 R W2.0	Providers enter, update and assure the accuracy of information pertinent to the individual in the ABC system, including demographic information.	• Ask support coordinator about their procedures for interacting with the ABC system. • How often do they access the ABC system? How frequently do they update information in the ABC system? • During record review, compare record information with that appearing in ABC to determine accuracy and currency. • Review claims and person-centered review information related to the review to compare against available ABC information. Note: The provider is responsible for the cost of the electronic access to the Agency's intranet site. **Failure of the waiver support coordinator to enter, update and assure the accuracy of this information could result in the recoupment of funds paid to the waiver support coordinator**.
42	Provider assures that all appropriate central record information is transferred to new vendors or to the Area Office, within two weeks of the effective date of actions such as new vendor selection by the individual or termination of support coordination services.	• Ask support coordinators to describe their process for handling of central records in instances of individual's transferring to new support coordinators or terminating support coordination services. • Check with Area Office to determine that they are receiving central records of individuals who terminate support coordination from the provider.
Standard: The Support Coordinator is fully qualified and trained to provide support coordination services. *For all training related elements of performance associated with this standard: Review Area Office requirements for mandatory meetings and training documentation. Review provider's training records to determine if documentation is maintained, and at a minimum includes: The topic of the training; Length of the training session; Training dates; Participants' signature; Instructor's name; Objectives and/or a syllabus.*		
43 🔔 W4.0	Level two background screenings are complete for all direct service employees.	Review available personnel files or records to ascertain compliance. Check for: • Affidavit of good moral character; • Proof of local background check; • Documentation of finger prints submitted to FDLE for screening and screening reports on file. • Criminal records that include possible disqualifiers have been resolved through court disposition.



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44 W4.0	All employees undergo background screening every 5 years.	Review available personnel files or records to verify that employees undergo background re-screening at least every 5 years. Look for evidence of completion and submission of an FDLE Form, identified as either attachment 3 or 4. *Note: Fingerprint cards are not required on resubmission.*
45	All solo and agency waiver support coordinators (WSCs), directors, managers and supervisors have a Bachelor's degree from an accredited college or university.	• Ask solo support coordinators for the file that they maintain relative to their credentials and training as required by the Area Office. . • Review pertinent personnel and training records at an agency to determine if the agency support coordinators, supervisors, directors and managers meet minimum qualifications and training requirements.
46	All solo WSCs and agency supervisors, directors and managers have three years of professional experience in developmental disabilities, special education, mental health, counseling, guidance, social work or health and rehabilitative services (a master's degree can substitute for one year of experience).	• Ask solo support coordinators for the file that they maintain relative to their credentials and training as required by the Area Office. . • Review personnel and training records at an agency to determine if the agency support coordinators, supervisors, directors and managers meet minimum qualifications and training requirements.
47	All agency WSCs have two years of professional experience in developmental disabilities, special education, mental health, counseling, guidance, social work or health and rehabilitative services (a master's degree can substitute for one year of experience).	• Review personnel and training records at an agency to determine if the agency support coordinators meet minimum qualifications and training requirements. *Score this element Not Applicable when reviewing a solo provider.*

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48	All solo and agency WSCs, directors, managers and supervisors have a minimum of 34 hours of statewide pre-service training.	• Ask solo support coordinators for the file that they maintain relative to their credentials and training as required by the Area Office. • Review personnel and training records at an agency to determine if the agency support coordinators, supervisors, directors and managers meet minimum qualifications and training requirements. • Verify source of training is appropriate per requirements listed below. • Pre-service training for solo providers and agency directors, managers and supervisors must be conducted by the department, or a trainer prior approved by the department. • Support coordinators employed by agencies are required to receive the same number of hours of training and are to be trained on the same topics covered in the statewide training; however, this training may be conducted by the support coordination agency.

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49	All solo and agency WSCs, directors, managers and supervisors have a minimum of 26 hours of district-specific pre-service training within 90 days of completion of statewide pre-service training.	• Ask solo support coordinators for the file that they maintain relative to their credentials and training as required by the Area Office. • Review personnel and training records at an agency to determine if the agency support coordinators, supervisors, directors and managers meet minimum qualifications and training requirements. Verify source of training is appropriate per requirements listed below. District specific training for solo providers and agency directors, managers and supervisors must be conducted by the Area Office, or a trainer prior approved by the department. Support coordinators employed by agencies are required to receive the same number of hours of training and are to be trained on the same topics covered in the statewide training; however, this training may be conducted by the support coordination agency. Area Office training includes: • Orientation to Area Office staff, responsibilities and resources, • ABC training, and • General Area Office operational procedures.
50 NEW	All support coordinators have district training and certification in the proper administration of the department approved assessment tool for ascertaining the recipient's level of need within 90 days of completion of statewide pre-service training. The provider must re-certify every two years.	Note: agency trainers may conduct this training once approved by the Department. WSCs currently enrolled must become certified within 90 days of the effective date of the implementation of this rule (June 23, 2005?). Failure to become certified will result in termination.

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51 W2.0	All solo and agency WSCs have Personal Outcome Measures training conducted by the department or a department certified trainer within 90 days of receiving Area Office certification.	• Ask solo support coordinators for the file that they maintain relative to their credentials and training as required by the Area Office. • Review pertinent personnel and training records at an agency to determine if the agency support coordinators, supervisors, directors and managers meet minimum qualifications and training requirements. *Note: This training satisfies the annually required 24 hours of job-related training for that year.*
52 W2.0	All solo and agency WSCs who have not completed Personal Outcome Measures training have a trained waiver support coordinator in attendance when using the Personal Outcome Measures as part of the initial and annual support planning process.	Ask the provider if they have received the POM training. If the solo provider or all agency WSCs have received the training, score this element as Not Applicable. If the solo WSC has not had the training, ask about the arrangements they have in place to have a POM trained WSC accompany them when performing initial and annual support planning with individuals. Ask the agency provider about the process they have in place for WSCs that have not yet attended POM training to be accompanied by a POM trained WSC during initial and annual support planning. This could be a mentoring program or precept program, or could be part of routine orientation for new hires. For both solo and agency providers, ask to see some evidence that a POM trained support coordinator is accompanying the untrained individual. This could be documented in the support plan, or on the POM tool or in another note in the central record.

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53	All solo and agency WSCs, agency supervisors, directors and managers attend 24 hours of job-related in-service training annually.	• Ask solo support coordinators for the file that they maintain relative to their credentials and training. • Review personnel and training records at an agency to determine if the agency support coordinators, supervisors, directors and managers meet minimum qualifications and training requirements. • Verify through documentation that appropriate trainers are utilized as identified below. *Note: Agency internal management meetings do not apply toward the 24 hours requirement unless approved by the Area Office.* *Note: For agency support coordinators and supervisors, trainers outside the agency must provide 12 hours of the 24-hour in-service requirement*
54	The provider attends mandatory meetings and training scheduled by the Area Office and/or Department.	• Ask the provider if they are aware of Area Office and Department mandatory meeting and training schedules. Ask the provider if they can produce any notices, announcements, or agendas received about meetings or training. • Ask the provider what Area Office and Department meetings or training they have attended during the review period. • Ask the provider for any evidence they have to verify attending the meeting or training. • Look for evidence in documents supplied by the provider of attendance at Area Office and Department meetings, such as notes in personnel files or other records.
55 NEW	The provider and/or agency staff has received training in the Agency's Direct Care Core Competencies Training.	Look for documented evidence that the provider and/or agency staff have received this training or an equivalent which has been approved by the Agency. Training was received within the required timeframes as developed by the Agency. This training may be completed using the Agency's web-based instruction, self-paced instruction or classroom-led instruction.

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56	The provider and each of its employees receive training on responsibilities and procedures for maintaining health, safety and well-being of individuals served.	• Ask the provider and/or their staff about what types of training programs they have and continue to attend. • Look for evidence of training in personnel files, human resource records or other locations as identified by the provider. Training on health, safety and well-being of individuals could include such topics as: • Fire safety for the environment; • Evacuation procedures in the event of natural or other disasters; • Training on what to do in the event of personal health emergencies involving consumers; • Transportation safety; • Basic infection control training, e.g., hand washing before and after all contact with consumers. • Signs and symptoms of illness • Medication administration practices • Recognizing adverse drug reactions, drug-to-drug interactions or food and drug interactions. *NOTE: The Area Office is not the sole source for a provider to find training programs and activities referred to in the Core Assurances. Providers may develop their own curriculum for their staff; provider and their staff may attend a program offered through another provider.*

Cite		Probes
57	The provider and each of its employees receive training on required documentation for service(s) rendered.	Look for evidence that the provider and/or staff have received training on the type and format of documentation that is required for the services and supports that they render. Examples of this training could include: • The proper format and content of a progress note, • Recording data related to an individual's progress towards achieving goals, • Documenting the activities that individuals participate in during their time with the provider. • Instruction on documentation that is required for reimbursement and monitoring purposes. *NOTE: The Area Office is not the sole source for a provider to find training programs and activities referred to in the Core Assurances. Providers may develop their own curriculum for their staff; provider and their staff may attend a program offered through another provider.*
58	The provider and each of its employees receive training on responsibilities under the Core Assurances.	Look for evidence that the provider and/or staff have been familiarized with and have had some training related to the Core Assurances section of their Waiver Services Agreement. Examples of this training could include instruction on: • The rights of individuals in the program and how the provider respects these rights; • Maintaining confidentiality of consumer information; • Offering individual's choice of services and supports; • Recognizing and reporting of suspected abuse, neglect or exploitation; • Assisting individuals in achieving personal goals and desired outcomes; • Rendering services in an ethical manner. *NOTE: The Area Office is not the sole source for a provider to find training programs and activities referred to in the Core Assurances. Providers may develop their own curriculum for their staff; provider and their staff may attend a program offered through another provider.*

Cite		Probes
59	The provider and each of its employees receive training on responsibilities under the requirements of specific services offered.	Look for evidence that the provider and/or staff have been familiarized with and have had training related to the service specific sections of their Waiver Services Agreement and the DS Waiver Services Florida Medicaid Coverage and Limitations handbook. Examples of this training could include instruction on: • Implementation plan development and monitoring; • Specifics of rendering services and supports; • Service limitations; • Service documentation requirements • Billing for services; and • Outcomes established for service delivery. *NOTE: The Area Office is not the sole source for a provider to find training programs and activities referred to in the Core Assurances. Providers may develop their own curriculum for their staff; provider and their staff may attend a program offered through another provider.*
60	The provider and each of its employees receive other training specific to the needs or characteristics of the individual as required to successfully provide services and supports.	Look for evidence that the provider and/or staff assigned to render services and supports to individuals have received some orientation to an individual and their unique characteristics and needs. The family or guardian, a physician or nurse, CBA or other providers or people who are in regular contact with and understand the unique characteristics and needs of the individual can provide this orientation. Examples of this training could include instruction on: • Communicating with the individual; • Instruction on a behavior program, if applicable to the individual; This training may be one-on-one in nature, and therefore documentation may take the form of an agenda, or curriculum with handouts and outline. Look for evidence in the consumer's record, such as in progress notes or other provider documentation for this evidence.

Cite		Probes
61	Proof of required training in recognition of abuse and neglect and the required reporting procedures, to include domestic violence and sexual assault, is available for all independent vendors and agency staff.	Review personnel records and other provider training documentation for evidence of required training. • If applicable, ask staff about training they have received. • Training should include prevention, detection and reporting requirements.
62	Agency trainers attend a train-the-trainer session conducted by the Department and mandatory refresher courses as required by the Department.	• Review the agency's training plan for support coordinators for evidence of Area Office approval • If an agency trainer provides statewide and/or district specific pre-service, review agency training or personnel records to determine for each agency trainer that they have been prior approved by the department. *Note to Reviewers: Score these elements as Not Applicable for solo waiver support coordinators.*
63	Agency trainers and the agency training plan are approved by the Area Office prior to training of staff.	
Standard: Support Coordinators maintain caseloads within established limits.		
64	Waiver support coordinators maintain a caseload of no more than 36 individuals.	• Review the support coordinator's caseload • Review claims to determine whether caseload ever exceeds 36 and determine why.
65 R	When a vacancy occurs the provider may exceed the 36 maximum caseload size for 60 days for each vacancy.	• Determine caseload sizes for coordinators. Compare the date of the caseload increase to the review date to determine the length of the increase. • Determine any vacancies which may impact on the caseload increase. *Note: Caseloads may exceed 36 for a period of 60 consecutive days for vacancies; or a period of 60 working days for leave under the Family and Medical Leave Act.* • Review available documentation to determine involvement of Area Office in caseload redistribution for any that exceed the 60 day limit. **This Cite is subject to recoupment for any caseload over 36 which exceeds 60 consecutive or 60 working days without the required conditions being met.**

Cite		Probes
66 R	Provider must notify the Area Office of any vacancies or leaves of absence within 5 days of the vacancy.	Review documentation to determine Area Office notification and the time line for notification. Notification must be for each vacancy. **This Cite is subject to recoupment for failure of the provider to notify the Area Office within stated time frames.**
67	Provider accepts all individuals who select them for support coordination services or are referred to them within the geographic boundaries previously approved by the Area Office.	Check with the Area Office: • to determine if there is any history of refusing to provide services; • for reasons why consumers changed support coordinators. • When available, analyze the results of person-centered reviews to identify if the individual/family/ guardian has the support coordinator they prefer. *Exceptions to this requirement may be granted in writing by the Area Office in accordance with Department policy. Exceptions must be maintained on file.*
68	Provider expansion or downsizing has been accomplished in a manner that prevents, as much as possible, a negative impact on the individuals served.	If downsizing has occurred check; • For compliance with handbook requirements; • The transition process between support coordinators; • For any negative impact to individual. • Any voluntary (short-term) moratorium is reflected in the records of the provider. If expansion has occurred: • *The expansion was approved by the Area Office* • *The provider received at least an 85% on monitoring during the past year;* • *The provider hired a new support coordinator and provided the required training within the 60 day period allowed for exceeding caseload sizes;* • Required support coordination services were continued for all individuals in the caseload.

<table>
<tr><th>Cite</th><th></th><th>Probes</th></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">Standard: The support coordinator is accessible to the individual and is available to perform required and needed supports.</td></tr>
<tr><td>69

W2.0</td><td>Provider has an on-call system in place that allows individuals to access support coordination services 24 hours per day, 7 days per week. Access to the provider or back-up are available without toll charges to the individual.</td><td>• Review provider procedures for on-call and back-up systems
• Ask provider to discuss examples of when these procedures are implemented
• Ask if the procedures are tested and how frequently
• Analyze results of person-centered reviews to assure that provider is responsive to calls from individuals
• Contact consumers of this provider and ask about responsiveness.
• Review support coordination's satisfaction information to determine if there have been any concerns raised about visit scheduling or responsiveness to calls/contact.</td></tr>
<tr><td>70</td><td>Back-up waiver support coordinators are certified and enrolled waiver support coordinators.</td><td rowspan="2">• Review support coordination's satisfaction information to determine if there have been any concerns raised about visit scheduling or responsiveness of calls/contact.
• If available, review Area Office complaint data to determine if there has been any registered for this support coordinator around the issue of visit scheduling or contact.
• Ask for evidence that demonstrates certification of back-up provider, e.g., personnel files
• Talk to a sample of consumers to determine if they know who to call if their WSC is not available. How are they made aware of back-up arrangements?
• Review results of person-centered reviews for concerns in this area.

Note: The provider should have a name in writing in their documentation to indicate who their back-up is. This can be an agency or an individual.

• Determine how the provider makes information available to individuals and the Area Office on support coordinator back-ups and procedures for accessing services.</td></tr>
<tr><td>71</td><td>Name(s) and contact information for back-up waiver support coordinators are clearly communicated to the individual and to the Area Office.</td></tr>
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<tr><th>Cite</th><th></th><th>Probes</th></tr>
<tr><td>72</td><td>Contacts with individuals in community settings are planned in advance of the visit and not incidental.</td><td rowspan="2">Ask the support coordinator about the locations in which they see individuals and how they schedule these visits
Interactively, with the support coordinator, review records of several individuals to determine if visits are pre-scheduled with the individual
Talk to consumers about their contacts with the WSC. Determine if the contacts are scheduled.
When available, obtain information from person-centered review process to determine if visit pre-scheduling consistently occurs for this provider</td></tr>
<tr><td>73

W2.0</td><td>Contacts with individuals are scheduled based on the individual’s choice and are at a time and in a location convenient to the individual receiving services.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">Standard: The support coordinator provides the amount and type of contact and supports needed to meet the individual’s goals and needs as evidenced by progress notes and other information.
Note: This standard examines the presence or absence of required documentation of support coordination activities.</td></tr>
<tr><td colspan="3">The individual’s central record contains:</td></tr>
<tr><td>74</td><td>The individual’s current support planning information including Personal Outcome Measures information and notes.</td><td rowspan="6">Review a sample of at least three (3) records per support coordinator for the information noted in the standards.
Waiver Eligibility Worksheet should be current, correct, dated, and signed by the individual.
Support Plan should be dated and signed by the individual.
Cost plan should be signed by the individual.
Cite 76 and 77 are subject to recoupment of funds as reimbursement documentation for each day from the effective date of the support and cost plan that these plans are not available, if the WSC was responsible for the delay.</td></tr>
<tr><td>75</td><td>The individual’s current support planning information including the assessment instrument approved by the Department, and any other assessment information used in planning.</td></tr>
<tr><td>76</td><td>The individual’s current support planning information including the current Waiver Eligibility Worksheet.</td></tr>
<tr><td>77 R</td><td>The individual’s current support planning information including the current support plan.</td></tr>
<tr><td>78 R</td><td>The individual’s current support planning information including the current approved cost plan.</td></tr>
<tr><td>79</td><td>The individual’s current support planning information including progress notes.</td></tr>
</table>

Cite		Probes
80 R	One face-to-face contact with the individual, at a frequency based on living situation of the individual, related to or accomplishing one or more of the following: ❑ Assisting individual to reach goals of support plan, including gathering information to identify outcomes ❑ Monitoring health and well-being of the individual ❑ Obtaining, developing and/or maintaining resources needed or requested by the individual, including natural supports, generic community supports and other types of resources ❑ Increasing the individual's involvement in the community ❑ Promoting advocacy or informed choice for the individual ❑ Following up on the individual's or family's concerns	• Determine whether progress notes contain information relating to tasks identified for the face-to-face and whether the amount and type of contact appears sufficient to address the individual's needs. • When a face-to-face contact is conducted with an individual who does not communicate verbally, there should be an indication that the support coordinator interacts with and observes the individual, and communicates with others who know the individual well to determine information listed. • When possible, face-to-face contacts should occur in a variety of locations, days of the week and times of the day according to the individual's convenience. • Face-to-face contacts should focus on the individual and should not be opportunities for progress reports, etc. from other providers. • Progress notes should show some evidence of use of the POMs to follow-up on any issues, conflicts and desired changes to services and supports. *Note: Monthly face-to-face contacts are required for individual living in a licensed residential facility or in supported living.* *For individuals living in their family home, a face-to-face contact is required every three months.* **This Cite is subject to recoupment of funds as reimbursement documentation for each individual and month when a face-to-face contact was required and did not occur.**
81 R	Progress notes reflect results of face-to-face visits in the place of residence every three months for individuals residing in supported living, licensed facilities or in his or her own home.	Review progress notes in the sample of the support coordinator's records for evidence • that face-to-face visit requirements in the individual's place of residence are consistently met when applicable to the individual. Determine if progress notes reflect individual and family preference for frequency of visits when the

Cite		Probes
82 R	Progress notes reflect results of face-to-face visits in the place of residence at six-month intervals or more frequently if requested by the family, for individuals living with his or her family.	individual lives with his or her family. **Cite 80 and 81 are subject to recoupment of funds as reimbursement documentation for each individual and occurrence that the face-to-face contact did not occur at the required frequency.**
83 R	Progress notes reflect at least one other contact/activity (non-incidental and non-administrative) per month related to the individual if a face-to-face contact was made. If no face-to-face contact occurred for the month, at least one other contact/activity (non-incidental and non-administrative) per month related to the individual should be reflected in the progress notes.	• Review for the type of additional contact(s) made during the month. Contact should relate to the individual, their services and supports and follow-up or planning needed. Administrative activities such as typing, filing, mailing, data entry for billing, or leaving messages are not considered an additional contact. Letter writing would qualify as another contact if related to services and benefits specific to a consumer's needs. This would exclude form letters to confirm meetings, etc. These contacts may be either with the individual or with other persons, such as family members, service vendors, community members and so on, and may be conducted face-to-face or by phone. **Cite 82 is subject to recoupment as reimbursement documentation if no documentation is available to support this requirement.**
84	Central records contain copies of annual or professional reports and individual implementation plans submitted by other providers as required and appropriate to each service.	• In the record sample, review for the presence of annual or professional reports and implementation plans from other providers. • Ask the provider about their process for obtaining and maintaining this information.
85 W2.0	Central records contain current and correct demographic information, including current health and medical information and emergency contacts.	• In the record sample, review for the presence of demographic information, health and medication information and emergency contacts. • Ask the provider about their process for keeping this information current.

Cite		Probes
86	Central records or provider records contain results of annual satisfaction surveys.	In the record sample, review for the presence of results of annual satisfaction surveys. *Note: Annual satisfaction survey results and data on selected service outcomes may not be kept in the individual's central record. Maintenance in alternative locations is acceptable.*
87	Central records or provider records contain performance data on the Projected Service Outcomes.	In the record sample, review for the presence of performance data on the projected service outcomes. These include individuals: • Having maximum freedom of choice in all areas of their lives; • Demonstrating an increase in abilities, self-sufficiency and changes in their lives consistent with personal goals; • Are satisfied with their support coordination services based on results of annual satisfaction survey or are satisfied that their concerns raised on the survey are being addressed.
88	Central records contain documentation through progress notes of all other support coordination services, activities or contacts that assisted individuals to: ❑ Meet their support plan outcomes/personal goals ❑ Become more integrated into their communities and/or ❑ Address individual's or family's concerns.	In the record sample, review for the presence of progress notes documenting support coordination activities or contacts.
89 NEW	The WSC shall provide a copy of the notice of privacy practices required by HIPAA regulations to the individual or legal guardian upon initial contact and at any time there is a significant change that necessitates the protection of a recipient's healthcare information.	Review the individual's record to determine if there is documentation which supports compliance with this element.

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<tr><th>Cite</th><th></th><th>Probes</th></tr>
<tr><td>90
NEW</td><td>If the provider transports the recipient in his private vehicle, the provider has proof of valid driver's license, car registration, and insurance.</td><td>• Ask the provider if they transport individuals in their private vehicles.
• If an agency provider, ask about procedures that are followed when direct service staff transport individuals in their private vehicles, such as when they collect and how they maintain information on employees rendering transportation.
• Review provider and staff personnel files or other records for driver's license, vehicle registration and insurance to determine that they are current.</td></tr>
<tr><td colspan="3">For individuals receiving supported living coaching, complete elements 90 – 93. Score these elements as Not Applicable if no individual in the sample receives this service.</td></tr>
<tr><td>91

W2.0</td><td>Progress notes reflect results of quarterly meetings with individuals and supported living coaches for individuals receiving supported living coaching services</td><td rowspan="4">• The coordinator is responsible for arranging, scheduling and documenting a quarterly meeting in which the person, Coordinator and Supported Living Coach review the current supported living services.
• For quarterly meetings occurring with the individual in the individual's own home, the meeting with the supported living coach meets requirements for the quarterly face-to-face visit in the individual's own home.
• Review documentation in progress notes to determine that the quarterly meeting is scheduled at a time mutually agreeable to participants.
• The meeting covers the review of supported living needs, satisfaction with coach's services, to assure that there is an updated housing survey, a review of health, safety and a determination that financial support is adequate. The financial subsidy should be reviewed and updated as needed.

Note: It is the support coordinator's responsibility to schedule the meeting. The purpose is to have a face-to-face with the coach and individual, unless there is documentation that the individual requests that the coach not be present.</td></tr>
<tr><td>92</td><td>Progress notes reflect review of supported living services to determine that they are meeting the individual's needs.</td></tr>
<tr><td>93

W2.0</td><td>Progress notes indicate a review of the individual's health, safety and well-being and an updated housing survey.</td></tr>
<tr><td>94

W2.0</td><td>Progress notes support a review of the individual's fiscal status to include a review of the individual's bank statement and other financial information if the supported living coach is acting as fiscal agent.</td></tr>
</table>

Cite		Probes
Standard: The support coordinator meets projected outcomes for service delivery.		
95	The provider has established a systematic method of data collection to measure success on projected service outcomes.	• Ask the provider to discuss the goals and Projected Service Outcomes that they are monitoring. • Ask the provider what data they are collecting and how they collect the data (e.g., record review, specially developed forms completed by employees, consumer satisfaction surveys, etc.) • Ask for samples of the tools or other evidence that confirms data is being collected and monitored. • Ask the provider to describe how it is determined they are meeting \ Projected Service Outcomes. • If the provider has any data or reports that they produce and maintain related to the goals and projected outcomes, ask to see these reports and identify how long the provider has been tracking this data.
96	There is evidence that projected service outcome data are reviewed periodically and that corrective measures are put in place if the data indicates the service outcomes are not being achieved.	• Ask the provider how it is determined they are achieving Projected Service Outcomes. • Ask the provider how frequently they perform this monitoring. • Ask the provider if they have identified any areas in need of improvement and what corrective actions they have taken. • Look for evidence that the provider is collecting and monitoring data according to the time frames they have defined.
For elements 96-99, document findings in comments as # met/total sample. 100% of the sample must meet criterion in order for the elements to be designated 'Met' **except where otherwise indicated**. Outcomes should be measured considering individual skills and circumstances. Reviewers will determine achievement of projected service outcomes at the time of the review Reviewers will also use the results and status of recommendations from the Person-centered Reviews applicable to the provider, information from the sample records and documentation reviewed, and discussions with the individuals receiving the services.		

Cite		Probes
97 W2.0	Individuals receiving support coordination services have freedom of choice in all areas of their lives, including setting personal goals, being fully informed about service options and making all possible decisions with regard to the conduct of their lives.	Look for evidence that the provider offers the individual choices at every given opportunity. Interview individual to determine if they are provided with opportunity to express choice. Providers are educating, informing and providing individuals with opportunities for exposure and experiences regarding their rights, choices and services. If the individual has a legal guardian, look for evidence that they participate in decision- making and receive information regarding services and rights and are afforded choices.
98 W2.0	Individuals receiving services demonstrate an increase in abilities, self-sufficiency and changes in their lives consistent with their support plan.	Look for evidence in supporting data that the individuals are achieving or making progress towards their personal goal. Look for evidence that the provider is consistently monitoring and reviewing the individual's progress in all supports and services to assure goal attainment. Look for evidence that the provider has documentation regarding discussions with the individual and support provider when issues or problems are impeding progress and that solutions are facilitated. Through interview with the individual/guardian it can be verified that the individual has made progress at least on one of their personal goals, the provider is working with the individual on identifying goals, and this is verified through documentation.

Cite		Probes
99 W2.0	All Individuals served who have responded to an annual satisfaction survey are satisfied with their support coordination services based on the results. or the provider has addressed any concerns raised during the survey.	Review annual satisfaction survey for results. Discuss satisfaction with individuals receiving services. Review steps/actions that the provider took to respond to individual's concerns. Provider should track the results of the satisfaction surveys and address aggregate concerns. Provider should ensure the effectiveness of any corrective measures put in place by monitoring the status of quality improvement initiatives as needed and makes adjustments as necessary to ensure improvement in their service delivery system. Look for documentation that the provider has distributed satisfaction surveys to each individual receiving the service.
100 NEW	There is evidence that the provider advocates for the individual on an on going basis to achieve a personally identified goal.	Through interview and documentation look for evidence that this is occurring and the provider is assisting the individual in advocating for themselves. Examples of advocacy could include: Assisting with obtaining supports and services. Assisting with exploring areas of interest (e.g., places of worship, volunteer opportunities, community organizations, possible employment, etc.) Providing the individual with information in assisting them in making their own decisions. Provide the individual with information on self-advocacy groups. Following up on a request for a change in goals or services and exploration of the individual's personal interest on a continued and on-going basis. For denied services the provider has educated the individual on due process procedures and helps the individual look for supports and services to assist the them in achieving their goals. This is part of the interview process with the individual.

Cite		Probes
NOTE: Score the following elements only when determined appropriate. This service is only for those individuals moving from institutional settings and is billed as transitional support coordination at a higher monthly rate. ***Score these elements as Not Applicable when this service has not been provided during the review period.***		
Standard: The Support Coordinator assists the individual to successfully transition from an institutional setting to community services, safeguarding the individual's health, safety and support needs.		
The Support Coordinator:		
101	Works with the individual to arrange for the provision of community-based services and supports upon discharge (waiver and other).	• Ask support coordinator how they conduct transitional support coordination. • Talk with consumers about the transitioning experience. • When available, obtain information from person-centered review process to determine if transitions are occurring according to plan and that the individual's health, safety and support needs are being addressed. • Review authorizations for services and supports • Look for evidence that the individual is receiving services and supports as authorized. • Interactively, with the support coordinator, review an individual's record who is receiving, or has received, transitional support coordination services for ➢ Evidence in support plans of arrangements being made with guidance from the individual ➢ Services and supports to be effective upon the individual's discharge ➢ There is evidence the provider worked with the institutional provider and staff to plan for discharge including facility record information and assessments. ➢ Evidence that the facility's discharge planning process has been involved with the follow-up planning ➢ Evidence of weekly face-to-face contact with the individual for the first 30 days following discharge ➢ Support plan update at the end of the 30 day post discharge period
102	Works with the institutional provider and staff and coordinating their activities with facility's discharge planning process.	
103	Develops an initial support plan to assist the individual in adjusting to their new living environment, based on the person's goals and needs and current assessments (including the facility's summary of the individual's developmental, behavioral, social, health and nutritional status and post-discharge plan).	
104	Assures community supports and services are in place at the time of discharge, and reflect the individual's desired goals and identified needs.	
105 R	Maintains at a minimum weekly face-to-face contact with the individual for the first 30 days following discharge to ensure community supports and services meet the individual's needs.	

Cite		Probes
106	Updates the support plan at the end of the 30-day period from discharge, identifying progress made with transition to community-based living and changes to supports and services as appropriate.	**Failure to provide weekly face-to-face contact during the first 30 days following discharge may result in recoupment of funding if services were billed at the transition rate for that period.**

Support Coordination 2-16-05.doc
Rev. 08.31.01; 09.03.01; 09.07.01; 09.11.01; 09.21.01 final draft; 10-30-01 final changes from DS Program; 11-13-01; 09.16.02; 10.02.02;12.03.02; 01.03; 02.03.03; 02.04.03; 10-25-05; 11-22-05; 2-14-06