

**NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
BISMARCK, NORTH DAKOTA  
March 25, 2015**

**IM 5239**

**TO:** Directors, County Social Service Boards

**FROM:** Karen Tescher, Assistant Director, Medical Services - Long Term Care Continuum

**SUBJECT:** Individual Care Plan, SFN 1467

**PROGRAM(S):** Home and Community Based Services Policies and Procedures

**EFFECTIVE:** March 30, 2015

**RETENTION:** Until Manualized

**SECTIONS AFFECTED:** 525-05-60-60 Individual Care Plan, SNF 1467

The purpose of this IM is to amend the following section of Service Chapter 525-05. The link to the form is:

<http://www.nd.gov/eforms/Doc/sfn01467.pdf>

**Individual Care Plan, SFN 1467 525-05-60-60**

Purpose:

The Individual Care Plan is a summary of the needs and service options identified in the assessment process and is an outline of the plan developed by the client and Case Manager to meet the client's needs.

This form is only completed for SPED and EXSPED clients.

When Prepared:

The Individual Care Plan is required for all SPED and EXSPED clients receiving HCBS Case Management and TCM Case Management. It is to be revised or updated as client's needs warrant. It is to be reviewed with the client at the annual/six-month review, and complete a new form if necessary due to changes in service(s) and/or amounts.

The Individual Care Plan must be revised when a change occurs (unless it is a result of legislative action).

By Whom Prepared:

The client's HCBS case manager will complete the Individual Care Plan in conjunction with the applicant/client or his/her legal representative. The signature of the client or legal representative on the ICP completes the care planning assessment of needs process.

If the client or representative refuses to sign the ICP, the reason for the refusal should be noted in the case file, and that the client was made aware of the right to appeal.

Section I Client Identification:

Enter the name, physical address, client identification number, county of residence, and county code. ~~and effective date of screening of level of care or SPED/ExSped Pool Authorization.~~ Mark yes or no if this plan overlaps the current plan filed at the department.

Section II Approved Services:

Check the appropriate funding source/sources. If receiving Rural Differential Rate (determined under Rural Differential policy 525-05-38) mark the correct tier (RD 1, 2, or 3) for rate.

SPED  ExSPED  RD1  RD2  RD3  RD Removed

Column Headings:

- a. SERVICE: Enter the service that has been identified for which the client is eligible, a provider is available, and the client has accepted.
- b. SERVICE PROVIDER: Identify the qualified service provider (agency or individual) who will provide the service (including the service of Case Management).
- c. PROVIDER NUMBER: Enter the provider's number (including the service of Case Management).
- d. UNIT RATE: Refer to the Qualified Service Provider (QSP) listing for rate. Enter the QSP unit rate (including the service of Case Management).
  1. If RD box was marked – rate should match rates determined within Rural Differential policy. (Total rate cost may be over cap however units should match cap: example: 70 units' individual or 50 units' agency cap out Homemaker services.)
  2. If removal of Rural Differential is required: make the box "RD removed" and write the end date by QSP name being removed from RD, cross off RD rate and write correct rate.

- e. UNITS PER MONTH: Enter the total number of units of service to be provided per month.
- f. COST/MONTH: The cost per month is calculated based on the amounts in the columns headed "Unit Rate," and "Units per Month" (based on a 31-day month).

Case Management has been pre-entered on the form. The Service Provider, Provider Number, and Unit Rate must be entered by the Case Manager. The Units Per/Mo has been pre-entered, Cost/Month section has a pre-entered notation.

Complete the "Estimated Monthly Cost to Client for Services" and complete the "Plus the Amount for HCBS Case Management."

The Contingency Plan must be completed. A Contingency Plan is required if the provider is not an agency. If a contingency plan is not required, N/As need to be entered in this section.

Total Cost: The total per month costs of services is the total to be reimbursed SPED/Expanded SPED Programs. The Grand Total does NOT include the cost of HCBS Case Management. When authorizing services by unit and or daily rate, the maximum amount must not exceed on the program and/or service cap.

### Section III: Other Agencies/individuals Providing Services.

The HCBS Case Manager records the services not authorized by the county social service board but being received by the applicant/client or being arranged. This would include home and community-based services provided by a home health agency or senior service provider (home delivered meals, congregate meals, transportation, etc.) for example.

#### Column Headings:

- a. SERVICE: Name of the service being arranged or received.
- b. PROVIDER: Name of the agency, or if an independent contractor, name of the person.

Section IV: Goals: For all recipients, the case manager will discuss with the recipient the goal(s) they may be striving to achieve; and this section must be completed on all care plans.

#### Column Headings:

- a. CLIENT STATED GOAL: Enter the client's stated goal.
- b. DATE GOAL ESTABLISHED: Enter the date the goal was established.

- c. Date GOAL COMPLETED: Enter the date the goal was completed, do not complete when the goal is determined to no longer be applicable.
- d. CONTINUED: Check if the goal was continued from the last care plan and enter the date the goal was established.
- e. COMPLETED: Check when the goal is completed.
- f. NO LONGER APPLICABLE: Check if the goal is no longer applicable.

A goal should not be removed from the care plan until it has been checked completed or no longer applicable. After it has been completed or is no longer applicable, it does not need to be listed on the ICP.

Section V: ADLS and IADLS Scores (scores from functional assessment):  
ADL's & IADL's Scores must be added from the Functional Assessment scoring.

Section V VI: Signatures:

The client/legally responsible party must check all applicable boxes acknowledging agreement and or awareness of the specific information.

The signature of the client/legal representative and HCBS Case Manager is required in the left hand portion of all ICPs.

"Six-Month Review": If there is NO change to be made in Section I as a result of the six-month review, the client can sign the original ICP, SFN 1467, in the area provided. The signature of the HCBS Case Manager completes the six-month review requirements for the ICP.

Number of Copies and Distribution:

The original is filed in the applicant's/client's case record. One copy is provided to the applicant/client when completed. One copy is mailed within three working days to Medical Services Division - HCBS/DHS. This includes ICPs completed annually, continued, updated at the six-month contact and a care plan that identifies a change.

This form is available from Office Services and an electronic copy is available through the state e-forms.