5th Edition • Spring 2026

Gold Book

Understanding the Office of Developmental Programs

Supporting People with Intellectual and Developmental Disabilities, Autism, and Complex Medical Conditions, and their families.

To access an online version of the Gold Book, scan this QR code:

Dedication

This book is dedicated to people with disabilities and their families and the advocates, allies, and supporters who make Everyday Lives possible for ALL people in Pennsylvania.

We thank the subject matter experts who participated in the development of this edition for their time and commitment to make this a working document that will assist people and families across the Commonwealth.

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This book could not have been created without the talent, encouragement, and support of Vision for Equality, Inc. who recognized the need to inform people and families, sought the answers, and made it happen.

Acknowledgments

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Mission

The mission of the Office of Developmental Programs (ODP) is to support Pennsylvanians with developmental disabilities and their families to achieve greater independence, choice, and opportunity in their lives. ODP seeks to continuously improve an effective system of accessible services and supports that are flexible, innovative, and person-centered.

Pennsylvania
Department of Human Services

April 15, 2026

Dear Individuals and Families:

It is with tremendous pleasure that I write this introductory letter to the Gold Book: Understanding the Office of Developmental Programs. As one of the authors of the first version of the Gold Book, I know how incredibly valuable this guide is for individuals and families who are navigating service systems.

The mission of ODP is to support Pennsylvanians with developmental disabilities and their families to achieve greater independence, choice, and opportunity in their lives. Our vision is to continuously improve an effective system of accessible services and supports that are flexible, innovative, and person-centered. We recognize, at times, our services can be complicated and difficult to navigate. For this reason, we have organized information to be more accessible and helpful for individuals and families.

This book has been compiled in part by people who were aware of this need and undertook the challenge of writing it – individuals and families. I wish to acknowledge Disability Rights Network of Pennsylvania, the Pennsylvania Family Network, and Self-Advocates United as 1 for their contributions.

In the following pages, you will find information to help guide you through the intellectual disability and autism services, supports, and resources in the Commonwealth of Pennsylvania.

Sincerely,

Kristin Ahrens

Deputy Secretary

About This Book

The service system that is supported by ODP is varied and vast. For those new to the system, this can be overwhelming. For individuals and families new to the system or for anyone interested in navigating ODP, this book is intended to be a guide to that system. The information contained in this publication was gathered from a variety of sources. It has been compiled and related in what we hope is a readable and helpful format.

Throughout this book, we often use the word "you," directly addressing people who need or are receiving services, but this book is also intended to be a resource for individuals and families, Supports Coordinators, and anyone who supports an individual with disabilities.

There are several terms that appear throughout this book, and you may use the glossary to understand them. One term which is very important is "person-centered." Person-centered simply means that what is important to the person who is receiving services is always first.

In order to implement person-centered practices, we must recognize that family is an integral part of everyone's everyday life. We are born into families, and we also choose those we consider family. Families are the foundation of our early development and often our achievements as adults.

If people with disabilities are to enjoy the everyday life that all citizens enjoy, families must play a key role. This role begins in childhood with families having a positive and promising vision for their child, facilitating their child's full inclusion in school and the community, and ensuring their child has the experiences and opportunities needed to learn and grow to adulthood. Families can be strong and resourceful but may also need assistance. Families may need information, advocacy skills, and connections to other families. The realization of Everyday Lives is dependent on the service system successfully partnering with families to achieve the hopes and dreams of their loved ones.

This Gold Book is intended to assist people with intellectual disabilities, developmental disabilities, including autism, along with their families and those who provide support, to help them better understand what services and supports are available and how to access them.

Contents

Chapter 1

Everyday Lives and the LifeCourse Framework

An everyday life is about opportunities, relationships, rights, and responsibilities. It is about being a member of the community, having a valued role, and having one's rights as a citizen fully respected. Understanding this concept will also help you understand the service system and how it is constructed.

How we live our lives is often described as "walking along the path of life." If you were to draw a picture of how your life started and where it is now, you might draw a picture of yourself on a winding path. That path may also be called a course. The LifeCourse Framework uses this idea to help you look at your life, examine what you need to make your life more fulfilling, and provide you with tools for achieving whatever you want in life.

Welcome

This first chapter describes the foundation for the ODP services system: Everyday Lives and the LifeCourse Framework. Everyday Lives is a set of values and beliefs that guide the design of the service system. The LifeCourse Framework is an approach and set of tools to help people achieve an everyday life. The idea that everyone is entitled to an everyday life is the basis of everything in our service system.

What is everyday lives?

Everyday Lives is the name of a 1991 publication developed by a group of people convened by the state office that is today known as the Office of Developmental Programs. Self-advocates, families, advocates, providers, and county and state government representatives collaborated over several months to develop a vision for people with disabilities in our state. This vision included a set of values that have guided the service system in Pennsylvania since that time. Everyday Lives communicates the belief that, no matter who we are, we all have the same rights and should have the same opportunities to live the life we choose. It makes clear that services provided to people in the Commonwealth must be founded on that belief.

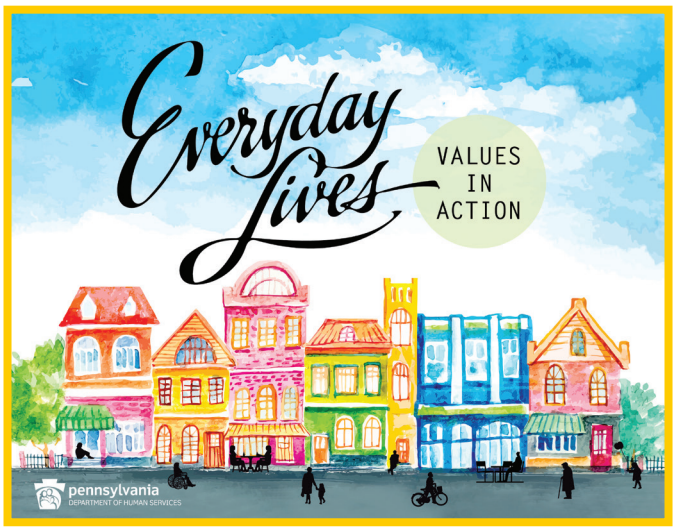
This is Only the Beginning

Your life, your decisions, your plans for the future: these are all important factors in ensuring that you are being treated the way you want and deserve to be treated, and in ensuring that you are receiving all the services and supports you need to help you live your life.

What follows is material directly from ODP's *Everyday Lives* and the LifeCourse Nexus, sponsored by the University of Missouri - Kansas City, Institute for Human Development, University for Excellence in Developmental Disabilities.

In 2016, ODP convened people with disabilities, families, advocates, providers, and county and state representatives to take a fresh look at *Everyday Lives*. After several months of collaboration, the publication was updated with:

- Values statements for individuals;
- Values statements for families; and
- 14 specific recommendations.



"Our goal should be clear. We are seeking nothing less than a life surrounded by the richness and diversity of community. A collective life. A common life. An everyday life. A powerful life that gains its joy from the creativity and connectedness that comes when we join in association as citizens to create an inclusive world."

– John McKnight, Emeritus Professor at Northwestern University,
Everyday Lives: Values in Action

EVERYDAY LIVES VALUE STATEMENTS FOR INDIVIDUALS: WHAT IS IMPORTANT TO PEOPLE WITH DISABILITIES

Control

I have control over all areas of my life. My family and supporters know these are my decisions and work with me to achieve greater control.

Choice

I decide everything about my life. My family, supporters, and community help me learn about opportunities and together we make them happen.

Freedom

I have the same rights as all other members of the community, and I can fully use them. My family, supporters, and community respect my rights.

Stability

Changes to my life are made only with permission and input. My family, supporters, and community do "nothing about me without me."

Relationships

I decide who is in my life: friends, family, partners, neighbors, pets, and others in the community.

Responsibility

I am dependable and honor my commitments. I keep my word. My family and supporters are honest and fair and keep their word.

Partnership

I need people in my life who will honor my life's journey. My family, supporters, and community work together with me to form connections.

Employment/meaningful contribution

I want to work at a job with good wages and benefits, start my own business, or volunteer.

EVERYDAY LIVES VALUE STATEMENTS FOR INDIVIDUALS: WHAT IS IMPORTANT TO PEOPLE WITH DISABILITIES

Communication

I am listened to and understood; my input is valued. My family and supporters listen to me and communicate in ways that work for me.

Health and safety

I am healthy and safe in all areas of my life. I, my family, supporters, and community balance health, safety, and risk according to my wants and needs.

Individuality

I am respected and valued for who I am. My family, supporters, and community treat me with dignity and support me in a person-centered way.

Connected

I am a full member of my community with respect, dignity, and status. My family, supporters, and community know me as a person, welcome, and accept me.

Quality

I want my life my way. I, my family, supporters, and the community make sure the services I choose are proven to be of high quality.

Success

I am the best I can be in the goals that I decide. My family, supporters, and community learn how to support me to achieve my goals.

Advocacy

I am the best person to let others know what I want and need. My family, supporters, and community listen to assist me.

EVERYDAY LIVES IN ACTION: WHAT FAMILIES VALUE

The unique role of family

Families represent the very heart of life throughout the lifespan.

Supporting families throughout the lifespan

Our families must be encouraged and supported early on in their children's lives to hope, dream, and reach for the future.

Health and safety

People should be safe at home, work, school, and in the community.

Mentoring

Families value mentoring as a strong component to informing and supporting families.

Communication

Good communication involves everyone working toward common goals and respecting one another in partnership.

Respect and trust

Respect must be granted to families, their values and beliefs, homes, and privacy.

Choice and control

Families seek freedom, on behalf of their family members, to make responsible and personal choices in all aspects of life.

Knowledge and resources

Families want to feel strong so they can provide for and support their loved ones.

Simplicity and flexibility

Families value a simplified and transparent system that is easy to access, understand, and navigate.

Collaboration

Along with self-advocates, family members must be part of the discussion, planning, and creation of every element of the service system.

Opportunity for innovation

Families support innovative, creative approaches that can be the key to truly person-centered solutions and often offer the most cost-efficient solutions.

14 Recommendations: Everyday Lives Values in Action

For a copy of the most recent report on the 14 Recommendations, which also includes its strategies and performance measures, please see this site:

ISAC Recommendation Report

1. Assure effective communication: Every person has an effective way to communicate to express choice and ensure their health and safety. All forms of communication should consider and include the use of current technology.

2. Promote self-direction, choice, and control: Personal choice and control over all aspects of life must be supported for everyone. Choice about where to live, whom to live with, what to do for a living, and how to have fun are all key choices in life.

3. Increase employment: Employment is a centerpiece of adulthood and must be available for everyone. The benefits are the same as for people without disabilities: getting a paycheck, meeting new people, building new skills, and paying taxes.

4. Support families throughout the lifespan: Families need support to make an everyday life possible. They need information, resources, and training.

5. Promote health, wellness, and safety: Promote physical and mental health, wellness, and personal safety for every individual and their family.

6. Support people with complex needs: People with physical and behavioral health needs receive the services and supports they need throughout their lifespans. Opportunities for a full community life are dependent on adequate supports.

7. Develop and support qualified staff: People receiving services benefit when staff who support them are well trained. Values, ethics, and person-centered decision making can be learned and used in daily practice through mentorship and training.

8. Simplify the system: The system of supports and funding of those supports must be as straightforward and uncomplicated as possible. This will allow for greater understanding and use of the system by individuals needing and receiving supports and their families.

9. Improve quality: Plan and deliver services that continuously improve an individual's quality of life. All stakeholders must be engaged in the process of measuring how well services assist people in achieving an everyday life.

10. Expand options for community living: Expand the range of housing options in the community so all people can live where and with whom they want to live.

11. Increase community participation: Being involved in community life creates opportunities for new experiences and interests, the potential to develop friendships, and the ability to contribute to the community.

12. Provide community services to everyone: Some people are waiting for community services. The goal is to build a system with capacity to provide services for all people who need supports.

13. Evaluate future innovations based on Everyday Lives principles: Future consideration of service models and reimbursement strategies must be based on the principles of person-centered planning, individual choice, control over who provides services and where, and full engagement in community life. Innovative approaches should be evaluated based on the recommendations of Everyday Lives.

14. Promote racial equality: Communities are richer, more just, and stronger when we honor and respect the whole of racial diversity. Access to a quality, person-centered, culturally competent system of supports and funding must be equally available regardless of race. Services must include planning over a lifespan and address racial disparities, including disparate outcomes. The duty to ensure that racial diversity is promoted and supported, at all levels within the services system, must be embraced.

What is the LifeCourse Framework and how will it help you?

The LifeCourse framework emphasizes two things:

1. Human beings are interdependent and family is the primary arena for experiencing and understanding the wider social world; and
2. Experiences in early life are linked to experiences later in adulthood.

Families are the core unit in our society, serving as a source of support for all its members. For people with disabilities, the role of family is central to their growth and development, facilitating learning and inclusion in all facets of community life. The experiences that children have early in life are the foundation for their development into adults.

The LifeCourse Framework teaches that when we talk about providing support to families, we generally put all focus on providing actual goods and services. But families need more. The LifeCourse Framework classifies family support into three areas:

1. **Discovery:** Families are empowered when they have access to information. Sometimes, what we need first is good information to understand what we need to do, to make decisions, or simply know what's going on.
2. **Connecting:** Making connections with peers, people who can help, and people who have been in your shoes.
3. **Goods and services:** The day-to-day tangible items you buy or use from public and private organizations in your community. These are the things that we connect with to make our daily lives possible and successful.

The Three Buckets:

Strategies for Supporting Families

All families need supports that change as the family members transition throughout their life stages and as roles, needs, and abilities of family members change. Strategies to address different needs fall into three "buckets."

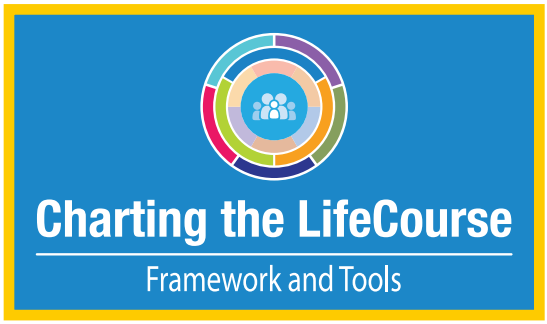
1. **Discovery and navigation,** which means having the information that you need;
2. **Connecting and networking** with peers and resources; and
3. **Goods and services** available within our communities and service systems.

The PA Community of Practice for Supporting Families — Discovery & Connection

ODP has adopted several strategies that provide individuals with disabilities and their families opportunities to receive information, learn, and network with each other. The organizations listed below are led by individuals with disabilities and families in partnership with other stakeholders in the system.

ODP's Regional Collaboratives for Supporting Families brings stakeholders together in their naturally connected communities to create networks and discover local strategies to support families. The Regional Collaboratives are supported by ODP regional leadership.

LifeCourse Tools to Plan for a Good Life



We are all on a path and where we are today leads to where we will be in the future.

Life is about relationships and experiences. At each stage of our lives, there are people we want to be with and experiences we want to have. Children want to play, teens want to experience independence, adults want to work, and everyone wants to have a little fun in their lives. Along the path, we meet people and build relationships that remain important to us throughout our lives.

The LifeCourse Framework was created to help you and your family to develop a vision for a good life. The LifeCourse tools offer a different way of thinking, encouraging high expectations, having life experiences to move life in the desired direction, and identifying and integrating multiple types of support.

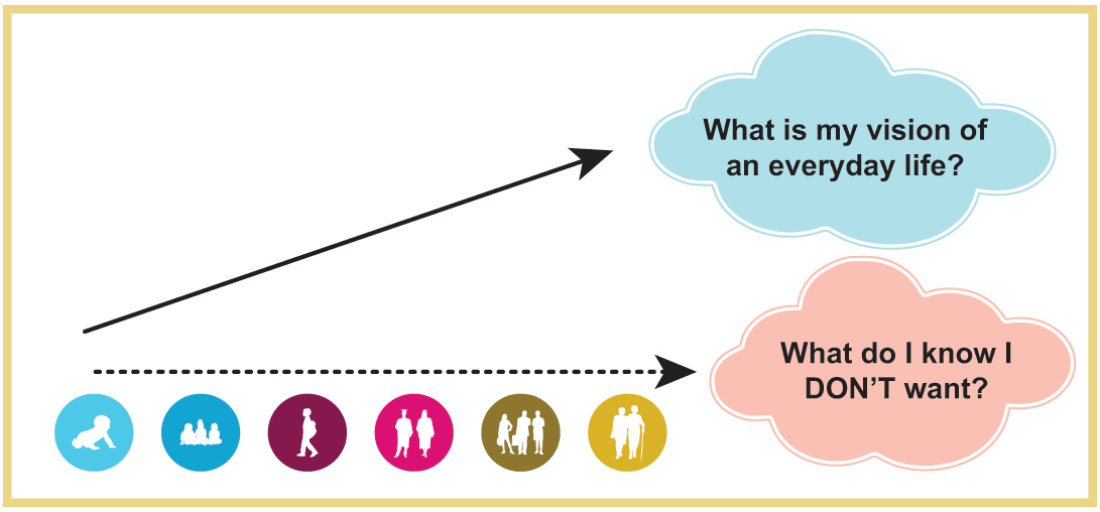
The LifeCourse Framework will help you plan the future by helping you to:

- Examine what you really want and expect out of life.
- Figure out what you need to know and do to get there.
- Identify what resources are available to you and how they can help you get to the future you want.

The following section is an introduction to some of the LifeCourse tools. These and many additional tools and guides are available at Homepage - LifeCourse Nexus.

The Trajectory Planning Tool

What happens to us early in our lives can have a significant impact on our quality of life and well-being in the future. The **Trajectory Planning Tool** will help you think about what a good life means to you and identify what you know you DO and DON'T want. Both are equally important for planning.

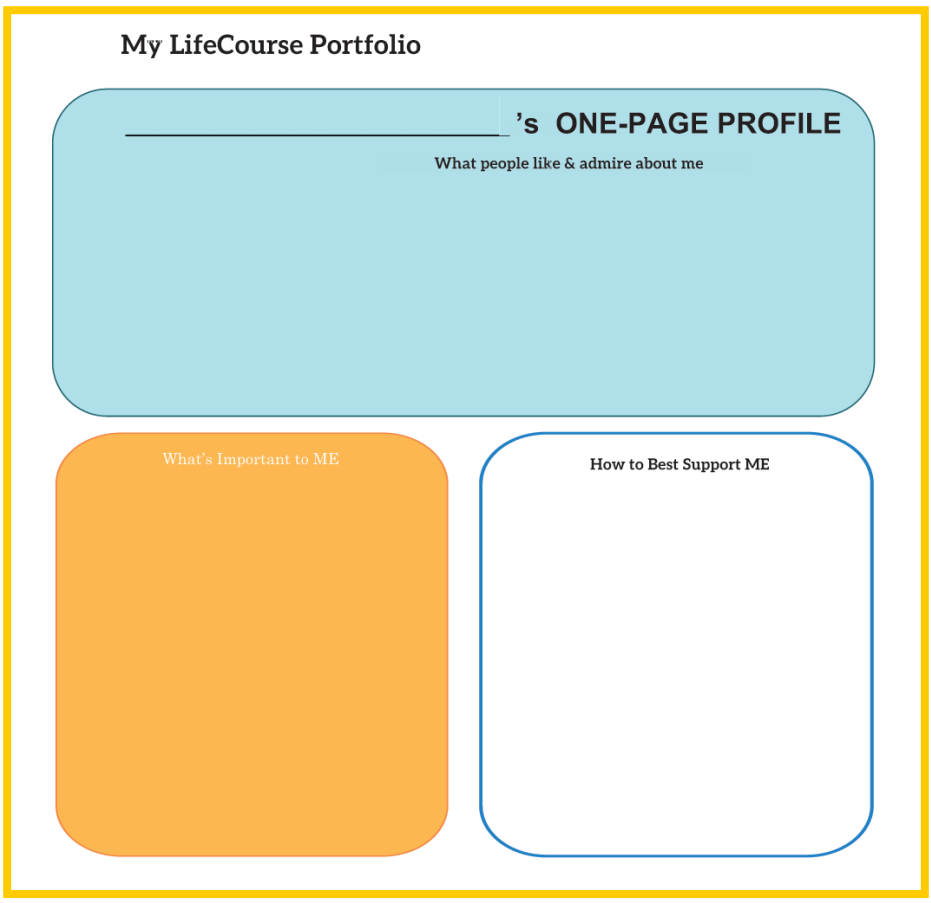


Trajectory across all ages: for additional guides for trajectory planning specific to school age, transition to adulthood, adulthood and aging, go to Quick Guides in the Life Experience Series.

The One Page Profile

A One Page Profile captures all the important information about a person on a single sheet of paper under three simple headings: what people appreciate about me, what's important to me, and how best to support me. This information makes it easier for everyone to get to know the person by understanding what truly matters to them.

Click on each image to be taken to corresponding link



This information is basic to developing both a vision and a plan. For additional resources, go to [Person-Centered - LifeCourse Nexus].

The [Life Domains Vision Tool] — How we all experience our day-to-day

People lead whole lives made up of connected domains that are important to a quality life:

- Daily life and employment;
- Community living;
- Health lifestyles;
- Social, spiritual, and leisure interests; and
- Advocacy and being a citizen.

These are interconnected. What happens in one area affects the other.

Life Vision

Name of Person Completing: _____ **Date:** _____

On Behalf of: _____

Life Domain	Description	My Vision for My Future	Priority
Daily Life & Employment	What a person does as part of everyday life – education and training, employment, volunteering; routines, responsibilities and skills for individual and family life.		
Community Living	Where and how someone lives - housing and living options, universal design, and modifications; transportation options, neighborhood considerations and community access.		
Social & Spirituality	Having friendships, social and personal relationships, leisure and recreational activities; exploring faith or spiritual aspects of life.		
Advocacy & Engagement	Determining how one's own life is lived, making choices, setting goals, speaking up, leading and partnering; Building valued roles, having meaningful experiences, and participating in community.		

Continued on Page 2

Life Vision

Life Domain	Description	My Vision for My Future	Priority
Healthy Living	Managing and accessing health care – medical, mental, and behavioral health, sexual and reproductive health; long-term health needs; wellness, fitness, nutrition and self care.		
Safety & Security	Staying safe from abuse, exploitation and injury; Preparing for emergency or disaster situations; legal rights with regard to decision making, end of life, and other legal issues.		
Supports for Family	Families often have valuable information, perspective, and opinions. How do I want my family to still be involved and engaged in my adult life?		
Supports and Services	What support will I need to live as independently as possible in my adult life, and where will my supports come from?		

Charting the LifeCourse Framework and Tools

Charting the LifeCourse Framework and Tools, iconography, and assets developed by the LifeCourse Nexus © 2024
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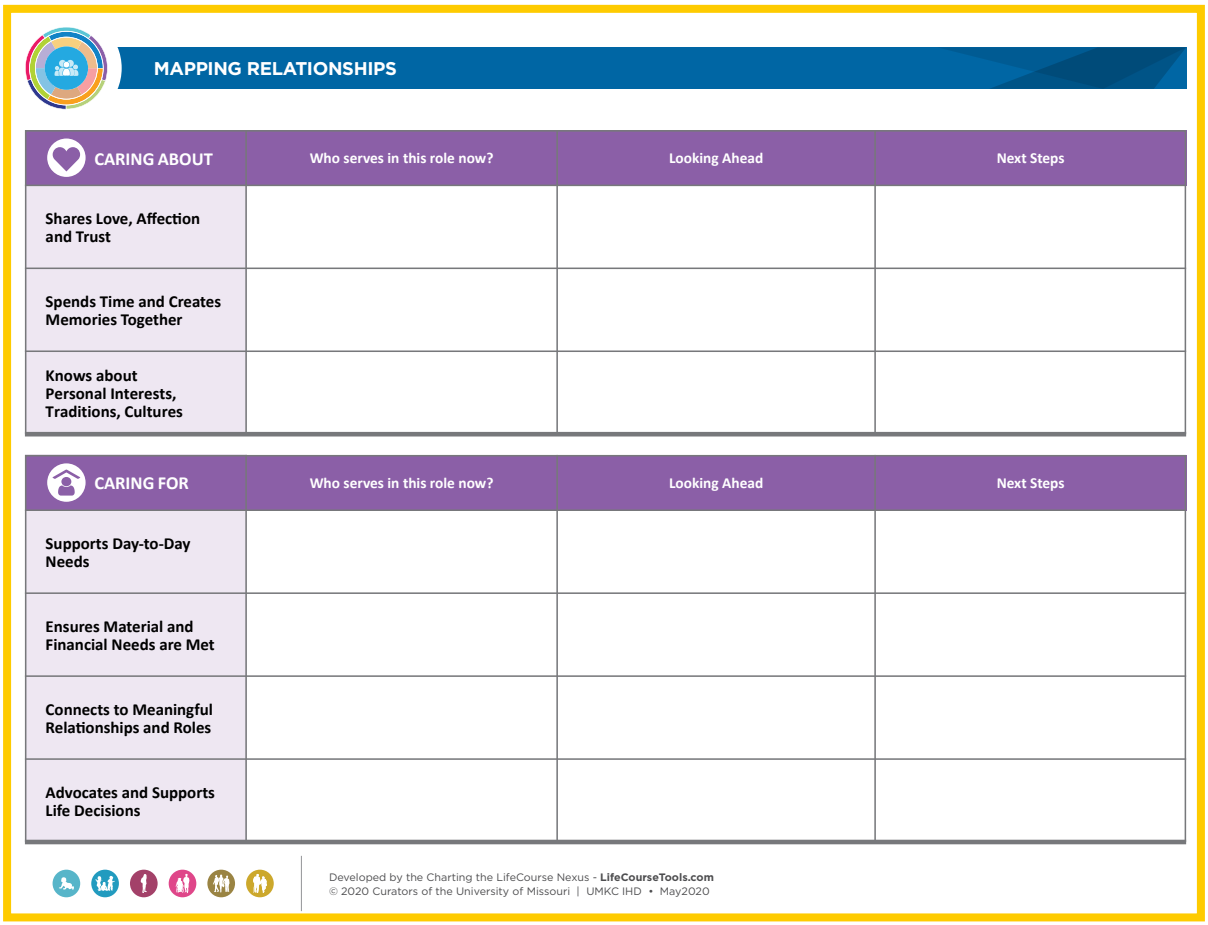
Mapping Relationships Tool

The **Mapping Relationships tool** will help you identify the different people and ways that they support you. Some of the people in your life might fulfill a lot of different roles while others might have only one significant role. It can help you have conversations about the future and who may fill those roles when others are no longer able.



MAPPING RELATIONSHIPS

CARING ABOUT	Who serves in this role now?	Looking Ahead	Next Steps
Shares Love, Affection and Trust			
Spends Time and Creates Memories Together			
Knows about Personal Interests, Traditions, Cultures			

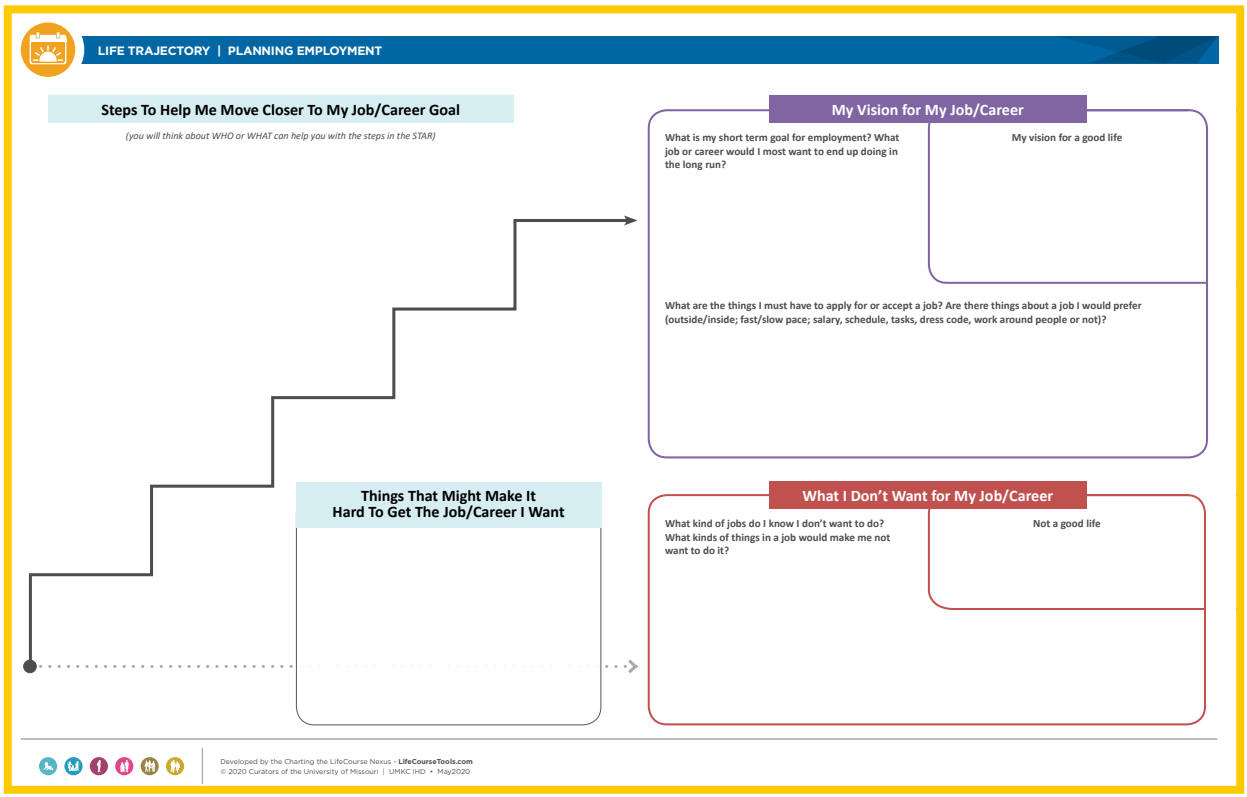
CARING FOR	Who serves in this role now?	Looking Ahead	Next Steps
Supports Day-to-Day Needs			
Ensures Material and Financial Needs are Met			
Connects to Meaningful Relationships and Roles			
Advocates and Supports Life Decisions			

Developed by the Charting the LifeCourse Nexus - **LifeCourseTools.com**

Transition to Daily Life and Employment Tool

There are many transitions throughout our lives. The major transitions are from childhood to adolescence, from school to adult life, and retirement. But throughout our life we are transitioning to new homes, new jobs, new friends. We leave some things but are purposeful about keeping some things in our lives from the past.

Planning for transitions means starting early, deciding where you want to be next, and then planning the next steps you need to get there. Your family, friends, and your Supports Coordinator (SC) can help you plan that transition and help you get to your new destination. The Planning to Adulthood guide is available at **Daily Life and Employment**.



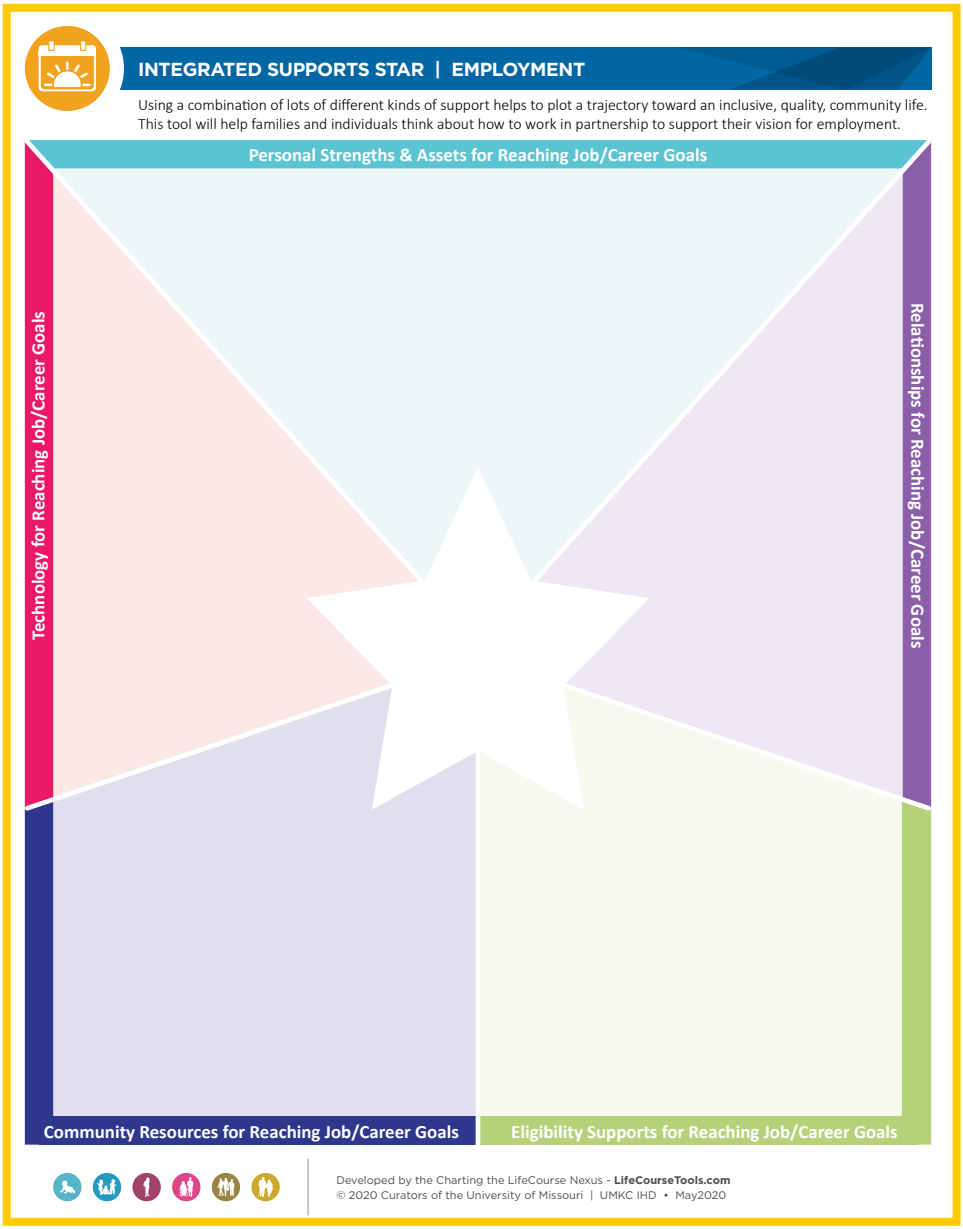
Transition to Daily Life and Employment

Before you know it, school is ending, and adult life is beginning. This guide is designed to help you and your family think about questions to ask, things to do, and resources to lead you to a job, career, volunteering, college or continuing education and, ultimately, the life you want.

Integrated Supports Tool

It takes a variety of supports to achieve our good lives, not just the formal services system. Integrated supports include:

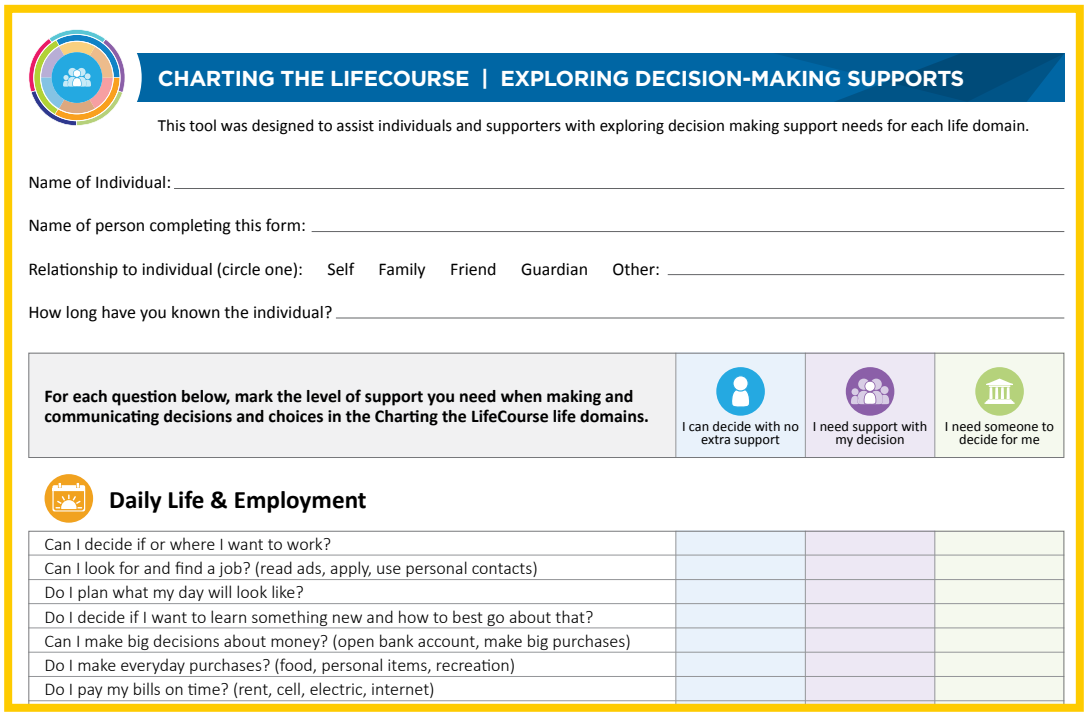
- Our personal strengths, assets, and interests;
- Relationships that provide natural supports;
- Community resources we count on;
- Technology; and
- Public and private services.



Supported Decision-Making Tool

To support individuals making their own decisions, this tool will help with identifying personal priorities and the supports needed for understanding options, communicating choices, and following through with decisions. It can be completed by the person in need of support, or with help from family, friends, or professionals.

The tools for Supported Decision-Making can be found at **The Supported Decision-Making portfolio**.



CHARTING THE LIFECOURSE | EXPLORING DECISION-MAKING SUPPORTS

This tool was designed to assist individuals and supporters with exploring decision making support needs for each life domain.

Name of Individual: _____

Name of person completing this form: _____

Relationship to individual (circle one): Self Family Friend Guardian Other: _____

How long have you known the individual? _____

For each question below, mark the level of support you need when making and communicating decisions and choices in the Charting the LifeCourse life domains.	I can decide with no extra support	I need support with my decision	I need someone to decide for me
Daily Life & Employment			
Can I decide if or where I want to work?			
Can I look for and find a job? (read ads, apply, use personal contacts)			
Do I plan what my day will look like?			
Do I decide if I want to learn something new and how to best go about that?			
Can I make big decisions about money? (open bank account, make big purchases)			
Do I make everyday purchases? (food, personal items, recreation)			
Do I pay my bills on time? (rent, cell, electric, internet)			

ODP has more information and resources about the LifeCourse Framework and tools on the website.

We encourage you to register with the MyODP website and the ODP listservs so that you will receive information and regular notices related to services. You will also receive a MyODP News Online digest approximately twice a month.

For more information on the PA Family Network, which provides training in LifeCourse, or to schedule family workshop sessions in your area, contact the PA Family Network at **pafamily-network@visionforequality.org** or call 717-839-5437 or 1-844-PA FAMILY (1-844-723-2645).

Chapter 2

The Service System Structure

The Commonwealth's system to deliver services is both large and complex. This chapter describes how the service system is structured. It includes information about state and county offices, as well as local agencies that play a part in delivering services to individuals and families. This information will help identify who is responsible for funding and delivering services and who monitors the quality of services.

To understand the process for obtaining services, it is helpful to understand the structure of the service system, beginning with ODP, so that you can understand the roles and responsibilities of each office and agency. The diagram on the following page describes the layers of the service system including state and county government offices, private agencies, and the role of each in delivering services.

NOTE: This chapter is not a "how to" chapter. It describes the service system structure. Later chapters will explain components of the system and steps you must take to receive services.

The following offices are part of the Pennsylvania Department of Human Services (DHS):

1. Office of Child Development and Early Learning (OCDEL)
2. Office of Children, Youth, and Families (OCYF)
3. Office of Developmental Programs (ODP)
4. Office of Income Maintenance (OIM)
5. Office of Long-Term Living (OLTL)
6. Office of Medical Assistance Programs (OMAP)
7. Office of Mental Health and Substance Abuse Services (OMHSAS)

For more information on each of these offices, please visit the **DHS Website** or **COMPASS** to apply for services.

The Office of Developmental Programs

The Office of Developmental Programs (ODP) is responsible for the statewide system that serves people with intellectual and developmental disabilities, including autism. ODP develops policy, enforces regulations, manages budgets and provides funding for services, licenses provider agencies, and administers federally approved waivers.

ODP carries out most of its work through four regional offices. These offices handle provider licensing inspections, investigations, outreach and training, and oversight and monitoring of the County/Administrative Entity (AE) agreement.

ODP is responsible for setting policy and administering services to individuals enrolled with ODP and to their families. The goal of ODP is to support everyone to live where they want, pursue work, enjoy leisure and recreational activities, and build meaningful relationships.

A wide range of services are designed to support individuals and their families in their home and community. Services include but are not limited to:

- Supports coordination – each person chooses a Supports Coordinator who helps with planning and accessing services.
- Employment services – to assist in finding a job and developing job skills.
- Community participation services – to support participation in activities such as volunteering, shopping, visiting the library, joining community groups, etc.
- In-home and community – to learn and improve daily living skills
- Home and vehicle modifications – to make changes to a person's home or vehicle to improve accessibility.
- Family and caregiver training – provides education and support to family members and caregivers.
- Respite care – short term relief for families when someone else provides care for a few hours or days.
- Assistive Technology – an item, piece of equipment, or products system that is used to increase, maintain or improve an individual's function or independence.

ODP includes the option for individuals and families to direct their own services (self-direction) with the authority to hire and manage people to support them. These services are listed and described in Chapter 6.

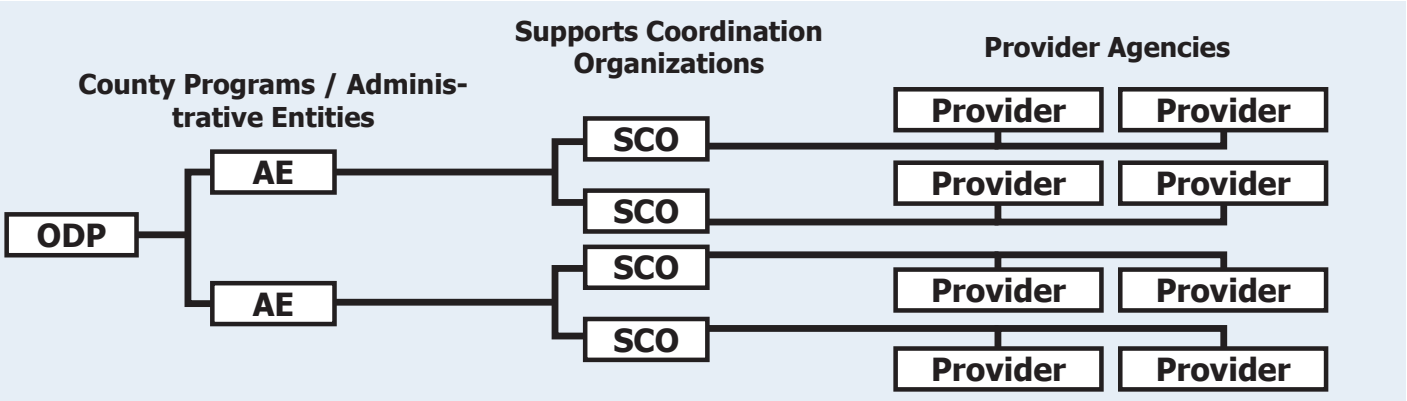
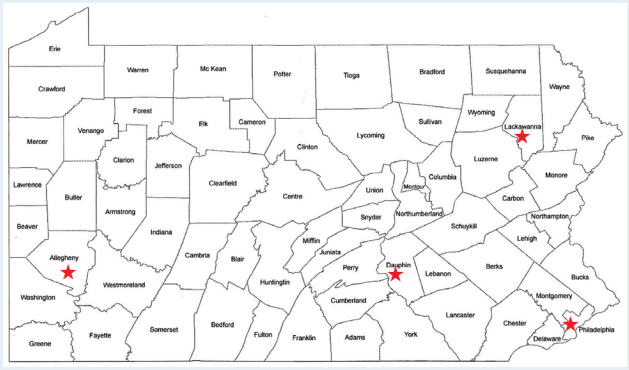


Chart structure does not apply to the Adult Autism Waiver and the Adult Community Autism Program. The AAW is directly administered by BSASP and not the Administrative Entities (AEs).

County/Administrative Entities (AE)

The 48 County/AEs, through an operating agreement with ODP, carry out administrative functions that enable individuals to enroll in services and ensure that services are available to meet quality standards. The County/AE is your first stop in the services system. The County/AE is responsible for: [1.]

- Determining eligibility and enrolling individuals in the ODP service system.
- Managing capacity in the Medicaid Waivers, enrollment of individuals into services, and ensuring that individuals have choice of providers.
- Reviewing individual support plans and authorizing services.
- Providing individuals with a notice of their Right to Fair Hearing and Appeal.
- Maintaining an adequate network of service providers, providing technical support, providing orientation and training for providers, and conducting provider qualification reviews.
- Overseeing incident management including reviewing incident reports, conducting investigations, conducting trend analysis by provider, training providers, and training individuals and families on their rights.
- Maintaining a human rights committee.
- Conducting quality management activities including developing a quality management plan, setting target objectives in line with ODP priorities, collecting and analyzing data, and implementing improvement strategies.
- Maintaining the Independent Monitoring for Quality (IM4Q) function.
- Conducting provider risk screening.



Regional Offices

1. Central Region Office in Harrisburg
2. Northeast Region Office in Scranton
3. Western Region Office in Pittsburgh
4. Southeast Region Office in Philadelphia

[1.] For Adult Autism Waiver (AWW), the County/AEs are only responsible for determining eligibility. The Bureau of Supports for Autism and Special Populations is responsible for all other administrative functions for AAW.

The first step in accessing services is through the County/AE. To locate your county office, call the ODP Customer Service Line at 1-888-565-9435 or contact the local County Mental Health/Intellectual Disabilities (MH/ID) Program Office. For a step-by-step description of the process in accessing services, see Resource D of this book.

Supports Coordination Organizations (SCO)

SCOs are responsible for developing an individual support plan (ISP), and then locating, coordinating, and monitoring needed services and supports. Sometimes these are also called "case management" services. By managing your plan and services, the SCO connects you and your family to both community resources and paid supports.

Supports help promote your independence.

After qualifying to enroll in the services system, you and your family choose a SCO to work with you. The Supports Coordinator (SC), who works for the SCO you choose, works with you, your family, and your advocates, using the LifeCourse Tools whenever possible to identify the supports necessary for you to live the best life possible. Your SC will coordinate your assessments, help and guide you during your individual support planning process, work with you to identify your outcomes and goals, assist in finding providers, and monitor your services. You should be able to discuss your life and vision for the future freely with your SC. Chapter 7 discusses the Individual Support Plan (ISP) in depth.

Supports Coordination Organizations (SCOs) are reviewed through Quality Assessment & Improvement (QA&I) and Performance-Based Contracting (PBC).

QA&I reviews focus on how effectively SCOs support person-centered planning, individual health and safety assurances, timely service coordination, and adherence to state and federal regulations. These reviews identify strengths and areas where improvement or additional support may be needed.

QA&I Review results can be found at:
QA&I Reports - MyODP

Performance-Based Contracting focuses on the quality of supports people receive over time. SCO performance is measured using clear performance standards that focus on four key areas: service sustainability, workforce stability, access to services, and the ability to support people with more complex needs. Results are used to recognize strong performance and improve services for individuals and families.

Performance-Based Contracting results can be found in the:
Supports Coordination Organization Directory

Self-Advocacy

Self Advocates United as 1 (SAU1), is a group of people who envision a world where people with developmental disabilities and their families are united to share knowledge, empower others, and use their voices to transform their communities and people's lives.

What kind of providers are there?

There are over 1,100 providers that vary in size and specialty. Some are large and provide services in many counties, while others may support fewer people in limited areas. Some provider agencies provide a wide array of services, others specialize in only one or two services. Your SC can help you find providers in your area for the services you need. Later in this guide, you will find a chapter to advise on how to choose a provider.

Provider Agencies

Provider agencies are the front line of the service delivery system. Providers deliver services authorized in the ISP. How the services are delivered is outlined in the ISP. Much like the AEs and SCOs, provider agencies also sign an agreement with ODP which includes conditions providers must meet to provide services.

PA Family Network
Supporting Families Throughout the Lifespan

Family Advocacy

Partnership with the PA Family Network is a family-directed program that provides information, connections, and support through family advisors, individual and family mentoring, informational materials and workshops on the LifeCourse, and how to make the LifeCourse tools work for your family.

What qualifies a provider?

Providers must be registered with ODP and must complete a provider qualification application. For every service provided there are general qualifications as well as requirements specific to each of the services. Performance Based Contracting is an approach to contracting with residential providers and support coordination organizations that rewards quality and results. Providers and support coordination organizations are monitored and managed based on agreed upon quality standards and performance measures. In order to be a qualified provider with ODP, providers must submit information annually to ensure performance measures are met. Providers that perform in the top tier are designated as Select or Clinically Enhanced and receive additional funding. New providers must go through a provider orientation and training prior to being qualified. Providers must meet all requirements established through regulations and policy.

How are services monitored for quality?

There are multiple approaches to how services are monitored by ODP, AEs, and SCOs, including the following:

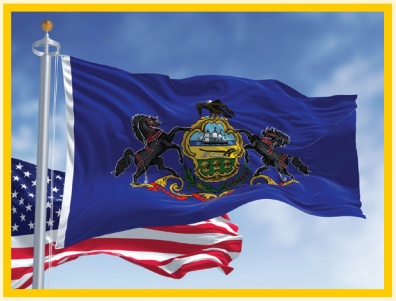
- SCs are required to monitor services at regular intervals by visiting individuals in a variety of settings while services are being delivered, and speaking with you in person about your experiences.
- Licensing inspections are conducted annually of facilities such as group homes and day programs and are governed by regulation.
- County/AEs/ODP also conduct provider oversight through incident management and through the requalification process.
- Regional quality oversight groups review region-specific findings.
- Local Independent Monitoring for Quality (IM4Q) teams that are not involved in service provision conduct interviews with a sample of individuals in each county. Findings of these teams are acted on by County/AEs and ODP.
- Individuals and families can report issues to their SC, the County/AE or directly to ODP through the Customer Service Line at 1-888-565-9435.

Can I choose my provider?

A requirement in the Medicaid program for Home and Community Based Services (HCBS) is that individuals be given the right to choose any willing and qualified provider. You may interview providers, review information available on the internet, and discuss your options with anyone you choose prior to making a choice of provider. You also have the right to change providers at any time. Chapter 8 in this guide will help you choose a provider.

Chapter 3

Programs, Services, and Eligibility



State-Funded Services

Pennsylvania's Mental Health/Intellectual Disability (MH/ID) Act of 1966 established intellectual disability as the eligibility standard for services and provided funds for services for the first time. Funds (referred to as base funds) are appropriated by the legislature and allocated by DHS to the County/AE programs to provide services. Counties are required to pay a portion of the cost of services. The funding appropriated by the legislature is flexible but limited. It may support people who are not eligible for federal Medicaid programs and those who are on the waiting list to receive waiver services. These services – called base-funded services – are limited. The service system for people with disabilities has evolved over many decades. The disability service system began at the state level in the 1960s. In the 1970s, the federal government began to fund disability services. Over the decades, new programs have been added, creating a system that is made up of a variety of programs. These programs include base services, state plan services, waiver services, and institutional services, among others. Eligibility for these programs and types of services differs across each program. This publication provides descriptions of the different programs and services offered, who is eligible to receive services, and information to help people understand the disability service system in Pennsylvania.

Federally-Funded Programs under the Medicaid Program

Most services provided by ODP are funded through Medicaid, which is funded jointly by the federal and state governments. Each state designs and manages their own Medicaid state plan programs by deciding which groups of individuals will be covered, services that will be provided, and how much providers will be paid to provide those services.

By participating in Medicaid, Pennsylvania is making an agreement with the federal government regarding how it manages its Medicaid programs. It promises that Pennsylvania will follow federal rules and, in turn, may claim federal matching funds for Pennsylvania's program activities. These funds help the state of Pennsylvania pay for ODP programs, such as HCBS Waivers.

What is a HCBS Waiver?

A HCBS Waiver is a program that helps people to live in their homes and communities, rather than in institutional settings, while still receiving the services and supports they would otherwise receive if they did live in a facility.

Waivers provide most of the funding for the supports and services for individuals with intellectual disabilities, developmental disabilities, medically complex conditions, and autism.

HCBS Waivers, which must be approved by the federal government through the Centers for Medicare and Medicaid Services – commonly referred to as CMS – allow states the authority to:

- Specify who is eligible for the waiver program;
- Define the number of people who may receive services;
- Determine the types of services that may be provided, the provider qualifications; and any service limitations.

What does Waiver mean?

In 1981, Congress amended the Social Security Act to permit states to shift their Medicaid resources from institutional settings (like Intermediate Care Facilities for Persons with Intellectual Disability, or ICF/ID, programs) to more integrated community-based settings. To do this, Congress gave states flexibility to "waive" certain federal requirements so that they could create these HCBS programs. This is the origin of the term "waiver."

Waivers are approved by CMS for a period of five years, after which the state must submit a renewal application that requires that state to issue a draft application for public comment prior to submission.

Choosing between institutional care or HCBS

As part of the eligibility process for a HCBS Waiver, individuals must first be determined to meet an institutional level of care (LOC), meaning they meet the need to live in a facility that provides all of their care. Next, individuals must make a choice between institutional services and HCBS. This is because HCBS Waiver services are an alternative to institutional services and a person can still choose to receive services in an institution. There are two institutional LOCs that are used to qualify people for HCBS Waivers provided through ODP. They are:

- ICF/ID: Intermediate Care Facilities for Individuals with Intellectual Disabilities
- ICF/ORC: Intermediate Care Facilities for Individuals with Other Related Conditions

Completing the eligibility process for a HCBS Waiver and having a LOC determination made does not create any risk for an individual being placed in an institution. This is simply a process that is required to receive waiver services.

ODP Programs

Below is a description of each of the ODP programs. With the exception of base funding, all of these programs are funded under Medicaid. Links to each of the approved programs including the most current and complete description of the services and eligibility can be found in Chapter 5 and online at ODP Everyday Lives Waiver Descriptions.

Base Funding – Base funding is a state-only funded service provided through the county program to either an individual who is not eligible for a HCBS Waiver, an individual who is on a waiting list for a HCBS Waiver, or for a support that is not eligible through a HCBS Waiver.

Targeted Support Management (TSM) - Supports Coordination Services – TSM, sometimes referred to as Targeted Case Management, is an optional service included in Pennsylvania's Medicaid state plan. TSM provides supports coordination for individuals of any age with intellectual disabilities (ID) and/or autism spectrum disorder (ASD), children birth through age eight who have a diagnosis of developmental disability with a high probability of resulting in an ID or ASD, and children birth through age 21 with medically-complex conditions. To receive TSM, individuals must be eligible for Medical Assistance. TSM is provided to individuals who are either not eligible for a HCBS Waiver, who only need TSM supports, or who are on a waiting list for a HCBS Waiver.

Person/Family Directed Support Waiver (P/FDS) – P/FDS Waiver supports individuals of any age to live more independently in their homes and communities by offering a variety of services that promote community living, employment, communication, self-direction, choice, and control. Individuals are eligible at birth with no age limit to participate. There is an individual cost limit of $47,000 per person, per fiscal year. If there is a need, the limit can be exceeded by $15,000 for Supported Employment or Advanced Supported Employment services. The cost of supports broker services and supports coordination is excluded from the limit. At the time of this publication, this waiver supported over 13,416 people.

Community Living Waiver (CLW) – The CLW supports individuals of any age to live more independently in their homes and communities by offering a variety of services that promote community living, employment, communication, self-direction, choice, and control. There are no age limits for the waiver. There is an individual cost limit of $97,000 per person, per fiscal year. The cost of supports coordination is excluded from the annual limit. At the time of this publication, this waiver supported over 8,820 people.

Consolidated Waiver – The Consolidated Waiver supports individuals of any age and with the greatest needs to live more independently in their homes and communities by offering a variety of services that promote community living, employment, communication, self-direction, choice, and control. There are no age limits for the waiver. There is no individual cost limit. Services are determined by the assessed need. At the time of this publication, this waiver supported over 19,558 people.

Adult Autism Waiver (AAW) – AAW supports adults with ASD to live more independently in their homes and community by offering a variety of services that promote community living, employment, communication, choice, and control. Individuals must be age 21 or older. There is no individual cost limit. At the time of this publication, this waiver supported 743 people.

Adult Community Autism Program (ACAP) – ACAP is a managed care program which supports adults with ASD who are age 21 and older. It is a fully integrated, comprehensive system of care that includes physical health, behavioral health, social, recreational, transportation, employment, therapeutic, educational, crisis, in-home support, and independent living services. ACAP is offered in Dauphin, Lancaster, Cumberland, and Chester counties and is limited to 200 individuals.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/ID) – ICF/ID is a residential service available for individuals in need of, and receiving, active treatment services. Active treatment refers to aggressive, consistent implementation of a program of specialized training, treatment, and health services. All services are based on an evaluation and individualized program plan (IPP) developed by an interdisciplinary team. Facilities must meet federal building codes and program certification requirements.

ICF/ID facilities can be as small as four individuals living in standard housing in the community and as large as hundreds of individuals. Pennsylvania state institutions are ICF/ID facilities. There are also private agencies that operate both small and large facilities.

Over 2,200 individuals receive services in ICF/ID programs.

Program Eligibility

Eligibility refers to the conditions an individual must meet to receive services. Eligibility is a complicated topic because the service system was developed over decades and, as programs were added, eligibility was established for each new program. So, there are some differences across programs. Since Medicaid waivers and state plan services are amended frequently, the surest way to get accurate information about the eligibility standards is by going to the program on the DHS website or by going to the ODP Everyday Lives Waiver Descriptions.

Eligibility Definitions for ODP Programs

Autism eligibility is defined as having a diagnosis of Autism Spectrum Disorder (ASD). Individuals may also have an ID diagnosis, but autism must be present for AAW and ACAP.

Intellectual disability eligibility is defined as having a full-scale IQ assessment that is at least two standard deviations below the mean, or approximately 70 or below.

Developmental disability eligibility is defined as having a condition of substantial developmental delay or specific congenital or acquired conditions with a high probability of a resulting ID or ASD manifested prior to the age of nine in an individual who is eight years old or younger, and the disability is likely to continue indefinitely.

Medical complexity for children birth through age 21 eligibility is defined as having one or more chronic health conditions that meet both the following conditions:

- Cumulatively affects three or more organ systems; and
- Requires medically-necessary skilled nursing intervention to execute medical regimens for technology used for respiration, nutrition, medication administration, or other bodily functions.

LOC is the non-financial element that determines a person's eligibility for the Consolidated, Person/Family Directed Support (P/FDS) or Community Living (CLW) and Adult Autism (AAW) waivers. There are four criteria that must be met prior to an individual with an ID or ASD being determined eligible for ICF/ID or ICF/ORC level of care.

1. The individual must have a diagnosis of ID or ASD; this also includes youth with a developmental disability due to a medically complex condition or who have a strong likelihood of an autism or ID diagnosis.
2. The individual must have substantial adaptive skill deficits in three or more areas of major life activity based on a standardized adaptive functioning test;

Adaptive Skill Deficits

An adaptive skill deficit is when a person has not been able to successfully perform or learn an adaptive skill. Whether or not a person has substantial adaptive skill deficit is determined by an standardized assessment of adaptive functioning.

Impairments in adaptive functioning means having a significant limitation in meeting the standards of maturation, learning, personal independence, or social responsibility of the individual's age and cultural group.

For base services, only two areas of adaptive skill deficits are necessary and this only applies to a person with an intellectual disability.

3. The ID or ASD must have occurred prior to age 22; and
4. The individual must be recommended for an ICF/ID or ICF/ORC level of care based on a medical evaluation.

Adaptive skills are abilities a person needs to be successful in everyday life. For the purposes of waiver and TSM eligibility, ODP looks at six major areas of adaptive skills. They are:

- Self-care;
- Understanding and use of language;
- Learning;
- Mobility;
- Self-direction; and
- Capacity for independent living.

Financial eligibility:

- For Medicaid Programs, the person's income can be no greater than 300 percent of the Supplemental Security Income (SSI) federal benefit. Through Medical Assistance for Workers with Disabilities (MAWD), individuals who are employed can have more income and keep their eligibility.
- For ACAP, the person must meet MA eligibility requirements.
- For county MH/ID base funded services, there is no asset or income limit.

ODP Program Chart – Eligibility, Age, and Annual Caps

Program	Eligibility	Location	Annual Cap	Age
Base Service	ID. Substantial adaptive skill deficits in two or more areas for individuals with ID.	County/AEs	None	Birth +
Targeted Support Management	ID, ASD, developmental disability, or children with a medically-complex condition. Substantial adaptive skill deficits in two or more areas for individuals with intellectual disability; 3 or more areas for ASD, developmental disability or children with a medically complex condition.	Statewide	None	Birth +
Consolidated Waiver	ID, ASD, developmental disability, or children with a medically-complex condition. Substantial adaptive skill deficits in three or more areas.	Statewide	None	Birth +
Community Living Waiver	ID, ASD, developmental disability, or children with a medically-complex condition. Substantial adaptive skill deficits in three or more areas.	Statewide	$97,000	Birth +
P/FDS Waiver	ID, ASD, developmental disability, or children with a medically-complex condition. Substantial adaptive skill deficits in three or more areas.	Statewide	$47,000	Birth +
AAW	ASD, substantial adaptive skill deficits in three or more areas.	Statewide	None	21 +
ACAP	ASD, substantial adaptive skill deficits in three or more areas.	Dauphin, Cumberland, Chester, Lancaster counties	None	21 +
ICF/ID	ID, substantial adaptive skill deficits in three or more areas, and requires active treatment.	Private agencies	None	Birth +

Types of Services

Services are designed to support people where they want to live, with whom they want to live, and enable them to live the everyday life they choose. A good everyday life includes being part of a family and community, feeling valued, having **opportunities to learn and grow, and to contribute to the community.** The purpose of ODP services is to enable each person to have a good everyday life.

The list of services below are available in most but not all programs. There is a chart further down that identifies which waiver programs provide each service. For a full description of the services, the purpose of the service, how often and for the length of time it can be provided, as well as the qualifications providers must meet, see Appendix C of the specific waiver. You may review each program at ODP Everyday Lives Waiver Descriptions.

Waiver Services At-a-Glance

American Sign Language (ASL) - English Interpreter Service is for individuals who utilize ASL. Interpreting is the process of conveying English in grammatically correct ASL and the process of conveying ASL in English. Interpreters maintain the role of a facilitator of communication. Individuals may use this service at the same time as other services except the Communication Specialist service.

Assistive technology is equipment or product used to increase, maintain, or improve an individual's functioning.

Benefits counseling assists individuals in understanding how work impacts their federal and state benefits.

Behavioral support includes a comprehensive assessment and development of strategies to support the individual, the provision of interventions and training to the individual, staff, and caregivers.

Communication specialist supports individuals with non-traditional communication needs by determining the need, educating the individual and his or her caregivers on the individual's communication needs, and the best way to meet them.

Community participation support provides support for community inclusion and building interest in and developing skills. The expected result is the individual developing a range of valued social roles and relationships, building natural supports, increasing potential for employment, and experiencing meaningful community participation and inclusion.

Waiver Services At-a-Glance

Companion services are provided to individuals aged 18 and older for the limited purposes of providing supervision or assistance to ensure the individual's health, safety, and welfare, and to perform activities of daily living. People in residential settings can also receive this service at their place of employment.

Consultative nutritional services are provided by a licensed dietitian to assist unpaid caregivers and/or paid support staff in carrying out a treatment/service plan that is not covered by the Medicaid state plan.

Education support may cover the cost of tuition for adult education classes offered by a college, community college, technical school, or university, on campus peer support, adult education, or tutoring program for reading or math instruction. The individual must have an outcome related to employment or a skill attainment goal documented in their ISP.

Employment services are a range of services to assist in finding employment, learning job skills, and maintaining employment.

Family/caregiver training and support is for unpaid family members or caregivers who provide support to an individual. This service is intended to develop, strengthen, and maintain healthy, stable relationships among the individual and all members of the individual's informal network.

Family Medical Support Assistance Service assists with management of services in the participant's private home related to the medical needs of participants with a Needs Group 3 or higher who use medically necessary technology and require nursing.

Home accessibility adaptations includes making modifications to the private home of the individual including homes owned or leased by relatives or friends and LifeSharing Homes.

Homemaker/chore services enable the individual or the family member with whom they reside to maintain the home. Chore services are those needed to maintain the home in a clean, sanitary, and safe condition. These may only be provided when neither the individual, nor anyone else in the household, can perform the function.

Housing transition and tenancy sustaining services are pre-tenancy and housing sustaining supports to assist individuals in being successful tenants in private homes owned, rented, or leased by the individuals.

Waiver Services At-a-Glance

In-home and community support are provided in home and community settings to assist individuals in acquiring, maintaining, and improving skills necessary to live in the community, to live more independently, and to participate meaningfully in community life. Included are activities of daily living, developing practices to promote good health, manage medical care, develop relationships with members of the broader community, exercise rights as a citizen, and make decisions.

LifeSharing usually supports individuals to live in the private home of a host family. The host family can be the individual's relative(s), legal guardian, or persons who are unrelated to the individual. The responsibilities of caregivers are based on an ISP. A qualified provider agency supplies training, support, and supervision of the arrangement.

Music, art, and equine-assisted therapy are services provided to individuals who could benefit from the provision of therapy to maintain, improve, or prevent regression of the individual's condition and assist in the acquisition, retention, or improvement of skills necessary to live and work in the community.

Participant-directed goods and services are services, equipment, or supplies not otherwise offered in a HCBS Waiver, the Medicaid state plan, or a responsible third party. Participant-directed goods and services must address an identified need in the participant's service plan and must achieve specified objectives in the ISP.

Remote Supports are supports that involve the use of technology that uses two-way real time communication in a person's home or community, allowing off-site caregivers to monitor and respond to the person's health and safety needs. For example, Arya uses a stove sensor in her home that is monitored by a direct support professional who is off-site. The direct support professional calls Arya when the stove has been turned on longer than 30 minutes and checks in on what Arya is cooking and asks if she needs assistance.

Residential habilitation are community homes (group homes) that provide supervision and support to enable individuals to live in and engage in community life. No more than four individuals usually live in these homes and the homes must be located in the community to maximize community participation. For ID/A waivers, homes are licensed. Homes can be unlicensed if they serve three or fewer individuals over the age of 18 who need 30 hours or less of support per week.

Respite services are provided on a short-term basis to supervise and support individuals living in private homes, giving the person(s) normally providing care a period of relief that may be scheduled or due to an emergency.

Waiver Services At-a-Glance

Shift nursing includes health counseling, care supportive to or restorative of life and well-being, and medical regimens as prescribed by a licensed physician or dentist. Shift nursing services can only be provided to adult individuals.

Specialized supplies are incontinence supplies that are medically necessary and are not a covered service through the Medicaid state plan, or private insurance. This includes diapers, incontinence pads, cleansing wipes, under pads, vinyl or latex gloves, and personal protective equipment. Specialized supplies can only be provided to adult waiver individuals aged 21 and older.

Specialty Telehealth and Assessment Team (STAT) is a service to provide a right-on-time telehealth assessment when the participant's primary care physician is unavailable or unable to determine the best clinical course of action, often avoiding unnecessary emergency room visits. Specialty Telehealth and Assessment Team services are designed to coordinate participants' care with local emergency departments, urgent care facilities, primary care physicians, and other healthcare providers to enable real time medical support, consultation, and coordination on physical health issues and to assist participants, families, and providers to understand presenting health symptoms and to identify the most appropriate next steps.

Supported living is direct and indirect services provided to individuals who live in a private home that is owned, leased, or rented by the individual. Individuals will be supported to live in their own home in the community and to acquire, maintain, or improve skills necessary to live more independently and be more productive and participatory in community life.

Supports broker is a service available to individuals who elect to self-direct their own services. Designed to assist individuals with employer-related functions to be successful in self-directing some or all the services.

Supports coordination is a service that involves the primary functions of locating, coordinating, and monitoring needed services and supports for individuals. Everyone enrolled in the waiver receives supports coordination services.

Therapy services are direct services provided to assist individuals in the acquisition, retention, or improvement of skills necessary to live and work in the community. The services include training to caregivers.

Waiver Services At-a-Glance

Transportation is a service that enables individuals to access services and activities specified in their approved ISP. Transportation may be delivered by providers, family members, or other licensed drivers. Payment ranges from reimbursement per mile, per trip, or to a public transportation vendor.

Vehicle accessibility adaptations consist of certain modifications to the vehicle that the individual uses as their primary means of transportation to meet their needs.

ODP Service Chart by Waiver

Service	Consolidated Waiver	Community Living Waiver	P/FDS Waiver	Adult Autism Waiver
American Sign Language (ASL) - English Interpreter Service	X	X	X	X
Assistive Technology	X	X	X	X
Behavioral Support	X	X	X	X
Benefits Counseling	X	X	X	
Career Planning				X
Communications Specialist	X	X	X	
Community Participation Support/ Day Habilitation	X	X	X	X
Community Supports				X
Community Transition Services				X
Companion Services	X	X	X	
Consultative Nutritional Services	X	X	X	X
Education Support	X	X	X	
Family/Caregiver Training and Support	X	X	X	
Family Medical Support Assistance	X	X	X	
Family Support				X
Home Accessibility Adaptations/ Home Modifications	X	X	X	X

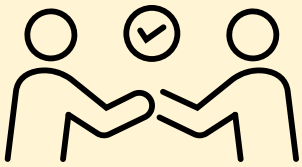
Service	Consolidated Waiver	Community Living Waiver	P/FDS Waiver	Adult Autism Waiver
Homemaker/Chore Services	X	X	X	
Housing Transition and Tenancy Sustaining Services	X	X	X	
In-Home and Community Support	X	X	X	
LifeSharing	X	X		X
Music, Art, and Equine Assisted Therapy	X	X	X	
Participant Goods and Services	X	X	X	
Remote Supports	X	X	X	X
Residential Habilitation	X Licensed & unlicensed	X Unlicensed		X Licensed
Respite	X	X	X	X
Shift Nursing	X	X	X	
Small Group Employment	X	X	X	X
Specialized Supplies	X	X	X	
Specialty Telehealth and Assessment Team	X	X	X	
Supported Employment	X	X	X	X
Supported Living	X	X		
Supports Broker	X	X	X	
Supports Coordination	X	X	X	X
Systematic Skill Building				X
Temporary Supplemental Services				X
Therapy services	X	X	X	
Therapy – Speech/Language				X

Service	Consolidated Waiver	Community Living Waiver	P/FDS Waiver	Adult Autism Waiver
Therapy – Counseling				X
Transportation	X	X	X	X
Vehicle Accessibility Adaptations	X	X	X	X

For more information on ID/A waivers, please reference the ISP Manual for Individuals Receiving Targeted Support Management, Base Funded Services, P/FDS, Community Living, or Consolidated Waiver Services.

For more information on the AAW, please reference the AAW Provider Information Table.

Chapter 4



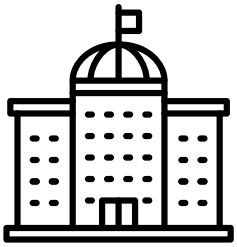
Applying for Services – Where do I begin?

The path to accessing all services begins in the county where you live. This section provides information on where and how to make an application to receive services. For a detailed step-by-step description of the process of accessing services, see Resource D of this book.

Registering with the County/AE for services

An important step to applying for services and supports is registering with the local County/AE. To locate your County/AE office, call the ODP Customer Service Line at 1-888-565-9435 or contact the local County Mental Health/Intellectual Disabilities (MH/ID) Program Office.

Once contact is made with the County/AE office, a representative for the office will set up an intake appointment. Individuals will be asked to bring information and documents to the appointment that include:



- Social Security card (if you have one);
- Birth certificate;
- Proof of address (for example, utility bill, lease, etc.);
- MA card (if you have one – also referred to as Medicaid, Access Card, Medical Assistance), or other insurance cards;
- Assessments or psychological evaluations (if available); and
- Legal guardian or custodial papers (if applicable).

The County/AE representative will ask individuals/families to sign a Release of Information form. This form authorizes the County/AE to obtain medical records and other supporting documents. County/AE programs can assist individuals and families to complete needed assessment and psychological evaluations. School records may also include the required information. Once the County/AE receives all required documentation, they will determine whether an individual is eligible for services. The County/AE must provide written notice of eligibility to all applicants within 14 days. If notification is not received in that time, call your County/AE program.

Choosing a Supports Coordinator (SC)

If you are determined eligible (guidance if you are ineligible below), the County/AE will provide you with information about SCOs so that you can choose the organization that will help you develop a plan and access services. Your SC will be your guide to the services system.

Find out more about SCOs near you using the Supports Coordination Organization Directory

Applying for Medicaid at the County Assistance Office (CAO)

To be eligible for waiver funded services and TSM, an individual must first be enrolled in the Medicaid program. Individuals can apply at the local CAO, which is different from the County/AE. The CAO is operated by DHS and processes applications to enroll in Medicaid as well as several other public programs such as Temporary Assistance for Needy Families (TANF) income support, Supplemental Nutrition Assistance Program (SNAP), and the Low Income Home Energy Assistance Program (LIHEAP) heating assistance. You may be eligible for other benefit programs as well.

Follow this link to find your local CAO.

Applying for Services

The SC assists in accessing services and supports funded by the ODP program as well as those available through other community resources. Receiving services through ODP programs will depend on whether you meet the eligibility requirements for the services.

Applying for county-administered base-funded services – For services funded directly by the county, the SC will make a request directly to the county. As explained earlier, the county administered base-funded programs are small, but they may meet an immediate or one-time need.

Applying for Medicaid Waiver services – The SC will also provide an application for the Medicaid Waivers to determine service eligibility. Once the paperwork is completed, a letter will be sent explaining the likelihood of meeting the eligibility for a waiver.

If funding is available, enrollment and services may begin. However, being determined eligible does not mean that services can begin. Each waiver has a limited number of people that can be served. There are waiting lists to enroll in waiver services. If services are not available immediately, the SC will assist you in completing a Priority of Urgency of Need for Services (PUNS) form. You will then be placed on the waiting list. When funding is available, you will go through the formal eligibility determination for the waiver.

Choice of Home and Community-Based Services (HCBS)

Anyone who is eligible for ID and/or Autism services and is enrolled in Medicaid must be provided with the opportunity to choose their preference in service delivery. You can choose between ICF/ID and HCBS. Every accommodation is available to the individual (for example, communication devices, interpreters, or physical assistance as needed) must be used to provide the opportunity to the individual to communicate a preference in services. Your choice in services (ICF/ID or HCBS) is determined by signing a HCBS or ICF Application and Service Delivery Preference Form (DP 457) which indicates your choice of HCBS or ICF services. This is presented to the individual/family by the AE or SCO.

Waiting Lists

The waiting list is comprised of individuals who are eligible to receive services and supports through ODP waivers who, due to insufficient resources, are waiting for services until funding becomes available. Capacity is increased only when funding is available to support it. The waiver capacity commitment is the maximum number of people that can be served at any point in time that year. A person on the waiting list can only enroll into services when capacity becomes available. Individuals on the waiting list are placed in one of three categories of need – emergency, critical, or planning – depending on their specific situation. The person with the most urgent need will have priority for enrollment.

What should I do if I am told I am not eligible for any services?

All applicants must be notified in writing if they are determined ineligible for any services. This includes eligibility for Medicaid, state and county funded programs, ICF/ID services, and waiver services. Eligibility can only be determined after a thorough review of the application and all required documentation. Written notice of a denial that also informs the individual of their right to appeal the decision must be provided.

Refer to Chapter 9 of this publication to learn more about rights and application.

A step-by-step guide to this process is contained in Resource D: Step-By-Step Waiver Application.

Prioritizing Individuals for Services

The PUNS process is designed to identify who is waiting for services, what they need, and the urgency of their need. The categories to determine urgency are:

Emergency – Person needs services immediately, within the next six months.

Critical – Person needs services more than six months but less than two years from now.

Planning – Person needs services more than two but less than five years from now.

This information is used by the state in planning for future service needs and informs the budgeting process. Your SC will assist you in completing the PUNS form.

The PUNS form includes the services that are currently being received as well as the services needed now or that will be needed in the future. Individuals receiving services through the capped waivers who have additional needs related to their health and safety should complete a PUNS form. Waivers that do not have a cap must meet all health and safety needs and therefore a PUNS is not necessary. A PUNS Assessment is not used for the Adult Autism Waiver.

If you have questions about the PUNS form or process, you can call your regional office or the ODP Customer Service Line at 1-888-565-9435.

PUNS Completion

The PUNS should be completed during a face-to-face meeting with the SC. Be honest when completing the PUNS form. We often put our best foot forward when talking about our lives and tend to diminish or lessen the problem we might be experiencing. Honesty in describing needs can make a difference in the category to which an individual is assigned and how soon an individual might be able to receive services or supports.

After the individual or family signs the form at the meeting, a copy of the PUNS form will be given to the individual and family in approximately three weeks, along with a letter describing the individual's rights and what to do if there is a disagreement with the information on the PUNS form. This is the information that was entered into the system by the SC.

PUNS forms should be updated yearly or whenever there is a life-changing situation such as a graduation or serious illness of a caregiver. All updates require a signature. It is important for the individual to know which PUNS category they are in. Remember, people in the emergency category are the top priority when funding becomes available.

ODP retains waiver capacity to address unanticipated emergencies such as imminent risk of institutionalization within 24 hours, substantial self-harm, or substantial harm to others. This imminent risk is precipitated by at least one of the following situations: illness or death of a caretaker, sudden loss of the individual's home (for example, due to fire or natural disaster), sudden loss of the care of a relative or caregiver without advance warning or planning.

What can I do if I am on the waiting list?

Waiting for services can be difficult but it is important to remember that ODP is not the only resource available. Everyone who applies to be enrolled in the ODP program will be assigned a SC. A SC can offer information about other resources or programs that you may be able to access for services, assist in developing an ISP to identify goals and outcomes, and help think about what other supports may be available in the community.

The Charting the LifeCourse Tools may also be helpful in planning for an everyday life and figuring out how to find support from other sources in the community. The Integrated Supports Star may be especially helpful (Chapter 1).

Other Community Resources

People with disabilities who need supports to live in their community can access a variety of public and private programs. Some are related to age, some to income level, others by the type of need that a person has. Private programs such as United Way, the Rotary, faith-based organizations, YMCA/YWCA programs, municipal recreation programs, or adult education programs can assist to meet individual needs and can also provide opportunities for staying connected to the broader community. Building these networks expands the range of supports that can be relied on.

Supports for Children

While they are not functions of ODP, the following supports are available for families with children supported through ODP.

Early Intervention (EI) Services provides support and services to families with children birth to age five, who have developmental delays and disabilities. EI support and services are designed to meet the developmental needs of children with a disability as well as the needs of the family related to enhancing the child's development in one or more of the following areas:

- Physical development, including vision and hearing;
- Cognitive development;
- Communication development;
- Social or emotional development; and
- Adaptive development.

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental, and specialty services such as:

- Early: Assessing and identifying problems early.
- Periodic: Checking children's health at periodic, age-appropriate intervals.
- Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems.
- Diagnosis: Performing diagnostic tests to follow up when a risk is identified.
- Treatment: Control, correct, or reduce health problems found.

The Children's Health Insurance Program (CHIP) is Pennsylvania's program to provide health insurance to uninsured children and teens who are not eligible for or enrolled in Medicaid.

Life Stages

Prenatal & Infancy	Early Childhood	School Age	Transition	Adulthood	Aging
					

Financial and Health Resources

Supplemental Security Income (SSI) – When an individual reaches the age of 18, they can apply as an adult and not have their parents' income included in the application; the individual cannot have countable assets of more than $2,000 to be eligible. Contact your local Social Security office.

Temporary Assistance for Needy Families (TANF) – Cash Assistance is available to individuals and families with low income and limited resources through TANF.

Low Income Home Energy Assistance (LIHEAP) – Helps families living on low incomes pay their heating bills in the form of a cash grant.

Supplemental Nutrition Assistance Program (SNAP) – Provides financial assistance to increase purchasing power at grocery stores and supermarkets with an Electronic Benefits Transfer (EBT) ACCESS Card.

PA ABLE – Offers individuals with qualified disabilities, their families, and friends a tax-free way to save for disability-related expenses, while maintaining government benefits. An ABLE account allows individuals to build assets to cover future expenses without jeopardizing Medicaid and SSI benefits.

Physical HealthChoices – Provided through the Medicaid program that covers physical health services, both inpatient and outpatient.

Behavioral HealthChoices – Provided through the Medicaid program. They include behavioral health and drug and alcohol treatment services.

Community HealthChoices – Provides physical health services for dually-eligible individuals (those receiving both Medicare and Medicaid), and individuals with physical disabilities.

Employment Support

Office of Vocational Rehabilitation (OVR) – Provides vocational rehabilitation services to help persons with disabilities prepare for, obtain, or maintain employment. Specialized services are available for students with disabilities transitioning to adulthood.

Ticket to Work – The Social Security Administration's Ticket to Work program is free, voluntary, and available to most people who receive Social Security Disability Insurance (SSDI) or SSI benefits. Eligible beneficiaries may choose to assign their ticket to an Employment Network (EN) of their choice, or to OVR. The ticket helps people get employment services and supports necessary to achieve a work goal.

Medical Assistance for Workers with Disabilities (MAWD) – MAWD is a state Medicaid program which encourages people to work. It allows the person who works to maintain a much higher income and resource level and still maintain Medicaid eligibility than a person who does not work. Contact your local county assistance office (CAO) to find out more about how MAWD works.

Information, Training, and Guidance

Pediatric Complex Care Resource Centers (PCCRCs) – Provide education, training, and non-medical support to caregiver teams to assist with building relationships and co-navigating the various systems and resources that are available to support them.

Autism Services, Education, Resources, and Training (ASERT) – A resource for children and adults with ASD that provides documents, forms, recordings of public webinars, recordings of live training sessions, and access to support groups.

MyODP – A resource for everyone receiving services through ODP that provides information on services, official notices, and training.

Health Care Quality Units (HCQUs) – Provide information and training to providers, County/AE programs, individuals, and families on how to best meet the physical and behavioral health care needs of people in the service systems.

Legal Services – A group of organizations is available to assist Pennsylvanians who cannot afford an attorney with legal matters. Legal help can be accessed at **Disability Rights Pennsylvania**.

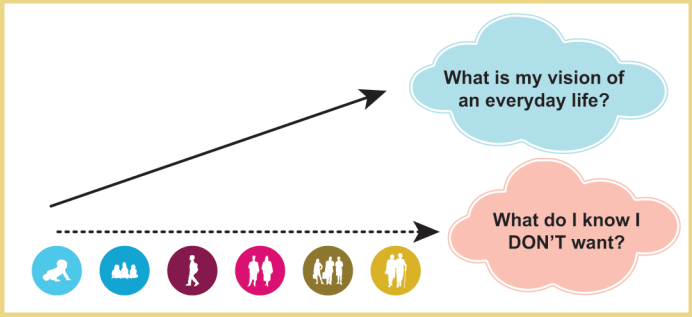
AID in PA – A resource collection for Pennsylvanians in the autism and intellectual disability communities. A joint effort between ASERT and the statewide HCQUs, this site is designed to connect individuals with disabilities, families, professionals, and community members with resources that can best serve them in different situations.

Self Advocates United as 1 (SAU1) – SAU1 is a group of people who envision a world where people with developmental disabilities and their families are united to share knowledge, empower others, and use their voices to transform their communities and people's lives.

Pennsylvania Family Network (PAFN) - Vision for Equality – PAFN was created under the leadership of Vision for Equality and is supported by ODP as part of Pennsylvania's Community of Practice: Supporting Families Throughout the Lifespan.

Services and Supports - Supporting a Vision for an Everyday Life – Services available through ODP have several purposes:

- Support personal growth and development;
- Support people's ability to engage fully in community life; and
- Support the life you want.



Services and supports can assist family, friends, and employers with achieving a vision of an everyday life.

Paid services can be woven in to enhance the support you receive from family, friends, and community resources.

Reminder

The LifeCourse Framework helps plan a future and determines what services will be most valuable (reference Chapter 1). The chapter organizes the services within the domains of the LifeCourse Framework.

Daily Life and Employment

The services in this section support individuals in their everyday life – school, employment, volunteering, engaging in community, daily routines, and developing life skills. Work is an important part of life. It provides opportunities to work with others, increases our income, and contributes to our communities. In addition, work also contributes to good physical and mental health.

Pennsylvania is an employment first state, which means all people will be offered the opportunity to work and the services to help them succeed. Services are designed to remove barriers and build incentives to work.

Concerns about income and maintaining eligibility for services can be addressed through establishing an ABLE account to build up a savings account without jeopardizing benefits.

Questions

In-Home Community Support, Respite, or Companion Services – How do I know which one?

The decision to choose in-home and community support is determined by the individual's assessed needs. Individuals may have one, or all, of these services in their ISP. There are limits on the number of hours per day, week, or year that many services can be accessed. Please check the definitions listed previously and/or with the SC.

In-Home and Community Support should be used when learning skills and working toward achieving the goals and outcomes in the ISP.

Companion Services can be used in situations where supervision is needed as well as minimal assistance to stay healthy and safe. These services are helpful when an individual is not learning, enhancing, or maintaining a skill. The outcome related to companion services only relates to assistance and supervision to ensure health and welfare.

Respite Services is the correct service when the family or caregiver, who is normally and primarily responsible to support an individual, is absent or needs relief from providing care on a short-term basis.

What do I do if I need more hours of services than the service definition allows?

If more hours for services are needed than what the service definition offers for a particular service, (like In-Home and Community Support) a request can be made to the SC to complete the variance form (DP 1086). The need for this variance (difference) must be discussed with the SC, and the ISP must reflect the need for the change. The variance will be submitted to the authorizing County/AE and ODP, as needed, for review of assessed need and a decision.

How do I find the right provider for the services I need?

One way to get help is to contact the County/AE, or for the AAW, the Bureau of Supports for Autism and Special Populations (BSASP), formerly the Bureau of Autism Services. These numbers can be found in the Resources at the end of this book. Many services and programs are already established and offered in the County/AE. Visit them and ask questions. See if they can provide the needed services. The SC is also another person that can be contacted to discuss the individual's needs.

All providers must meet provider qualification standards to deliver services. ODP has set requirements for education and training for the services in the waivers. Each provider must demonstrate that they meet or exceed those standards before they are permitted to provide services in Pennsylvania.

Things to Remember:

- The individual has a right to choose any willing, qualified provider in Pennsylvania.
- The individual may cross County/AE lines to find services and supports.
- The individual may be able to access some services through providers in neighboring states if they are willing and qualified to serve you.
- The individual may change providers at any time if they are not satisfied with the services they are receiving.
- If the individual moves to another County/AE, their waiver moves with them. Individuals and families should work with the new County/AE and the providers in the County/AE they are moving into to ensure a smooth transition to new providers if necessary. ACAP is not transferable except within the counties where it is available.

There are a few other ways to figure out who provides services in the area where you live:

- Use the Provider Online Directory
- Ask a SC; and
- Ask other families and friends.
- Use the Performance Based Contracting Supports Coordination Organization Directory

If an individual is enrolled in a waiver, they need to decide how they would like their supports and services managed. An individual can select the providers who provide their services, or an individual can self-direct their services by becoming an employer or managing employer to direct their services.

A traditional provider is one that enrolls with ODP to render services and hires staff (not self-directed or participant-directed). When selecting one or more traditional providers to manage the services, there are many things to consider. Chapter 7 reviews a list of possible questions to ask providers.

Once a provider is selected and they agree to provide services, they are expected to hire the necessary staff. Some providers will allow individuals to participate in the staff selection process. Providers are not required to do that so, if it is important to the individual, they should ask about participation in staff choice when selecting a provider/agency.

What services can be provided when traveling or on vacation?

These services can be provided to participants of the Consolidated, Person/Family Directed Support and Community Living Waivers anywhere during temporary travel. The only exception is Respite Camp which can only be provided in Pennsylvania, Washington DC, Virginia, or a state contiguous to Pennsylvania:

- In-home and community support
- Residential habilitation (licensed and unlicensed)
- Life Sharing (licensed and unlicensed)
- Supported living
- Shift nursing
- Supports Coordination
- Specialized supplies
- Supports broker
- Behavioral support
- Companion
- Respite
- Speciality Telehealth and Assessment Team (STAT) and Supports Coordination

The following services can be provided to participants in the AAW waiver anywhere during temporary travel.

- Specialized Skill Development - Behavioral Specialist, Systematic Skill Building and Community Support
- Supports Coordination
- Residential Habilitation
- Life Sharing
- Respite

An individual cannot exceed the authorized units for a service while on temporary travel. All service and program requirements, such as provider qualification criteria and documentation of services, apply during the period of travel. The location for temporary travel is not limited to Pennsylvania. Temporary travel can occur anywhere if the individual's health and welfare can be met during the temporary travel.

County/AEs shall ensure that this travel policy is explained to all individuals at the time of waiver enrollment and reviewed annually at the time of the ISP meeting. The SC shall document this annual review in a service note in HCSIS.

The following conditions apply to the travel situation:

- The provision of waiver services during travel is limited to no more than 90 calendar days per ISP plan year.
- The travel plans are renewed and discussed as part of an ISP team meeting, and the team identifies safeguards to protect the individual's health and welfare during travel.
- The roles and responsibilities of the individual and the direct service professionals providing waiver services are the same during travel as at home.
- The individual is responsible to fund their own travel costs through private or non-system funds.
- Travel costs for agency staff, contracted personnel, or individual providers may be funded through private funds of family members of the individual or non-intellectual disability system funds generated through fundraising efforts or other means.
- If the individual decides to pay for the travel costs, there must be documented team consensus that this was the voluntary and willful decision of the individual.

The waivers will not fund the travel costs of the individual, the provider, or the direct service professionals.

Chapter 5

Self-Direction through Participant-Directed Services

Self-direction refers to the ability of individuals and families to direct the supports and services that are received. Directing services and supports can be important for some individuals and families to have an everyday life for small things like what to eat or wear, to major life decisions such as where to live or whom to live with. The freedom to make decisions about our lives and to determine our future are essential for our personal growth, positive mental health, and happiness. When people need services and supports to live an everyday life, it is important that those services and supports accomplish what is necessary to have the life they want. The Life Course tools build self-direction into decision making and life planning by helping individuals and families think through all options, anticipating future needs, and thinking through what people need to have a good everyday life.

Financial Management Services (FMS)

Participant-Directed Services provide individuals and families with the ability to directly control services and supports. Directing services enables individuals and families to hire the people they want to support them, including friends and family members, and to schedule the support when it will be most helpful. There are two models of participant-directed services that provide the individual with control over their services and supports:

1. The individual/family can be the employer with the authority of an employer (Vendor Fiscal/Employer Agent (VF/EA)); or
2. The individual can choose to be a co-employer or managing employer along with an agency (Agency With Choice).

In both models, the individual will get assistance to carry out the responsibilities of an employer through FMS.

The primary functions that are performed by FMS are:

- To reduce individuals'/representatives' employer-related burdens by providing appropriate fiscal and supportive services; and
- To assure the Commonwealth and AEs/County/AE Programs that support services are being provided in compliance with federal, state, and local tax and labor requirements related to the employment of qualified support service professionals.

FMS provides payroll services for your support service professionals and pays federal, state, and local taxes, workers compensation premiums, and unemployment insurance on your behalf.

There are two models of FMS to choose from in the ODP system:

Vendor Fiscal/Employer Agent (VF/EA)

Under the VF/EA model, the individual is the common law employer. The VF/EA FMS receives approval from the IRS to be an "employer agent" on behalf of the individual for the limited purposes of handling employment and income taxes. The individual is the "Employer of Record."

Using this model, the individual will be able to:

- Recruit and hire qualified support service workers;
- Determine worker schedules;
- Determine worker tasks and how and when they will be performed;
- Orient and train workers;
- Manage the daily tasks performed by workers; and
- Dismiss workers when appropriate.

Agency with Choice (AWC) FMS

In this model, the AWC FMS is the legal employer/"Employer of Record." The individual is the managing employer and directs their workers daily activities. This means that the individual and the AWC will be co-employers.

As managing employer, the individual works with FMS to:

- Recruit and refer potential support workers to the FMS for hire;
- Provide and/or participate in training workers;
- Determine worker schedules;
- Determine worker tasks and how and when they will be performed;
- Manage the daily tasks performed by workers; and
- Dismiss workers when necessary.

Both models allow the individual to access supports broker services to assist with employer functions, like recruiting, interviewing, hiring, scheduling, and managing workers.

The individual may also designate a surrogate to assist in hiring and managing services and to act on behalf of the individual as the employer. A surrogate is someone the individual knows well and is trusted to help.

Who can direct their own services?

Individuals not receiving residential services may direct their own services if enrolled in the Consolidated Waiver, Community Living Waiver, and the P/FDS Waiver. This is not available in the AAW or ACAP. Individuals served in AAW or ACAP who are interested in directing their services should discuss this with their SC.

Individuals may also choose to direct their own services if living in a private home, in their own home or apartment, or the home of a family member. Individuals who receive Residential Habilitation, Life Sharing, or Supported Living generally cannot use participant-directed services. There is one exception for participant direction of Supports Broker when the person has a plan to move to a private home and self-direct services through a PDS model in that private home.

What services can you direct?

The services that can be self-directed include and are limited to:

- Companion
- Supports Broker Services
- Supported Employment
- In-Home and Community Support
- Homemaker/Chore
- Respite.

Individuals receiving residential habilitation services may use support broker services only when transitioning to participant directed services.

Individuals who self-direct have access to all other waiver services (except residential) including: transporation, home accessibility adaptations, vehicle accessibility adaptations, assistive technology, education support services, and specialized supplies.

Policies for Self-Directed Services

There are a number of rules for directing your own services. Below are some of the main rules:

Worker Qualifications

All support professionals that are hired must meet the criteria and qualifications for the services they are hired to provide. A SC or Supports Broker can help with understanding the criteria for each service.

Having a Backup Plan

All individuals are required to have a backup plan to address situations when a paid support person (paid relative or non-relative) or legal guardian does not report to work. ODP recognizes, however, that there may be extenuating circumstances that cannot be addressed through the plan. In general, these situations include, but are not necessarily limited to:

- Unexpected circumstances such as inclement weather, sudden illness, or the unplanned extension of medical leave, that prevent a regularly scheduled worker from arriving at the job site and where another worker/caregiver is not immediately available to work.
- Situations where a regularly scheduled worker is terminated or refuses to provide care without providing adequate notice (e.g. the worker notifies the employer that he or she refuses to work on the day he or she is scheduled to provide the service or is dismissed due to gross non-compliance or misconduct).
- If any of the above situations occur, ODP requires the backup plan to be reviewed and revised as necessary to prevent recurrence of the above.

Hiring Relatives

Individuals may be interested in having their parents, sisters, brothers, grandparents, and other relatives provide supports. Individuals may also want to consider hiring friends, neighbors, legal guardians, and other people they know and trust as support. There are specific requirements for hiring relatives and family members.

The basic requirements for support professionals are:

- 18 years old;
- Have a criminal background check;
- Are willing to carry out the services in the ISP;
- Have necessary training to implement the ISP; and
- Have a valid driver's license (if they are providing transportation).

The policies related to services by relatives, legal guardians, and legally responsible individuals are outlined below. Please note that there is one set of polices that apply to relatives and legal guardians and a separate policy that applies to legally responsible individuals.

A relative is any of the following related by blood, marriage, or adoption who have not been assigned as legal guardian for the participant: a spouse, a parent of an adult, a stepparent of an adult, grandparent, brother, sister, aunt, uncle, niece, nephew, adult child, or stepchild of an individual or adult grandchild of an individual. For the purposes of this policy, a legal guardian is a person who has legal standing to make decisions on behalf of a minor or adult (e.g. a guardian who has been appointed by the court).

If an individual lives in their own home, or in their family's home, family members can be hired to provide some services through the waivers.

Relatives and legal guardians may be paid to provide waiver services when the following conditions are met:

- The individual has expressed a preference to have the relative/legal guardian provide the service(s).
- The service provided is not a function that the relative or legal guardian would normally provide for the individual without change in the usual relationship among members of a nuclear family.
- The service would otherwise need to be provided by a qualified provider of services funded under the waiver.
- The service is provided by a relative or legal guardian who meets the qualification criteria that are established by ODP in Appendix C-3 of the approved waivers.

Services that relatives or legal guardians can provide are limited to the following:

- In-Home and Community Support;
- Companion;
- Life sharing;
- Supported employment;
- Shift nursing; and
- Transportation (mile).
- Supports broker services and respite services - may be provided by relatives and legal guardians who are not the participant's primary caregiver when the conditions in the bulleted list above are met. The primary caregiver is the person who normally provides care to the individual.

Relatives who do not live with the participant or are not responsible for direct care of the participant may render the Family Medical Support Assistance service.

Relatives or legal guardians may also provide base-funded respite services only when the relative or legal guardian does not live in the same household as the individual, and when the conditions in the bulleted list above are met.

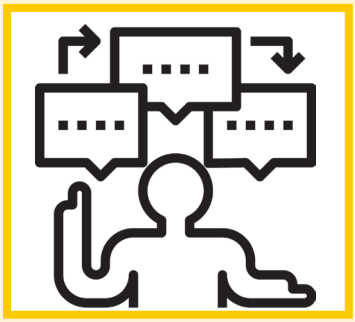
There are limits on the number of hours of In-Home and Community Support and companion services that can be provided by relatives and legal guardians in both participant-directed service models. Those limits are:

- Any one relative or legal guardian may provide a maximum of 40 hours per week of authorized In-Home and Community Support, companion, or a combination of the two services (when both services are authorized in the ISP).
- When multiple relatives and/or legal guardians provide the service(s), each individual may receive no more than 60 hours per week of authorized In-Home and Community Support, companion, or a combination of the two services (when both services are authorized in the ISP) from all relatives and legal guardians.
- An exception may be made to the limitation on the number of hours of In-Home and Community Support and Companion provided by relatives and legal guardians at the discretion of the Agency with Choice organization or common law employer when there is an emergency or unplanned departure of a regularly scheduled support professional for up to 13 weeks in any fiscal year.

Legally responsible individuals may also provide the following services:

- Supported employment;
- Supports broker;
- Transportation (mile) solely to drive youth under the age of 21 to and from a waiver service or a job that meets the definition of competitive integrated employment; and
- In-Home and Community Support.

Chapter 6



Individual Support Planning

Forming a vision and beginning to plan for the future should be the driving force in developing a plan to create a full, inclusive, quality life in the community. This section will take individuals and families through the process, so everyone knows what to expect.

Evaluations and Assessment of Need

Once eligibility for services is determined, and prior to the initial planning meeting, individuals and families will participate in evaluations and assessments to identify needed supports. The Supports Intensity Scale (SIS™) and the PA Plus Supplement is the required statewide needs assessment for the P/FDS, Community Living (CL), and Consolidated waivers.

The AAW and the ACAP utilize the Bureau of Supports for Autism and Special Populations (BSASP) assessment protocol. The assessment tools that must be used for participants in the AAW:

- Autism Supports Assessment Protocol (ASAP)
- Periodic Risk Evaluation (PRE)
- Waisman Activities of Daily Living Scale (W-ADL)
- Social Responsiveness Scale, 2nd Edition (SRS-2)
- Online Readiness Checklist

In addition to the required assessments, the individual and team may also gather information from other evaluation and assessment tools. This may include functional behavior assessments, person centered planning tools, vocational assessments, and other formal and informal assessments which may be helpful to identify your specific needs.

"The future is not something we enter.
The future is something we create.
And creating that future requires us to make
choices and decisions that begin with a dream."

– Leonard Sweet

What are the SIS™ and PA Supplement?

The SIS™ and PA Supplement (specific to the P/FDS, CL, and Consolidated waivers) is a means of measuring the supports needed to live an everyday life. It is a standardized needs assessment, which means everyone is asked the same questions and receives the same measurements regardless of where they live or who does the assessment. The information from the assessment is made available to the SC, who will then share the results with the individual and anyone whom they choose, including members of the ISP team. The results help develop the ISP. All needs identified in the evaluation process must be addressed within the ISP. Not all needs require direct paid services. However, the ISP must describe how the need will be addressed through informal, unpaid supports or through other resources.

Supports Intensity Scale

The SIS™ is a nationally recognized assessment instrument developed by the American Association of Intellectual Disabilities and is used by many different states to determine need. Topics included in the SIS include home living, community living, lifelong learning, employment, health and safety, social activities, protection and advocacy, exceptional medical and behavioral support needs, communication, and assistive technology.

PA Supplement

The PA Supplement is a separate set of questions administered at the same time as the SIS to provide more information related to vision, hearing, ambulation, communication, safety needs, and information regarding the use of and/or need for assistive technology. In addition, the PA Supplement also considers information regarding the need for excessive supports.

By answering a series of questions with a PA trained assessor (interviewer), areas of life are examined to see how much, how often, and what kinds of supports are needed. The SIS™ focuses on what supports are needed to have an everyday life, not on what an individual cannot do.

The SIS™ and PA Supplement are used with other sources of information to help you and your team before and during the ISP planning process.

Who receives a SIS™ assessment and when?

As part of the process, everyone found eligible and applying for services through the P/FDS, CL, and Consolidated waivers will receive a SIS™ assessment. Assessments are typically done before the initial ISP and then every five years, unless the circumstances change and a new assessment is needed.

Who is involved in the SIS™ interview?

The individual and at least two qualified respondents, people chosen by the individual who can give good information about support needs, should be at the meeting. Respondents must be people who have known the individual well for at least three months and can describe their needs in a variety of settings. The person receiving services, their family members, direct support professionals, providers, friends, coworkers, and others may participate. It is up to the individual to decide who they want to invite to the assessment meeting. An assessor (interviewer) who lives in Pennsylvania and has extensive training will conduct the interview. The SC may participate as a respondent if they meet the criteria or they may attend to listen and observe to inform ISP development.

What is the assessment process?

Whether the SIS™ assessment or the AAW and ACAP assessment protocol are administered, a scheduler will contact the individual by telephone and discuss who will be attending and participating in the assessment process, as well as meeting times, dates, and other requested attendees. Every attempt will be made to schedule the assessments prior to the individual's ISP review date to allow the team access to the results before the ISP meeting.

Individual Support Plan (ISP)

The ISP is a plan designed by using a Person-centered Planning approach. Person-centered Planning discovers and organizes information that focuses your strengths, choices, and preferences. The LifeCourse tools can help do this. It involves bringing together people that will support the individual in the planning process, listen to the individual, describe the individual as fully as possible with a true focus on understanding who they are, and dreaming and imagining possibilities.

The ISP development process is not only about services.

This section describes how an ISP is developed in the service system, but having a plan is important whether or not the individual is in the service system or getting services. Knowing where you are going in life and figuring out how to get there is important for each of us. Services can help but they alone are not enough. Our relationships, community resources and activities, and our own creativity are just as important.

The ISP process, led by the individual and the SC, is the most critical activity in helping to envision a good life and develop outcomes to achieve the desired life. It is a way to help explore the experiences, opportunities, and resources available to the individual through family, friends, and the community.

It is also a way to identify what services can enhance those resources and opportunities. The ISP meeting is held at least annually, but also may be called whenever it is felt a change in the plan is necessary.

The SC assists the individual with understanding the ISP process. This includes thinking about relationships that are important to them, activities that are enjoyable and important, what kinds of growth experiences the individual would like to explore, what kind of job the individual might like, whether there are any health or safety risks that must be planned for, what the immediate needs are as well as the needs they anticipate in the future, and what types of services would be best for achieving the quality of life that the individual hopes to have.

Who is on my ISP team?

In preparation for the support plan development, the Supports Coordinator (SC) encourages meaningful participation from the individual. The SC also assists in ensuring the necessary supports and accommodations are provided so that everyone can participate.

The SC supports the individual in determining who should be present and involved in the development of the ISP. It is important to include people who know the individual best and who will offer detailed information about preferences, strengths, and needs.

The ISP team consists of:

- The individual;
- The Program Specialist or Family Living Specialist;
- The SC;
- Direct care staff;
- People who are important in the individual's life and that they choose to include; and
- Other provider staff supporting the individual.

The SC is responsible for reaching out to determine preferences about the date and location of the ISP meeting. The SC should make at least three attempts to contact the individual to discuss this information. After the discussion takes place, the SC is responsible for accommodating those preferences to the best extent possible.

Some things the SC should discuss with the individual regarding the meeting location include:

- It should be a place where they feel comfortable.
- It should be accessible to all ISP team members.
- It should have enough space to accommodate all ISP team members.
- It should be as free from distractions as possible, so the ISP team members can focus on what everyone has to say during this very important meeting.

If, by the third attempt, the individual refuses or has not provided input on their preference in scheduling the meeting, the SC will proceed in scheduling the meeting in accordance with current state guidelines.

ISP Invitation Letter

Once the ISP meeting details are confirmed, the SC develops the ISP meeting invitation letter and sends it to the individual, their family, team members, and other people of the individual's choice who may contribute valuable information during the planning process. The invitation must be sent to all ISP team members at least 30 calendar days prior to the annual ISP meeting.

Please note the SC can develop an ISP invitation letter that identifies all team members who are invited to participate in the ISP meeting or send a separate invitation letter for each invited team member.

The ISP Team Meeting

The ISP is developed by the individual and their ISP team. The meeting is facilitated by the SC. However, the individual can lead the ISP meeting if they choose.

All ISP team members play vital roles in the ISP meeting. It is to the individual's benefit to fully participate. Be prepared to share knowledge, perspective, and insight, so the SC can develop the ISP based on that information. Each ISP team member will ensure that information provided is current and presented professionally and with sensitivity. The information collected presents a complete picture of the individual. Specific examination of information will be part of the ISP process, including possible changes in the current living situation or health status, incident reports, monitoring findings or other changes that will impact the health and welfare, services and supports, or ability to have an everyday life. Service options must be promoted and fully explored with each individual.

To achieve an ISP that is relevant and leads to the life the individual wants to live, the process needs to happen in plain language and in a way that everyone, including the individual, can understand and participate in freely. It is important for everyone to be sensitive to the experiences the individual and their family have had, including cultural differences. If the individual communicates differently (sign language, Picture Exchange Communication, etc.) or if the primary language of the family is not English, the ISP process should use their way of communicating. Someone who knows the individual and the family well can interpret or a paid interpreter can be used.

Annotated ISP – Review the form before your ISP meeting.

Before the first ISP meeting, it may be helpful for the individual and family to review the ISP form (also called the annotated ISP). This will ensure they are prepared with information and have considered personal goals and expected outcomes. A copy of the ISP form is available from the SC.

What information should go into the ISP?

The ISP form is made up of six main sections: Individual Profile, Medical, Health and Safety, Functional Information, Financial, and Services and Supports. This form becomes the record of the individual's needs. The team will also receive a copy of this form to refer to whenever needed. Each plan should be written so that anyone who reads it will know who the individual is, what is important to them, what they need, and who to support them in their life.

Questions Related to Individual Preferences

The following questions will help the entire ISP team begin thinking of important information about the individual's preferences used in developing the ISP. It may be helpful for the individual and those who support them to make a list of these questions before the annual ISP meeting. Make some time to go over each question and write down answers to bring to the ISP meeting. Everyone should include their first name on their list of questions and answers, so the SC can easily identify who provided what information on the individual's behalf. The individual can also bring their own questions and ideas.

What do people like and admire about you? With your family, friends, and people who know you best, discuss what people like about you. What do they think you have done that you should be proud of? What are you good at? What do people think about when they think about you?

What makes sense for you? When answering this question, you and those who support you should write down what works best for you in your life right now, what needs to stay the same, and what can be improved.

What are the activities you would like to participate in or explore? Using the **LifeCourse Trajectory**, you can look at what experiences or opportunities you would like to have in your life that will lead you toward the vision you have of a good life.

Consider job/work opportunities, community connections/programs, learning new skills or hobbies, and things that you would find enjoyable such as connections with other people, helping others as a community volunteer, etc.

What activities are important to you? Make a list that describes what needs to stay the same in your life and/or changes that would be important for the team to address. Consider relationships, job situation, living arrangement, health and safety, etc. In the list, decide and prioritize what you absolutely need and strongly desire.

What does someone need to know to support you? Be sure to talk with the people who know you best to outline your traits, habits, coping strategies, preferences for interaction and communication, relationships, types of activities, approaches, or reminders that have been helpful to you. This information can assist others in supporting you.

What makes sense? What works for you? Ask those you know best. Their opinions will help you and your team reach agreement on the best supports to help you attain an everyday life.

What are your medical needs? A list of your medical history, diagnoses, and needs is required to complete your ISP. Part of the Waiver requirements is an annual medical evaluation. This is not optional.

Make a list of your prescribing doctors' and dentists' names, addresses, and phone numbers, a list of all medications and dosages, a list of any allergies, and the dates of any health evaluations (eye doctor, hearing test, specialist visits, etc.).

What does not make sense? When answering this question, you and those who support you should write down what's not working for you in your life right now, what needs to change, and what must be different.

Areas Related to Health and Safety

Health and safety risks are also part of the ISP. Information gathered during your SIS™ assessment is valuable and should be incorporated into your ISP. Health and safety questions describe your ability to give yourself medicine, note if you need protection from heat sources (stove, grill), and your needs in the following areas:

Outdoor Appliances – Your ability to use outdoor appliances (gas grill, lawn mower, weed whacker). This information should include the level of supervision required.

Fire Safety – Your ability to react during a fire. Have you received fire safety training? This information should include the level of supervision and assistance you need to evacuate any place you spend a lot of time.

Traffic Safety – Your traffic safety awareness. This information should include the level of supervision required.

Cooking/Appliance Use – Your ability to use cooking and kitchen appliances. This information should include the level of supervision required.

Safety Precautions – Your ability to understand safety precautions and instructions (such as wearing seat belts, bike helmets, and other safety equipment when necessary), including handling or storage of poisonous substances.

Knowledge of Self-Identifying Information

These questions are about your ability to give self-identifying information such as your name, address, and phone number, as well as your ability to responsibly carry this information.

Community Supervision – Some examples of community activities are eating in a restaurant, taking public transportation, etc. Can you be left alone during community activities? How long? Describe any plans to increase time alone. Always indicate if intensive supervision is required. Intensive supervision is defined as one-to-one supervision within arm's length.

Meals/Eating – Your ability to eat during mealtime. This information should include the level of supervision required during meals, information from dietary and nutritional appraisals, and any information about adaptive equipment/assistive technology.

Home Supervision – Can you be left alone at home? How long? Describe any plans to increase time alone. Always indicate if intensive supervision is required at home. Intensive supervision is defined as one-to-one supervision within arm's length.

Day Supervision – Some examples of day activities are volunteering, working, and attending training centers, etc. What is the level of supervision you need during day activities? Can you be left alone during day activities? How long? Describe any plans to increase time alone. Always indicate if intensive supervision is required. Intensive supervision is defined as one-to-one supervision within arm's length.

Behavioral Support Plan (BSP) – Do you have a Behavior Support Plan in place? Yes or no? If yes, is it restrictive? Does it limit your movement, activity, or function? Does your Behavioral Support Plan interfere with your ability to acquire positive reinforcement, result in the loss of objects or valued activities, or require a particular behavior that you would not normally do if you could choose?

In the absence of a BSP, certain licensed settings may find that a Social, Emotional, and Environmental Support Plan (SEEP) will be best to support your needs. This plan may be written by a medical professional, psychologist, etc… to support your health and safety in those settings beyond medications.

Stranger Awareness – Your ability to interact with strangers. This information should include the level of supervision required.

Functional Information

Physical Development – Describe your skills and needs that include gross (large muscle) and fine (small muscle) motor, vision, and hearing, as well as gait assessment, transfer, and positioning needs.

Communication – Describe your skills and needs that address expressive/receptive, language, and assistive technology skills and needs if appropriate. Communication can be verbal or nonverbal, overt or subtle actions or gestures that you use to tell others what you need, want, like or dislike, and what is important to you. Communicative actions help others understand you and respond in a helpful way. This is important knowledge of people who know you well, so that those you will meet in the future will understand your communication style. If you use assistive technology, it is important that your skill and needs be described. This is critical information to be included in your ISP.

Adaptive/Self-Help – Describe your skills and needs that include development in areas such as eating, drinking, toileting, bathing, etc. Also include skills and adaptations needed while showering and bathing (seating, rails, supervision, etc.).

Learning/Cognition – Describe your skills and needs about how you learn and process information, think, remember, reason, problem-solve, make decisions, manage money, etc.

Social/Emotional Information – Describe your skills and needs related to the process of learning to control your emotions, having empathy and respect for others, and having the ability to initiate and maintain social contracts.

Educational/Vocational Information – Describe your education and vocational needs. Are you a student? If yes, what school do you attend? What grade are you in now? Are you in a training program? Are you connected with the Office of Vocational Rehabilitation (OVR)?

Employment Information – Do you have a job? Do you want a job? What are your job-related goals?

Financial Information – You will need to provide your Social Security number (SSN) and information about Social Security and SSI benefits. You will need to provide other information on benefits you receive such as Veteran's benefits, railroad retirement fund benefits, civil service annuity benefits, etc. You should also have your personal resource information available. Personal resources include life insurance, trust/guardianship, burial reserve, burial plot, pre-paid funeral arrangements, checking and savings account information, ABLE account, and information about property you may own.

Services and Supports: Developing Outcomes in Your ISP

Each ISP team uses outcome statements to determine the needed services and/or supports. The health and safety of the individual must always be addressed throughout this process. All outcomes should be written down in the ISP, even if they are not supported by formal services. Outcomes or goals should look like the vision the individual shared in their Life Trajectory.

An outcome is a desired result. Outcomes show what will happen as a result of the actions taken or the support received. Outcomes represent what is important to the individual, what they want to happen, what they would like to maintain based upon the assessed needs, and things they would like to change. Information gathered during the ISP meeting about things that could make a difference in the individual's life and meet the assessed needs are used in developing outcomes. Any barriers and obstacles that might affect success in meeting outcomes, especially if these barriers impact health and welfare, should be addressed. Outcomes are written in plain language. Outcomes should build on the information and assessments that the ISP team gathers during the planning process and reflect a shared commitment to action.

NOTE: The AAW and ACAP waivers use the terms "goal" and "objective" instead of "outcomes." A goal is the long-term vision that an individual is wanting to achieve. It may take a few years to reach that long-term goal. An objective is the step or steps needed to reach the long-term goal. Typically objectives are written in terms of what is realistic to achieve within one plan year. Goals and objectives can be changed at any time to align with what the individual desires.

Writing an Outcome Statement – Outcome statements will link what the individual and team will be doing to the outcome the individual wants through phrases such as "in order to" and "so that" because they are helpful in connecting how the outcome will make a difference in the individual's life.

Typically, an outcome will use the person's name followed by the action and the reason for the action. An example is:

> *"Kate participates in the church bell group in order to enjoy music and socialize with friends in the community."*

"Kate participates" – the person and the action that is expected "in order to enjoy music and socialize with friends in the community" – why the action is important to or for the person.

> *"Matthew volunteers at the Salvation Army store so that he can decide whether retail work is something he can do."*

Another example – Matthew's ISP team knows that finding a job, being part of a team, providing a service for other people, and following a routine are important to him. Several ISP team members have expressed concern that working in a store could be too physically demanding for Matthew due to his physical disability.

This outcome will guide the team to the services and supports Matthew will need in order to move toward his dream of getting a job.

Services and supports can be directly tied to one or more outcomes and should promote the outcomes. "Outcome actions" is another term for identifying the supports and services an individual may need to live an everyday life.

Continuing with Matthew's example above, Matthew needs transportation to get to his volunteer work. The services and supports to meet that outcome might include a paid service, such as bus fare, and support to learn how to use the bus system. If buses are not available where Matthew lives, he might have to rely on a natural support such as a friend or a family member or a paid support person. In either case, transportation must be addressed in the ISP.

The Service Summary of the ISP will list the frequency and how long you need the service(s), the cost of each service, who is paying for it, and who is providing the service. In some situations, you might think that you need more service(s) or supports than is generally allowed.

Each Individual's Approval of the Plan: The ISP Signature Form

The ISP signature form is a department-approved form that the individual is asked to complete and sign at the end of the ISP meeting. Signing the ISP signature form says that the individual attended the ISP meeting and agrees with all the information that was discussed, the content of the ISP, and information that was changed as a result of the meeting. The individual will answer a series of questions that states they understand what took place and what is available to them.

If there is a disagreement with the content of the ISP, there is a place on the signature form where the individual can sign and indicate that they have an objection. The County/AE or the Bureau of Supports for Autism and Special Populations (for AAW or ACAP) has the responsibility to try to resolve the objections that are raised. This resolution process should not delay authorization of other services in your plan.

If the individual and their team have concerns that certain services do not meet the individual's needs because it has a limited number of hours, the team can request that the SC fill out a variance form (DP 1086). A variance is a requested change in the rules of a service definition or the way a service is usually provided. Things such as needing enhanced services (more intense support) or more funding for assistive technology also require a variance form to be completed.

What if I have an ID/A Waiver and disagree with something in the ISP? If the individual is in the P/FDS, CL, or the Consolidated waiver and the individual wants to ask for a change to the ISP or the services in the ISP that the team does not agree with, then the individual can complete a Waiver Service Request form and submit it to the County/AE. It must be submitted within 10 days of the team meeting. The SC will provide the form and assist with completion. The County/AE must provide a written approval or denial of the request within 20 calendar days of when they receive the form.

If the County/AE approves the request in full, a critical revision to the ISP is completed, the plan is approved, and the change is authorized. The requested service(s) should start within 30 calendar days of that written approval. If the County/AE partially approves the request, then partial or time-limited services will be approved through a critical revision of the ISP.

If the County/AE denies the request, the County/AE will send an explanation of why this request was denied at least 10 calendar days from the date of the written notice. The individual has the right to file an appeal and request a fair hearing. The County/AE must receive the appeal request within 30 calendar days of the date on the notification of denial.

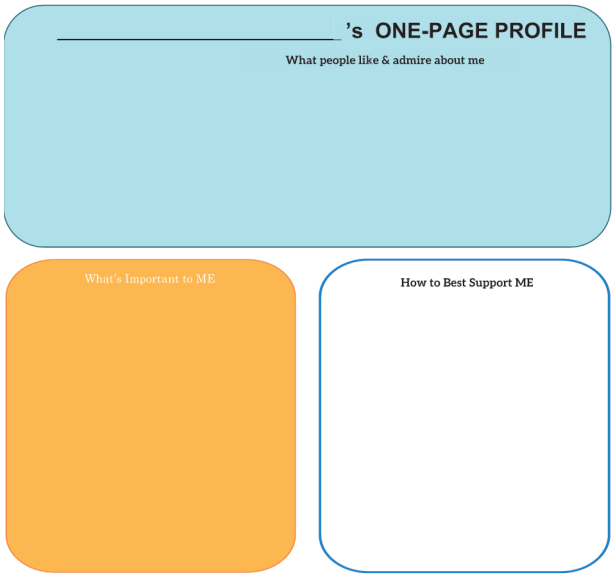
The process for AAW and ACAP is somewhat different. Counties are not involved. Ask the SC how a request to change the ISP is made and ask them to assist with the request.

The right to appeal applies to the AAW and ACAP. For further information on appeals and what your rights are in the waiver programs, you can turn to Chapter 5 of this publication.

Using the LifeCourse Tools to Help Develop the ISP

The LifeCourse Tools are comprised of values and principles that were created to help those of all abilities and all ages develop a vision for a good life based on an understanding of your dreams and preferences. In creating an everyday life, you need to be encouraged to think about what you need to know and do, how to identify or develop supports, and how to discover what it takes to live the life you want to live.

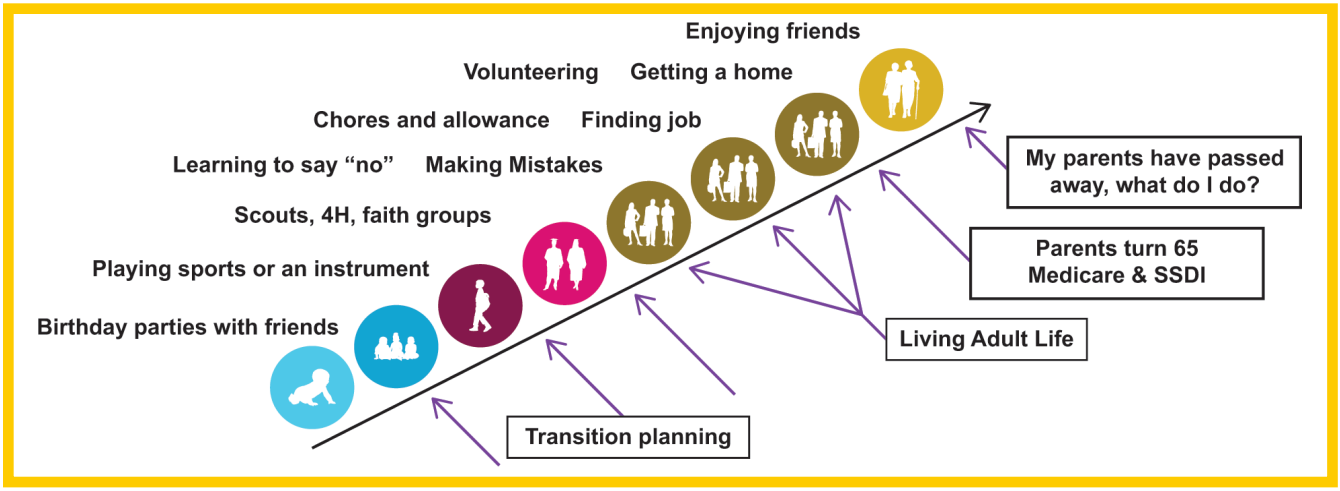
The LifeCourse Portfolio



One-Page Profile – A one-page description and person-centered thinking tool developed by the Learning Community and adopted into the **LifeCourse portfolio**. The One-Page Profile includes three parts:

- Like and Admire;
- Important to Me; and
- How to Best Support Me.

One-Page Profile tools are tools that can assist with positive support and change regardless of age and circumstances. They should be flexible and are useful for specific situations. They also provide an at-a-glance way of knowing what really matters to you as you move throughout the lifespan. You can use the information in your One-Page Profile in the Individual Preferences section of your ISP, right at the beginning of the planning process. This will ensure that the ISP contains the right information about what is important to you and that the services identified in your plan reflect how you wish to be supported.



The Trajectory – In developing your ISP, you can make sure your outcomes reflect your vision of a good life. The day-to-day experiences on your trajectory should be included in your plan so that you are supported to engage and participate in those community activities with your family and friends. You may focus on your current situation and stage of life, but you may also find it helpful to look ahead and think about life experiences that will help you move toward the life you want and one which includes all facets of community life.

The experiences and opportunities along your trajectory can be supported by paid services and other supports. In the past, conversations about supporting people with disabilities and their families mainly revolved around the supports offered by the disability service system. We are trying to help families, as well as organizations and policymakers, understand that we ALL access a variety of supports to make it through our daily lives.

The Integrated Supports Star can help you find supports. It is a problem-solving tool. In the center of the star, place your goal or concern you want to address. Around the center are five points each representing an integrated support that we all use to be successful in our everyday life including: Personal Strengths and Assets, Technology, Relationships, Community Based, and Eligibility Services.

In each part of the star, identify your current supports in that area. Think about your goal, specific experiences you want in your life, or a current concern. Now you can brainstorm or identify potential supports that may be helpful in creating a positive solution to assist you in achieving your desired outcome.

Everyone needs supports to lead good lives. Using a combination of different kinds of supports which include paid and unpaid supports, helps to create an inclusive, quality, and community life. The eligibility specific supports, like waiver services, can help bolster other points of the star. For example, In-Home and Community Supports can help you to develop relationships with people and provide services in community settings, like the YMCA, your church, or at the grocery store. The paid services can be used to improve your independence and build your capacity and skills to engage in community activities.

Every funded service must be linked to an outcome. However, not every outcome requires a funded service. There may be outcome statements that are important to the individual but do not relate to, or are not supported by, a funded service. Resources and opportunities available to the person through their family and community connections can result in achieving the outcome.

Updating Your Individual Support Plan

ISP teams must review your services once every 365 days at the annual review meeting. Your team should review what needs may have changed at the ISP meeting, as needs change throughout the year. If you disagree, you have the right to an appeal.

If, at any time, the ISP team or County/AE or BSASP determines the services that were included in the ISP because of previously made decisions have changed, the ISP should be revised to reflect the current needs of the individual. This is called a Critical Revision.

Critical Revision – A revision to the ISP is used when you have a change in need which requires a change in current services, addition of services, or a change in the amount of funding required to meet your needs. The ISP team members should discuss and agree on changes made to the ISP before all critical revisions are approved and authorized. If the individual, family member, or any other team member disagrees with the content of the ISP, this should be documented on the ISP signature form.

Chapter 7

How to Choose a Provider

Pennsylvania's Department of Human Services, Office of Developmental Programs (ODP) is changing how they work with Residential Service providers to improve the quality of services being delivered to individuals and families. The new program for managing Residential Service providers is called Performance Based Contracting (PBC). PBC was developed to establish performance standards for residential providers with goals of service sustainability, quality improvement, improving clinical capacity to serve individuals and families with complex needs, and implementing strategies to support the workforce.

The Services and Supports Directory

The Services and Supports Directory is a tool for individuals with an intellectual disability/ autism, their families, and circle of support to locate services and service providers in Pennsylvania. The directory can help you locate particular service providers or search for services and supports provided in an individual's community. Provider information in the Home and Community Service Information System (HCSIS) includes:

- The ability to search the **Provider Online Directory**.
- Provider Demographics such as corporate name, address, and phone number; contact person; website address; the services available in your community (county) or nearby communities; other non-licensed facilities.
- The ability to search the Adult Autism Waiver Service Provider catalog.

While it does not include all providers of service because not all providers are required to hold a license, the Provider Licensing Directory is an easy access directory of licensed human services facilities operating in Pennsylvania. You can access information on providers from across the Commonwealth. Begin by selecting the type of service you are seeking from a dropdown menu. Providers commonly working with ODP are listed under the following fields:

- Community Homes (Group Homes with eight people or fewer);
- Large Community Homes Services (Group Homes with nine people or more);
- Family Living (Family Living/LifeSharing);
- Intermediate Care Facility/Intellectual Disabilities (ICF/ID);
- Vocational Facility (Workshops); and
- Day Training Services for Adults (Facility Based Adult Day Training).

Once you have selected the service type, the search can be narrowed by county, ZIP code, a specific place (facility name), and/or legal entity name (an agency name). When the criteria for the search are entered and you click "Go," a list of all facilities matching the criteria will appear. The information will include:

- The name and address of the provider;
- The capacity (number of individuals who may live/work at the facility);
- The type of operation (profit, non-profit);
- The status of the facility (licensed or unlicensed); and
- The status of the license (full or provisional). A provisional license means the facility was cited for regulation violation(s). If the violation is considered minor, the facility may have a full license with an approved plan of correction in place.

You may then use the list provided to contact service providers to find more information about the specific nature of available services. If you are having difficulty locating provider information, you can contact your local County Mental Health/Intellectual Disabilities office for further information, or call the ODP HelpLine at 1-888-565-9435 (1-866-388-1114 for hearing impaired individuals) for assistance.

Supports coordination is a critical service that involves the primary functions of locating, coordinating, and monitoring needed services and supports for individuals and their families. SCs can also assist individuals and families with selecting a provider. For more information about the agencies providing supports coordination services, please visit the SCO Directory on MyODP. If you do not have a MyODP account, you may login as a guest to access this content.

Recommended Questions for Families and Individuals Selecting Providers

- How does the provider ensure that the individual is treated with dignity and respect by the staff?
- Are family and friends encouraged to participate in the planning process?
- What are the staff ratios for the program or is the provider able to meet the individual's needs?
- What is the back-up plan for when regularly scheduled staff are not able to work?
- What kind of screening and training do you provide to staff? To supervisors?
- How long does it take to fill staffing vacancies?
- How does the provider ensure the services for which they are authorized and committed to provide are delivered?
- How well does the agency handle individual suggestions, complaints, or concerns? Do they welcome suggestions?
- Do the people receiving services play any role in choosing the staff that will work with them?
- How can I arrange a visit?
- How would you describe the philosophy and values of your agency?
- May I talk to individuals and families who use your services?
- May I talk with some of your staff?
- May I have a copy of your annual report?
- May I visit the places where you provide services?
- How long have you provided services and supports in this county and in other counties?
- What are the qualifications of the staff that would be supporting me/my relative?
- How long do staff remain with your agency (by position, by site)?
- What is the agency's management structure in my county at particular sites? (e.g. Is there an office nearby? Is the site managed from afar?)
- How long has the CEO been with this agency? Can you tell me about him/her and his/her background?
- How long have other management staff been with this agency?
- Can I see your QA&I report?
- Can I see your licensing inspection report?

Chapter 8

Understanding Your Rights

This section will help you understand the rights that are guaranteed to you and how to seek assistance if you feel your rights are being violated.

Individual Rights

ODP advocates the following regarding rights: People receiving services from ODP enjoy the same right to self-determination as everyone else. Therefore, you must have opportunities, respectful support, and the authority to have control over your own life. You have the right to advocate on your own behalf. Everyone has the right to feel like a valued member of their community, and live a life of their choosing. All people have human and civil rights.

Human Rights and Civil Rights

Human rights are the basic rights and freedoms to which all humans are entitled, often held to include the rights to life, liberty, equality, and a fair trial, freedom from slavery and torture, and freedom of thought and expression. Civil rights are the rights belonging to an individual by virtue of citizenship, especially the fundamental freedoms and privileges guaranteed by the 13th and 14th Amendments to the U.S. Constitution and by subsequent acts of Congress, including civil liberties, due process, equal protection of the laws, and freedom from discrimination.

Your Rights in the System

To help ensure your rights, DHS has regulations to govern most of the services offered through ODP. The Chapter 6100 regulations include several sections that outline your specific rights, as they relate to the services you receive.

Rights in Chapter 6100 Regulations

This section concerning individual rights applies to all people and all services. The rights described in the 6100 Regulations apply to everyone receiving services through ODP.

Your rights cannot be taken away. You have the right to:

1. Be respected for who you are, for what you look like, for what you believe in, for how you communicate, and for who you love.
2. Choose people to help you make decisions.
3. Get help to communicate.
4. Vote.
5. Live without being hurt.
6. Make choices about your life and understand what may happen with your choices.
7. Privacy for yourself and your belongings.
8. Say no to activities.
9. Learn your rights and get help understanding them.
10. Control, get, and use your belongings whenever you want.
11. Choose how, when, where, and who provides your services.
12. Express complaints about services you receive.
13. Create and put into action your individual support plan (ISP) with the support you choose.
14. Look at your records when you want.

If you live in a provider-operated setting, the provider must protect your rights. You have the right to:

15. Manage your money.
16. Have food at any time.
17. Have visitors.
18. Have relationships.
19. Communicate with people privately whenever you want.

20. Send and receive mail, emails, texts, phone calls, and use technology privately.
21. Choose your roommate.
22. Decorate your home the way you like.
23. Lock your bedroom door.
24. Have a key to your home.
25. Make decisions about your healthcare.

Your rights cannot be taken away. Your rights should not impact the rights of another person.

Informing of Rights

The provider must inform you of your rights, explain your rights to you, and explain how to make a report if you feel your rights have been violated, when you first begin receiving services and annually thereafter.

The provider must keep a statement signed by a court-appointed legal guardian acknowledging receipt of the information on individual rights.

In addition to your individual rights as listed in the 6100 Regulations, ODP has protections in place to help you navigate its system. The following section helps you know what to do if you have difficulty or problems. These ODP processes are based on County/AE and state policies and are intended to help you.

How to Report a Problem

Identify the problem and how it affects you and write it down. Include names and dates of events and conversations. Keep careful records of all conversations and correspondence. Get it in writing from the County/AE, always keep information about your rights and other documents you receive, and establish a timeline for resolution.

You have a right to complain about any services or supports you receive if they are not meeting your needs. This includes the services you receive through your SC or any provider. Some disagreements need a formal complaint or appeals process; some do not.

When you have a problem, contact your SC and describe the problem. Let your SC know how you would like it to be resolved. If your SC cannot help or resolve the problem, you may discuss the issue with your SC Supervisor. If your SC Supervisor cannot resolve the problem, you may take it to your County/AE or contact ODP directly at the Customer Service Line at 1-888-565-9435.

It is your responsibility to be a good advocate - speak up for yourself! Write down every time you talk to somebody (include date/time/name). Keep copies of all paperwork that you are given or that you send to people. Take someone (friend/family or advocate) to any meetings or have them sit with you to take notes. Ask for any decisions in writing. This does not mean that you will always win, but it can help keep things from getting more confusing.

Disagreements Regarding County or Base Funded Services

When you receive services funded through County/AE or base funding, you have the right to disagree with and possibly appeal certain situations or decisions made by the county. The process to handle disputes at this level is different than that of services funded through the waivers.

If the county office says you are not eligible for ID/A services, you have the right to receive a written notice explaining why you are were denied. You have the right to disagree with what was decided. Notify the County/AE in writing that you disagree with the decision. Local agency law will apply. Further information regarding the application and eligibility for services is described in Chapter 2 of this publication.

Local Agency Law

Each county program will appoint an impartial reviewer to hear issues and arguments. A hearing will be scheduled. It can be recorded at no cost to you. You can also request a transcript of the hearing at your own expense.

You can provide testimony, documentation, and new information during the hearing. The reviewer may ask you questions. The county can also present information and facts about the decision. You can ask questions of the county program.

If you have services in place but the county reduces or terminates those base-funded services, they are required to give written notice. Unlike waiver recipients, the county program and/or provider can discontinue services due to lack of money. You are not entitled to have the services remain in place while you appeal the decision through the county process. However, you should argue and request that services remain until a resolution is found. The local agency law appeals process (described above) applies here.

Disagreements Regarding Waiver Funded Services

Once you are enrolled in the AAW, P/FDS, CLW, Consolidated waiver, or ACAP, you have the right to appeal decisions that impact your access to services. You have a right to be notified in writing of any County/AE or ODP decision concerning waiver services and you have a right to submit a Waiver Service Request form (DP 1022) if your team disagrees about needed services (details below).

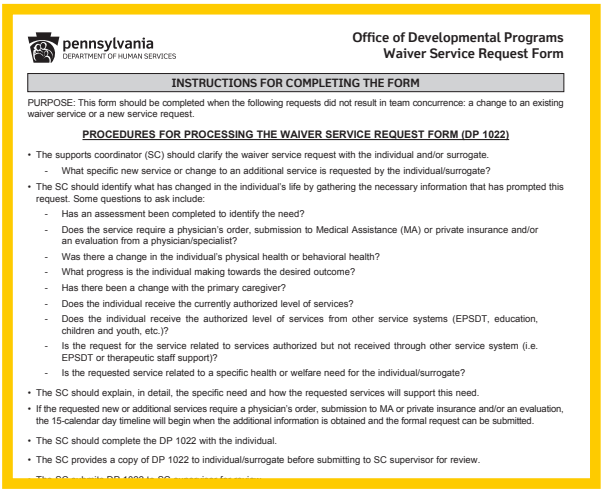
You should be provided with a copy of your appeal rights by the County/AE or ODP any time a decision is made which affects your services and when you apply for services.

If the County/AE initiates an action on waiver services and does not provide the written notice as required, you will have six calendar months from the effective date of the action to file an appeal. When this appeal is filed, services will be reinstated retroactively to the date of discontinuance and will continue until an adverse decision is rendered after the appeal hearing.

Services that are denied without first being authorized in the ISP cannot be provided pending appeal. In these circumstances, you are afforded 30 calendar days to appeal the denial of the service.

When waiver services are being provided and the County/AE determines that the services are going to be reduced, suspended, or terminated, you should receive written notification from the County/AE of this action. You will have 10 days to file an appeal for services to be maintained during the appeal process.

What is the Waiver Service Request Form?



pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Developmental Programs
Waiver Service Request Form

INSTRUCTIONS FOR COMPLETING THE FORM

PURPOSE: This form should be completed when the following requests did not result in team concurrence: a change to an existing waiver service or a new service request.

PROCEDURES FOR PROCESSING THE WAIVER SERVICE REQUEST FORM (DP 1022)

- The supports coordinator (SC) should clarify the waiver service request with the individual and/or surrogate.
  - What specific new service or change to an additional service is requested by the individual/surrogate?
- The SC should identify what has changed in the individual's life by gathering the necessary information that has prompted this request. Some questions to ask include:
  - Has an assessment been completed to identify the need?
  - Does the service require a physician's order, submission to Medical Assistance (MA) or private insurance and/or an evaluation from a physician/specialist?
  - Was there a change in the individual's physical health or behavioral health?
  - What progress is the individual making towards the desired outcome?
  - Has there been a change with the primary caregiver?
  - Does the individual receive the currently authorized level of services?
  - Does the individual receive the authorized level of services from other service systems (EPSDT, education, children and youth, etc.)?
  - Is the request for the service related to services authorized but not received through other service system (i.e. EPSDT or therapeutic staff support)?
  - Is the requested service related to a specific health or welfare need for the individual/surrogate?
- The SC should explain, in detail, the specific need and how the requested services will support this need.
- If the requested new or additional services require a physician's order, submission to MA or private insurance and/or an evaluation, the 15-calendar day timeline will begin when the additional information is obtained and the formal request can be submitted.
- The SC should complete the DP 1022 with the individual.
- The SC provides a copy of DP 1022 to individual/surrogate before submitting to SC supervisor for review.

For waiver participants in the P/FDS, CLW or Consolidated waiver, if the ISP team does not agree about a request for a service, or the service you are requesting is not eligible for waiver funding, there is a process to make that request in another way. This is the purpose of the Waiver Service Request Form. The form is available online or your SC can provide one to you and can also help you complete it.

Completion of the Waiver Service Request Form (DP 1022) begins the 30-day requirement within which the AE must provide a written response to your request. This process is helpful to resolve disagreements quickly without going through the formal appeals process.

The waivers outline the types of decisions you can appeal. The formal hearing and appeals process is in place for the following actions:

- Not being offered a Service Delivery Preference (ICF or Home and Community-Based Services);
- Denied Service Delivery Preference choice;
- Determined ineligible for ICF level of care;
- Denied services of choice including amount, duration, frequency, and scope;
- Denied choice of willing and qualified provider; and
- Action taken to deny, suspend, reduce, or terminate an authorized waiver service.

How do I file an appeal?

A Fair Hearing Request Form is filed by the individual, at the time of a denial, suspension, reduction, or termination of services. ODP has a Fair Hearing Request Form (DP 458) available on MyODP that you should use to submit your waiver related appeal. The County should send you this form with their decision letter. Complete the form and submit it to the department/ County/AE detailed within the notice. The form must be signed to be considered complete.

What is the appeals process?

After you file an appeal to the office that made the denial, you will have the option to participate in the following:

Optional pre-hearing conference with the department, County/AE who made the denial – During this meeting you may be able to reach an agreement. If so, then there is no need for a hearing and the process stops with the agreement. If no agreement is made then a Fair Hearing is scheduled.

Hearing with a Hearing Officer – Filing for a Fair Hearing with the Bureau of Hearings and Appeals (BHA) means you will present your case in front of a Hearing Officer, also called an administrative law judge (ALJ). The ALJ will ask questions and then make a ruling. You will also be notified later in writing as to the ALJ's decision.

When you file an appeal about a decision made by the County/AE, this will also initiate a Service Review. The Service Review assists the family, AE, and ALJ in the interpretation of the waiver and the issue.

A Service Review happens simultaneously with the Fair Hearing process and is triggered when you file for a Fair Hearing based on a decision made by the County/AE. This is applicable to waiver participants only in the P/FDS, CL, and Consolidated waivers. The regional office will review your situation to determine whether the County/AE is following all the rules and regulations about the service. Service Reviews were added to the process because it ensures that people who really know the ID/A system are reviewing the cases prior to the case going to an ALJ.

What happens at the Fair Hearing?

Hearings are held locally (in person) or over the telephone. You may represent yourself or have someone else act as a representative for you. Your case will be heard by an ALJ. This is a formal process to have your case reviewed by the judge. The ALJ will determine whether the County/AE or ODP followed all rules and regulations that apply to your situation. During the hearing, you may provide testimony, documentation, or information. The judge may ask you questions. The County/AE may also present information and facts about the decision. You may ask questions of the County/AE. The final decision from the Fair Hearing will be made within 90 days of filing.

If you disagree with the hearing results, you may ask the Secretary of Human Services for a reconsideration. The reconsideration request must be in writing, addressed to the Secretary of Human Services, but mailed to the Director of BHA. The request must detail the reason for reconsideration and must be sent within 15 days from the date of the ALJ's decision. You may also appeal to the Commonwealth Court.

Keep in mind that once the case goes to a Fair Hearing, the ALJ is not an expert in the ID/A waiver programs and may not know the ID/A system. BHA hears cases from all types of state-run programs such as any waiver program, SNAP, Medicaid, etc. The regional office will make a recommendation based on any findings within 15 days of the appeal. The recommendation from the regional office Service Review will be mailed to you and the County/AE. If you are not satisfied with the outcome or the issue is not resolved, it can go to a hearing. The recommendations from the Service Review may be presented during the Fair Hearing process. However, it is not sent to BHA.

For more basic information about appeals or to obtain assistance from a legal organization, contact Disability Rights Pennsylvania at 1-800-692-7443 or the Pennsylvania Health Law Project at 1-800-274-3258.

What are the timelines for waiver appeals?

If the County/AE or ODP proposes to reduce, suspend, or terminate any current services, they MUST send written notice at least 10 days in advance of the cut-off. If you file an appeal within 10 days of the date of the notice, most waiver services MUST be maintained until there is a resolution of the appeal. Otherwise, you have 30 days to file an appeal in most circumstances.

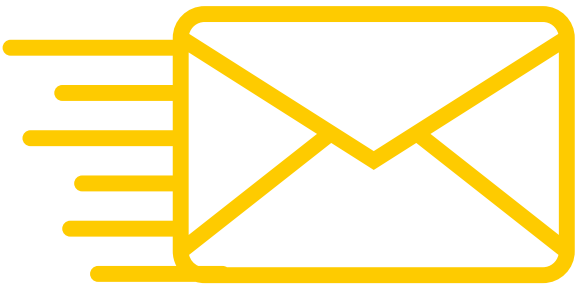
10-Day Rule

As soon as the County/AE or ODP mails out the 10-day advance notice of termination, suspension, or reduction of waiver services, you have 10 days to file an appeal with BHA. Unless appealed, the changes in the 10-day advance notice will take effect. The individual/family has 30 days to file an appeal with BHA. If you do give notice within 10 days, your services may not be altered in any way. **This does not apply to services that have not yet started.**

The 10-calendar day advance notice is determined from the mailing date of the written notice. The mailing date must be noted at the top of the written notice. The mailing date will be the actual date that the written notice is postmarked by the United States Postal Services. **Keep the envelope with the letter you receive!**

You may file by telephone. However, if you do, then you must follow up with a written appeal within three days. You may ask for assistance to file a written appeal when you call.

Your SC is responsible for explaining your rights to you, assisting you in filing an appeal of any decision that impacts your services, and helping you understand the process and timelines for hearings and appeals. You may also wish to contact a local advocacy organization for assistance. The resources at the end of this publication have listings for many of the statewide organizations that can help.



Chapter 9

Ensuring a Quality Life for All

An everyday life is the opportunity to fully participate in your community, to achieve greater independence, and to have the full range of opportunities enjoyed by all. A quality life, as described in *Everyday Lives: Values in Action* is:

"I want my life my way. I, my family, supporters, and the community make sure the services I choose are proved to be of high quality."

Within the Intellectual Disability/Autism system, you have the right to choose providers, the staff that supports you, and the right to change your mind, your plan, and the people/providers you selected. When combining the recommendations in *Everyday Lives: Values in Action* with the LifeCourse philosophy and tools, you can create and maintain a high quality of life within your community.

What does quality mean to you?

When we talk about quality, we can think about it from more than one perspective. Quality of life is very personal. You can think about your vision and what matters most to you.

Some questions to consider:

- Are you living the life you want?
- Do you have the support you need to build and keep relationships with your friends and family?
- Are you able to access the services you need to be successful at work, in the community, and in your personal life?
- Are you happy with the quality of the staff who support you?
- Do you feel safe, secure, and respected?
- Are you able to have choice and control in your day-to-day life?
- Is your provider offering services that are person-centered and promote self-determination?

The people who support you and the services you receive should always align with your vision for an everyday life. The LifeCourse Framework and Tools are helpful for you to describe and share your vision. Chapter 1 of this publication walks you through the process of outlining your vision and identifying services and supports. Use the **LifeCourse Portfolio** to guide conversations and planning with your team. Your ISP is a person-centered document that makes sure that you have what is important to you and that services are provided in a way that reflects your preferences, needs, and desired outcomes.

How does ODP measure and assure quality?

Provider Qualifications

One way that ODP assures quality is through the provider qualifications process. Providers offering services to individuals within the system must meet qualifications set by ODP. This process specifies required skills and competencies for enrollment for waiver providers, as well as the structure that affords all qualified providers the opportunity to enroll as Medicaid providers.

Standards or qualifications for provider participation are established by ODP and approved by the federal Centers for Medicare and Medicaid Services. The process is a first step in ensuring that providers deliver ongoing and consistent quality services. In addition, this process affords providers the opportunity to become a qualified provider in Pennsylvania and share this status with individuals and family members as they make informed choices regarding the services they receive.

Performance-Based Contracting

To improve quality, ODP changed the way residential and supports coordination services are managed. This new way of managing in the ID/A waivers is called "performance-based contracting." The performance-based contracting resource page can be accessed at: Performance-Based Contracting - MyODP.

Changes have been made to residential services, which includes Residential Habilitation, Life Sharing, and Supported Living services, in the Consolidated and Community Living Waivers in January 2025. Changes to supports coordination services in the Consolidated, Community Living, and Person/Family Directed Support Waivers began in January 2026.

Performance-Based Contracting establishes performance standards for residential providers and Supports Coordination Organizations with the goals of service sustainability, quality improvement, improving clinical capacity to serve individuals and families with complex needs, and implementing strategies to support the workforce. The residential provider directory can be accessed at **PBC Provider Directory**.

Incident Reporting

An "incident" is when something happens that can cause you harm, or did cause you to be hurt. This can be things like someone taking your money, hurting or abusing you, or a whole list of things the regulations describe below. The primary goal of incident management is to ensure that when an incident does occur, the immediate and ongoing response will be adequate to protect you. Anyone who receives funds from the intellectual disabilities system - either directly or indirectly to provide or secure services or supports for people, or resides in an ODP licensed facility - is provided the protections of the incident management policy. Providers who receive funds or are licensed by ODP must report incidents.

If you observe or suspect abuse, neglect or any inappropriate conduct, whether services are provided out of the home or in the home, you should contact your SC, or call the ODP Customer Service Line at 1-888-565-9435.

When you receive services in your home from a provider or contracted staff, they must report incidents that occur when they are present in your home. The following are the types of incidents that are reportable: Abuse (physical, psychological, misapplication/unauthorized use of restraint, seclusion), Sexual Abuse, Behavioral Health Crisis Events, Death, Exploitation, Fire, Law Enforcement Activity, Missing Individual, Passive Neglect, Self Neglect, Rights Violation, Serious Illness, Serious Injury, Site Closures, Suicide Attempts, Physical Restraints, and Medication Errors. Please see the Bulletin for the definitions for each type of incident. In the event of death of a person living in a residential setting, the family will be notified by the SC or provider.

The providers must report suspected or alleged abuse immediately. When you are only receiving supports coordination services, the SC will report incidents of suspected abuse and neglect whenever they learn of them.

Incidents identified as critical are subject to investigation. If you are the victim of an incident, you will be provided the results of the investigation.

If you have questions about incident management policy, please contact your SC.

ODP Quality Assessment and Improvement (QA&I) Process

ODP uses QA&I to monitor AEs, Supports Coordination Organizations (SCO), and providers. By collecting information about the experience of specific individuals served by each part of the service system, ODP is able to evaluate how well the system works for individuals. Findings from the QA&I process are used to set targets for improvement in each part of the system. The findings of the reviews are made available to the public.

Independent Monitoring for Quality Program (IM4Q)

IM4Q is another tool that the state and each County/AE uses to ensure an overall quality of life, including the paid services and unpaid supports a person receives. Individuals are randomly selected each year to voluntarily participate in the IM4Q process. The in-person or virtual interviews are conducted locally by independent monitoring teams. Using a standardized questionnaire, you and your family members have the opportunity to give feedback on the supports and services being received. Considerations (suggestions for making your life better) may be offered by you or a family member, a paid staff member, or the IM4Q team. These considerations are then addressed by the SCO and the AE. Participating in the IM4Q interview offers you the opportunity to express how your life can be improved and provides a process through which the system can respond to your needs. The IM4Q data is collected statewide and may be used to inform overall changes to the service system, to help ensure an everyday life for all. For additional information about the IM4Q program, you can visit MyODP or Temple University - Institute on Disabilities.

Quality at the Local Level

Quality Councils engage stakeholders to review and discuss quality measures. The council is made up of professionals and interested parties. The council's purpose is to assess the quality of services provided in the local community and provide recommendations for improvement based on the analysis of data. The councils will then establish quality management (QM) priorities, identify and adopt improvement strategies, and choose performance measures to evaluate the results of implemented change.

Each County/AE also has a Mental Health/Developmental Programs (MH/DP) Advisory Board.

This board is mandated by Article III Section 302 of the MH/MR Act of 1966. The board is to consist of at least 13 members of the community, with representation drawn from at least six different categories. The board meetings, which occur four to six times a year, are open to the general public.

The board shall have the power and the duty to:

- Review and evaluate the county's mental health and developmental program needs, services, facilities, and special programs in relation to the local health and welfare needs, services, and programs.
- Recommend to local authorities not less than two persons for the position of administrator.
- Develop, together with the administrator, annual plans for the mental health and developmental programs required by Sections 301 and 509.
- Make recommendations to the local authorities regarding the program and any other matters relating to mental health and developmental program services in the County/AE, including purchase of service contracts and the extent of funds required to implement the program.
- Review performance under the mental health and developmental programs and to recommend a system of program evaluation.

"It is how we are living the vision that matters."

- Savannah Logsdon-Breakstone, ISAC member

Overall Quality Strategy

The Information Sharing and Advisory Committee (ISAC) became ODP's Stakeholder Quality Council in 2018, following the publication of *Everyday Lives: Values in Action*, and went on to create a detailed series of recommendations, strategies, and performance measures (PMs) to guide the Office of Developmental Programs (ODP) and gauge its progress in achieving the important goals outlined in *Everyday Lives*. These recommendations and strategies have influenced the development of new waiver applications, regulations, and policies, have improved trainings, helped to launch the Supporting Families Collaborative and employment initiatives, and continue to serve as a guide for everyone engaged in developing, providing, and advocating for services in the ODP system.

The ISAC continues to serve as the entity that provides sustained, shared leadership and a platform for collaborative strategic thinking for the ODP system. Together ODP and ISAC will continue to use our quality improvement framework to assess our progress and to plan for and make improvements in the system, while imbedding successful practices. This publication offers us a glimpse of where we are at now, and it will help us to continue to move forward and strive for a better tomorrow.

Chapter 10

Future Planning

As family members supporting someone with a disability, we must plan for the time when we can no longer provide the necessary support. This is called succession planning and the first step is to identify and develop other individuals/caregivers or agencies who may succeed us in providing vital support within our various roles in an individual's life. To make certain that we are properly supporting someone with a disability when making this plan, let's begin with a reminder of our values.

Values and Core Beliefs

The foundation of *Everyday Lives: Values in Action* is two statements:

- We value what is important to people with disabilities and their families, who are striving for an everyday life.
- People with disabilities have a right to an everyday life; a life that is no different than that of all other citizens.

The Core Belief, as we know from Charting the LifeCourse: "All people have the right to live, love, work, play, and pursue their life aspirations in their communities," should be the foundation for all discussion and planning regarding what happens in the future. Having a vision and finding the right supports are essential to this plan. Maintaining those supports over time can be challenging. However, most individuals with intellectual and developmental disabilities live with and are cared for by their families. Succession planning asks families to think about what will happen when a family or caregiver is no longer able to provide the daily supports, and to create plans that will provide continued support of a person's everyday life. Making this plan begins with open and honest conversations within families and with their supporters and allies. It is very difficult and sometimes painful to imagine how illness, aging, or death of a family member will impact the lives of those we love. This is true for all families but in situations where family members rely on one another for daily support, the impact is more dramatic and life changing. It requires courage to discuss these difficult topics. Many parents of individuals with intellectual and developmental disabilities fear that the lives they helped to create for their child, the supports they have developed and fostered over time, and the success their son or daughter has achieved will be at risk if they are not there to make sure these goals continue.

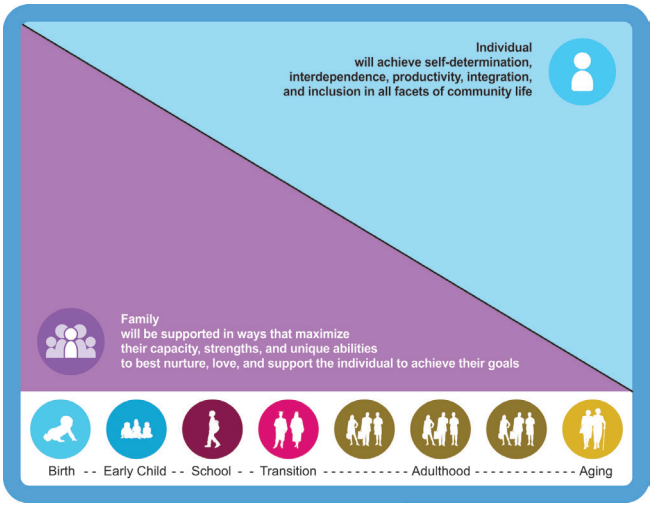
Confronting those uncertainties helps us to deal with them. Questions that keep many parents up at night include:

- Who will be there for my son or daughter when I am no longer here?
- How will my loved one have freedom, choice, and control over their lives long into the future?
- On whom can I rely and trust to do what I do?
- Who knows and loves my son or daughter as well as I do?
- Will my son's or daughter's future be safe, healthy, happy, and secure without me?

This chapter discusses the steps that you, your family, and your supporters can take to ensure that you can have the lives you have envisioned, even when there are changes.

The Family Unit

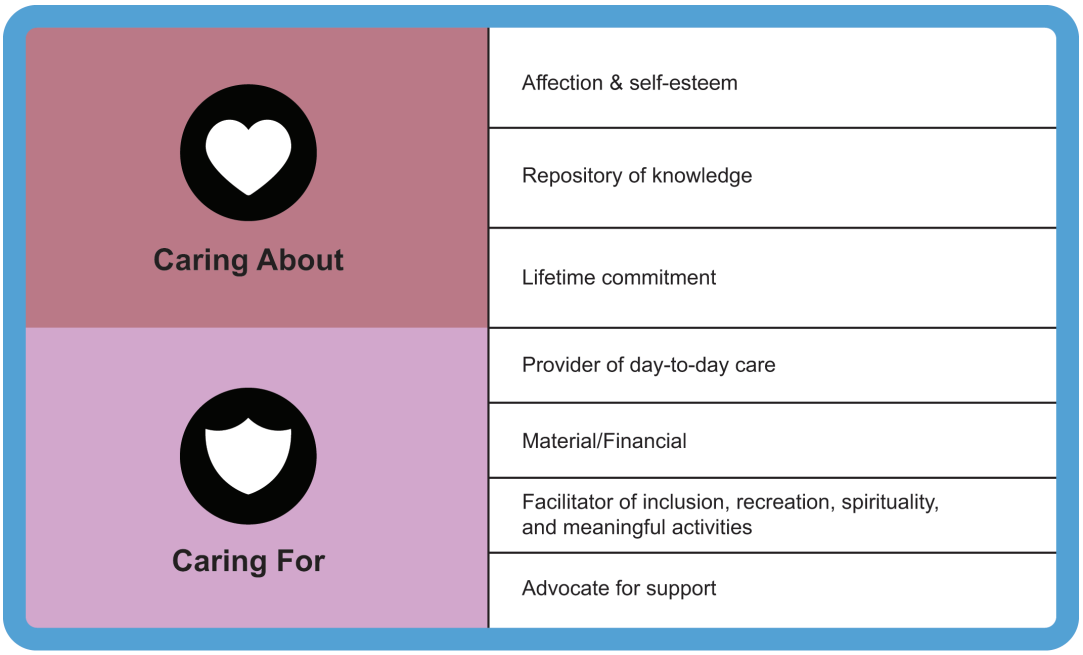
It is important to recognize that all people, no matter their age, exist within a family system. The role of the family changes and evolves as the child grows and changes, from infancy through childhood, school age, transition to adulthood, and adult years into aging. During infancy and the early years, the child is more dependent on their parents or family unit. During the transition years and through young adulthood, the person begins taking on decision-making, exercising choice and control, and setting their own vision for the future. Self-determination is a characteristic developed within a person and, as with other learned qualities, parents can start teaching skills and providing opportunities for children to learn self-determination as they grow. As the young person becomes more self-determined, the role of the parent and family changes. The Charting the LifeCourse Framework and Tools can help focus planning and discussions at each life stage and help everyone plan for the future, which means building an everyday life for all.



This figure shows how the family role may change over time, as the individual grows and increases their capacity for self-determination. Ultimately, supporting families means that each member of the family should be supported to fulfill their role and feel success.

Reciprocal Family Roles

Here is a graphic illustration of the various roles family members play in each other's lives. Caring About someone is one role played within a family. Caring For is another role. Qualities involved in each role are described in the graphic below.



Caring About refers to the emotional support families offer one another. Many members of families fulfill these roles and care about one another. Here are some examples of the roles:

Affection and self-esteem – Parents love their children. Brothers, sisters, other members of your family, and important friends or allies may also fulfill this role. These are people who genuinely care for you. These are people who make you feel good about yourself!

Repository of knowledge – Parents know their children well and have volumes of information from birth to the present day. There are things parents "just know." Parents need to share this information, verbally or in writing, with others who care about you to assure that this knowledge isn't lost. Sharing our stories and history with others can help ensure continuity when other people step into this role in the future.

Lifetime commitment – A parent will continue to love their child and make sure they are cared for long after they are no longer able to physically provide the day-to-day care needed. Siblings, cousins, and other family members are often also committed to caring about you throughout their lifetimes. It is vital to support these relationships over time.

Caring For refers to the tangible support families provide for each other. Here are some roles involved when we care for someone:

Provider of day-to-day care – Parents make sure their child is safe and well cared for on a daily basis throughout childhood. This responsibility may continue into adulthood when a son or daughter has a disability. The daily care may include a variety of activities including getting dressed, cooking, taking care of the home, and going out into the community.

Material and financial – Parents provide for the material and financial needs of their children during the school years: food, shelter, clothing, etc. However, when a child has a disability, this type of support may continue much longer. Long-term financial and material needs must be addressed in future planning.

Facilitator of inclusion and membership – Parents make sure their children have opportunities to meet people, have fun, participate in their faith or religious rituals, and connect with their community. They often serve as the gatekeeper and facilitator of inclusion in a variety of community groups and organizations.

Advocate for support – Parents and family help find and access supports and services from various sources, like school, government agencies, and the community. They often advocate and navigate systems on their family member's behalf.

Creating Reciprocity

The Caring About and Caring For chart is also helpful in thinking about how ALL members of a family support one another. Creating opportunities for a loved one with a disability to fill these roles for others will help foster ongoing connections and maintain relationships over time. Support isn't a one-way street. We all play the important roles of caring about and caring for each other. You can facilitate connections to facilitate opportunities for your loved one to demonstrate their capacity for both Caring About and Caring For others. For example, sending cards for birthdays or holidays, hosting family get-togethers, and inviting friends and family to enjoy community activities are all ways that members of a family show they Care About and Care For each other.

Caring About and Caring For as a Planning Tool

As a family is thinking about succession planning, the chart below can be expanded to create a worksheet for the future. Often it is overwhelming for a parent to figure out who will do everything that they do to help their loved one. If a parent thinks about the Caring About and Caring For roles as opportunities for other family members to contribute, based on their skills and talents, then the need to identify one person to handle everything is not always necessary.

You can add a column with guided questions. Identify who plays that role now and then figure out who may be able to fill that role in the future. It is possible to have several people in each role. Knowing one another and building upon these relationships will be important as you begin to share responsibilities. Once you identify the Caring About and Caring For people, it becomes easier to manage conversations.

Further, adding another column to capture action steps or vital information for those fulfilling that role will help in assuring continuity and quality moving forward. Here is an example of how this concept can be expanded and developed into a mapping tool:

MAPPING RELATIONSHIPS

CARING ABOUT	Who serves in this role now?	Looking Ahead	Next Steps
Shares Love, Affection and Trust			
Spends Time and Creates Memories Together			
Knows about Personal Interests, Traditions, Cultures			

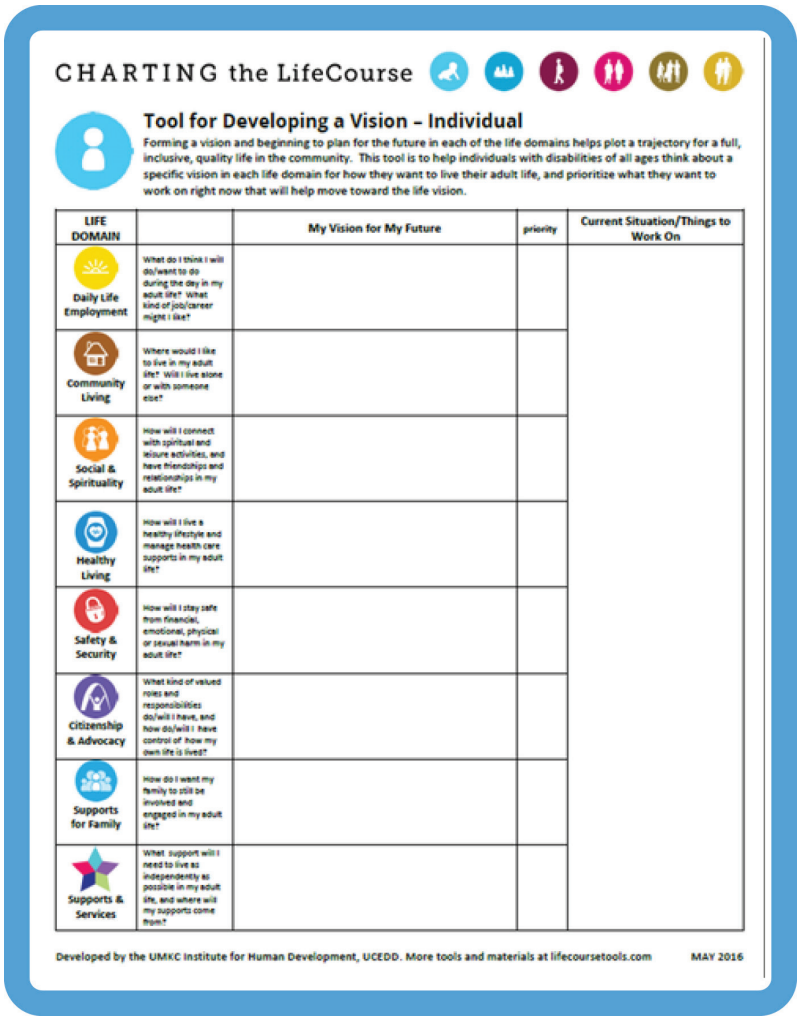
CARING FOR	Who serves in this role now?	Looking Ahead	Next Steps
Supports Day-to-Day Needs			
Ensures Material and Financial Needs are Met			
Connects to Meaningful Relationships and Roles			
Advocates and Supports Life Decisions			

Thinking and talking about the different roles of Caring For and Caring About is one way for a family to begin the hard conversation about who will begin to fill roles that are typically and primarily handled by the parents. In this way, family members can think about how they can share caregiving responsibilities in the future.

Using LifeCourse Planning Tools for Planning the Future

Creating a Vision by Life Domain

The Charting the LifeCourse Tools can be used by families for planning for the future. The **Creating a Vision by Life Domain** may be especially helpful because it breaks down the big picture into categories or life domains, which help to organize and prioritize what needs to happen. Another important feature of this tool, like many others in the toolkit, is that there are two sides. One side is from the perspective of the family and the other is from the perspective of the individual. This helps teams make sure they are focusing on the individual's vision of their life, and allows the team to honor and respect that the person has the right to chart their own course and control their future. Family members play an important role in supporting that vision but, ultimately, the person should have choice, control, autonomy, freedom, and self-determination in all life domains.



CHARTING the LifeCourse

Tool for Developing a Vision – Individual

Forming a vision and beginning to plan for the future in each of the life domains helps plot a trajectory for a full, inclusive, quality life in the community. This tool is to help individuals with disabilities of all ages think about a specific vision in each life domain for how they want to live their adult life, and prioritize what they want to work on right now that will help move toward the life vision.

LIFE DOMAIN		My Vision for My Future	priority	Current Situation/Things to Work On
Daily Life Employment	What do I think I will do/want to do during the day in my adult life? What kind of job/career might I like?			
Community Living	Where would I like to live in my adult life? Will I live alone or with someone else?			
Social & Spirituality	How will I connect with spiritual and leisure activities, and have friendships and relationships in my adult life?			
Healthy Living	How will I live a healthy lifestyle and manage health care supports in my adult life?			
Safety & Security	How will I stay safe from financial, emotional, physical or sexual harm in my adult life?			
Citizenship & Advocacy	What kind of valued roles and responsibilities do/will I have, and how do/will I have control of how my own life is lived?			
Supports for Family	How do I want my family to still be involved and engaged in my adult life?			
Supports & Services	What support will I need to live as independently as possible in my adult life, and where will my supports come from?			

Developed by the UMKC Institute for Human Development, UCEDD. More tools and materials at lifecoursetools.com MAY 2016

Aging Life Stage

Another important tool that can be used to plan for the future is the **Charting the LifeCourse Aging document**. This resource captures the important questions that need to be considered as a person ages. It is important to remember that, as parents age, their children age too. For all of us, growing older can bring significant changes to our lives. Often, we look forward to retirement, but what will we do to stay active and healthy? As we age, our families and friends may not be around anymore, or won't be able to be apart of our lives in the same way they once were. How will the "golden years" be happy, healthy, and productive?

This four-page resource is designed to help your loved one, your family, and team think about what a good life means later in life, and how best to support you at this life stage.

Who can help?

The SC can play an important role in assisting families planning for the future. Sometimes families hesitate to begin talking about succession planning because they don't know how to start. The SC can help the family think about whom to invite into the conversation. By encouraging families to invite others to team meetings and planning discussions, they are building the extended family's relationships with them, helping those team members begin to understand how the system should work, explaining the ISP process, and creating the opportunity for dialogue and relationships between family members beyond the parent and the providers of services. This is especially important when a service provider will be handling much of the day-to-day services and supports. It is vital for the people who Care About a person to build trust and relationships with those who are Caring For the person. The SC is the essential link between all members of the team.

Financial and Legal Issues

Legal and financial considerations are important aspects of succession planning. Special needs trusts, wills, insurance, trustees, power of attorney, supported decision making, medical decision making, guardianship, and ABLE accounts can all play an important role in the future. Everyone is unique, therefore, there is no one right way to plan for the future.

During succession planning, it is very important that the family discuss how to guarantee that individuals who are identified to support your loved one will have the authority and resources to fulfill their obligations.

It can be complicated, but it is best to have papers and plans in place before things happen that aren't expected. It is also very important to make sure that your loved ones know where important documents are kept. If you have a fire safe lock box, who has the key? Do you have a safety deposit box and will others be able to access that in an emergency?

Several financial planning options are available to assist individuals with special needs to maintain a high quality of life well into the future. Special Needs Trusts and ABLE accounts are designed to permit financial resources to remain available to assist an individual with disabilities who receives, or may receive in the future, Medicaid and/or SSI benefits, and/or Medicaid Waiver or other services managed by the MH/ID office or Bureau of Supports for Autism and Special Populations (BSASP).

Special Needs Trusts (SNT) - There are three different trusts available in Pennsylvania, each of which is defined by how it is funded:

- A Third Party Funded SNT involves funding by a third party other than the beneficiary.
- A Self-Funded SNT involves funding with the beneficiary's own monies.
- A Pooled SNT involves individual accounts funding a common fund with a non-profit fiduciary, similar to a mutual fund program.

ABLE Accounts – A Pennsylvania ABLE account gives individuals with qualified disabilities and their families and friends, a tax-free way to save for disability-related expenses, while maintaining government benefits mentioned above. The account can be set up by the individual or a parent or guardian. You do not need a lawyer or an accountant to open or maintain an ABLE account. Go to PA ABLE for more information.

Tips to Get Started

Getting started is often the hardest part of planning for the future. Here are some tips that will help you begin thinking and talking about what happens next. Create a vision for a good life, or everyday life, and share it with everyone. Give a copy of your **LifeCourse Portfolio** and/or talk about what you want with your family and friends, your SC, and service provider.

Get together with those who are important to you! Invite your family and friends to a relaxed get-together with snacks, music, and games. This will help you stay connected with people who care about you. If you can do this regularly, it will help everyone feel comfortable with each other when it comes to talking about difficult topics.

Parents should talk with their children about the future. Each of us has decisions to make as we age, and including all of our children, siblings, and other important family members in those discussions early will avoid conflict, misunderstanding, and confusion if an unanticipated change happens. Start with a few simple steps. Don't try and make all the decisions at once. Learn about financial planning, one step at a time.

Talk with the SC about the future and what services may be available. It is important to understand what services can be accessed to meet the needs that are currently being met by the family. Primary caregivers should begin sharing information with other family members (or those thought of as family) and asking for their help on a regular basis. It isn't easy to ask someone to do things for you, but if you start with a couple of simple tasks, people will feel confident and less anxious about stepping in later. Keep important documents organized and make sure people know where to find them in an emergency. Make sure providers, especially your SC, have contact information for the important people in your life. If something happens to the primary caregivers, service providers will need to know whom to call and how to reach them.

Contact local advocacy resources and keep your ears open for information and trainings that will help you through this planning process.

Call the PA Family Network. They can set up individual mentoring to help you use the Charting the LifeCourse Tools in envisioning the future, identifying the Caring About and Caring For people in your life, and designing a strategy for accessing supports and services.

Resources to Help You

There are several organizations that publish workbooks and checklists for future planning. Vision for Equality published a workbook that is free to families and available for download. You can find it at Vision for Equality. This workbook was developed by families and for families. Other valuable planning tools from the AARP, The Arc of US, Philadelphia Coordinated Health Care, and other groups are free and may be useful for you. Regardless of which tool you choose, getting started and having courageous conversations is essential for your peace of mind and the best possible future for the whole family.

Resource A

Glossary of Terms

Abbreviated ISP

Shortened version of the ISP used for people who receive under $2,000 in non-waiver services. The minimum screens must be completed: Demographics, Outcome Summary, Outcome Actions, Services and Supports Directory (Provider, Vendor, and/or FMS), and service details.

ACCESS Card

Medicaid recipients present this card to doctors and health care professionals to verify their eligibility for medical services covered by Medicaid.

Administrative Entity (AE)

An AE is typically a County MH/ID Program that holds an agreement with the Department of Human Services (DHS) to perform waiver-related activities and functions delegated by DHS. The role of the AE is to implement the waiver program(s) and other duties set forth in the operating agreement, adhere to all Office of Developmental Programs (ODP) policies and procedures and departmental regulations and decisions, and provide fiscal and administrative services. An AE can also be a non-governmental entity that holds a contract with the department to perform the waiver-related activities and functions.

Area Agencies on Aging (AAA)

There are 52 Area Agencies on Aging, covering all 67 counties. They are the local representatives for the Pennsylvania Department of Aging. They administer various programs and services available to older Pennsylvanians.

Bureau of Hearings and Appeals (BHA)

Departmental office that conducts formal appeals and hearings. BHA receives notice of appeal from the AE. In the service review process, BHA receives ODP's service review determination to inform the fair hearing proceedings.

Case Management

See Supports Coordination.

Centers for Medicare and Medicaid Services (CMS)

Federal agency in the Department of Health and Human Services that oversees Medicaid, Medicare, and State Children's Health Insurance Programs (CHIP).

Community Resources

Educational, recreational, civic, and other public services, buildings, and agencies available to the general public.

County Assistance Offices (CAO)

The 67 county assistance offices, which cover all 67 counties, administer DHS assistance programs, including SNAP, Medicaid, and cash assistance.

Eligibility

Criteria individuals need to meet to receive services under the Medicaid Waiver program.

Enroll

To officially register in a waiver, service, or with your County MH/ID program.

Fair Hearing and Appeal

The right to have a hearing before BHA when the individual is 1) Not offered the choice between an ICF/ID and waiver services, 2) Denied the service option of choice, 3) Denied the choice of a willing, qualified waiver provider, and 4) Home and Community-based services received are reduced, terminated, or suspended without consent.

Federal Financial Participation (FFP)

Federal funds authorized to states to assist in payment for services.

Financial Management Services (FMS)

An organization that provides assistance with employer-related tasks (example, payroll) for people who direct their own qualified support professionals. At a minimum, FMSs cut paychecks for an individual's support providers, take care of paying employment taxes, and file for workers compensation insurance on behalf of a person. Pennsylvania has two FMS models:

Vendor Fiscal/Employer Agent (VF/EA)

Individuals/families/representatives sign a Common Law Employer Consent Form that contains rules for participating in this model of service delivery such as 1) Recruiting and hiring their qualified support professionals, 2) Determining work schedule(s) for qualified support professionals, 3) Determining the tasks to be performed and how and when they are to be performed, 4) Orienting and training support professional(s),

5) Managing the day-to-day activities of their support professionals, and 6) Dismissing support professionals as necessary. You're the employer, but the VF/EA is the "bookkeeper".

Agency With Choice

Individuals/families/representatives sign a Managing Employer Agreement Form with an agency that contains rules for participating in this model of service delivery such as 1) Recruiting qualified support professionals to the agency for hire to support the individual, 2) Providing and/or participating in training professional(s) to support the individual, 3) Determining the professional(s) work schedule, 4) Determining the tasks to be performed and how they are performed, 5) Managing the day-to-day activities of the support professionals, and 6) Dismissing support professionals as necessary. The agency is the actual employer of record but you have a say in who is hired, scheduling of support professionals, and in managing the support professionals.

Financial Eligibility

Income and resource limits that have been established in order for people to qualify for Medicaid Waiver services and other Medicaid services.

Guardian

A court-appointed person who has the legal responsibility for the care and management of an estate, minor, or person declared incapacitated.

Health Care Professionals

Licensed or certified provider of health care services, including physicians, psychologists, therapists, and nurses.

Home

Any place a person chooses to live.

Home and Community-Based Services (HCBS)

Services and supports provided in home or community location to help persons live as independently as possible. These services include in-home supports, community group homes, transportation, etc.

Home and Community Services Information System (HCSIS)

The web-based system that Pennsylvania uses for data entry and tracking of Individual Support Plans (ISP), individual (demographic, enrollment, and eligibility) information, Prioritization of Urgency of Need for Services (PUNS), Supports Coordination (SC) monitoring and service notes, incident reports, and support provider information.

Home and Community-Based Services Waivers

Provides for supports and services beyond physical and behavioral health services covered by the Medicaid State Plan that enables a person to remain in a community setting.

Individual Support Plan (ISP)

An integrated planning document reflecting Person-Centered Planning, the core values of *Everyday Lives*, and positive approaches to result in an enhanced quality of life for everyone who receives ID services and supports in Pennsylvania. The ISP must outline the services and supports that address a participant's needs.

Intermediate Care Facility for Persons with Other Related Conditions (ICF/ORC)

A facility that provides health care, rehabilitation, and active treatment services for persons with severe physical developmental delays such as cerebral palsy, muscular dystrophy, epilepsy, or similar conditions diagnosed before the age of 22 and that result in three or more functional limitations of daily living. Services are not designed for persons with mental illness or intellectual disability.

Intermediate Care Facilities for Persons with Intellectual Disabilities (ICF/ID)

ICF/IDs are private facilities or state centers that provide health care, rehabilitation, and active treatment services for persons with intellectual disabilities. Conditions must be diagnosed before the age of 22 and result in three or more functional limitations of daily living.

Long-Term Care

Services designed to provide diagnostic, therapeutic, rehabilitative, supportive, or maintenance services for individuals who have chronic functional impairments. Services may be provided in a variety of institutional and non-institutional settings including the home.

Long-Term Nursing Facility

An institution licensed to provide nursing home services to residents. The facility may be for-profit, non-profit, hospital-based, or operated by a county. This does not include personal care homes, domiciliary care homes or boarding homes, and also does not include community care that does not operate under a long-term nursing facility license.

Medicaid

Health and long-term care services established under the Social Security Act, which a state adopts through its state plan or under an approved Medicaid Waiver.

Medicaid Provider Agreement

All providers, with the exception of unlicensed individuals providing services through a Vendor Fiscal/Employer Agent (VF/EA) Financial Management Service (FMS), must have a signed Medicaid Provider Agreement with DHS in order to receive waiver funding for payment of services. Unlicensed individuals must have a signed agreement with a VF/EA FMS under contract with DHS in order to receive waiver funding for payment of services. The agreement covers things like the provider agrees to follow all waiver rules and regulations, not accept additional payment from recipients, and to protect confidentiality.

Medicaid for Workers with Disabilities (MAWD)

A state Medicaid program that encourages people to work. It allows people to maintain a much higher income and resource level than they would under the current Medicaid program.

Medically Needy

Eligibility for Medicaid under specific financial requirements that includes income limits after incurred medical expenses have been deducted from the income.

ODP Quality Leadership Board

An ODP internal group of senior managers who oversee ODP Quality Management.

Operating Agreement

A contract between DHS and AEs for functions related to the implementation of the Consolidated and P/FDS waivers. The agreement reinforces the authority of ODP and outlines the roles and responsibilities of both the AEs and ODP. The new agreement also includes steps ODP can take if an AE is not fulfilling the contract.

Person Centered Supports

A type of service planning that allows the person to develop their own services and supports package to meet their needs and select their own services and providers.

Participant Directed Services

The individual receiving services has the number one role in determining the supports, outcomes, services, and decisions that affect them. A person living in their own home or family's home can choose to arrange and manage their own services and use FMS for payroll. They may also use a Supports Broker for assistance or designate a surrogate to act on their behalf.

Provider Agency

An agency that ODP has deemed qualified to provide HCBS Waiver services.

Provider Qualifications

ODP's standardized statewide process to qualify waiver providers.

Qualified Developmental Disability Professional (QDDP)

The QDDP determines whether a person meets ICF/ID level of care criteria. A QDDP may be any person who has at least one year of experience working with persons with an ID or other developmental disabilities and is one of the following: 1) A Doctor of Medicine or osteopathy, 2) A registered nurse, 3) An individual who holds at least a bachelor's degree in a specific professional category.

Rate Setting

Rate setting is a standardized method for determining rates that providers can charge for providing waiver services. ODP has developed standards that waiver providers must use in determining the rates for waiver services.

Regional Program Managers (RPM)

Oversee regional operations for ODP that includes fiscal and program planning, management, and oversight of community intellectual disability programs.

Regional Reviewers

Specific staff members at each ODP regional office who are assigned as part of the service review process to review all information regarding an appeal that meets the criteria for a service review. They are the first reviewers in the Service Review process. After reviewing all the information regarding an appeal, the reviewer makes a recommendation to the RPM.

Self Determination

A person's right to determine the course of his/her own life and to make decisions affecting it, along with the responsibilities.

Service Definitions

Descriptions of each service covered under the Consolidated, Community Living, Adult Autism, and P/FDS Waivers and through other ID funding. Service definitions provide a standardized definition, unit, and billing code for each service.

Service Definition Units

Each waiver service is assigned a billing code number (entered into HCSIS) and amount of time a service must take place to equal one unit. For example, 24 hours of in-home respite = 1 unit, 15 minutes of out-of-home respite = 1 unit, 15 minutes of habilitation = 1 unit. These units allow for standardized billing of waiver services.

Service Preference

Individuals who are likely to meet the ICF/ID level of care criteria, or their representative, have the right to choose between institutional and HCBS.

Service Provider

An agency or individual employed to provide a service. In order to provide services through Medicaid waivers, a provider must be willing and qualified to provide the service.

Service Review

Service Review is a formal process that takes place for waiver recipients prior to the Fair Hearing process. Service Review is used if waiver services have been denied, terminated, suspended, or reduced. It is protocol set forth by ODP to ensure consistent application of ODP polices. The Service Review process does not interfere with individual/families due process rights.

Services and Support Directory (SSD)

A web-based service directory that contains information about providers of services in Pennsylvania.

Supplemental Security Income (SSI) Resource Limit

The amount of money or savings a person can have and still be eligible for services under the waiver. The resource limit is $2,000 for a person and $3,000 for a couple.

Supports Coordinator (SC)

Formerly known as case managers, SCs help locate, coordinate, and monitor services and supports for individuals.

Supports Intensity Scale™ (SIS)

SIS™ is an assessment tool that evaluates the practical support requirements of a person with a developmental disability. SIS™ is a comprehensive and non-deficit based assessment that evaluates support needs throughout many life areas.

PA Supplement (PA+)

Additional questions may be created by Pennsylvania as an addendum to the SIS™. These additional questions address areas that the SIS™ itself did not fully address. ODP uses the SIS™ and PA+ as the standardized needs assessment for the Pennsylvania ID system (for Consolidated and P/FDS waiver participants ages 16-72).

Surrogate

An individual selected by the person to represent them, or in the case of some persons with a cognitive disability, an individual acting on their behalf.

Targeted Support Management (TSM)

Medicaid funded case or service management for persons with intellectual disabilities.

Under-Served People

People who receive some services but not all of the services they need.

Unserved People

People who do not receive any of the services they need.

Waiver Capacity

The number of waiver participants, approved by CMS, who can receive services through Consolidated, CLW and P/FDS waivers is known as Unduplicated Count. ODP submits a waiver amendment for each waiver to modify the number of unduplicated count. Each AE is provided with their maximum allotted waiver capacity to serve waiver participants via notification from ODP through an approval letter and the AE Dashboard. AEs will evaluate their allocated waiver capacity and budget on a quarterly basis using the AE Dashboard to determine ability to increase or modify waiver capacity. The AE is responsible for utilizing PUNS to determine who should be offered waiver enrollment. The AE is responsible to ensure waiver participants health and welfare needs can be fully met by CLW & P/FDS and all assessed needs are met by Consolidated waiver. ODP reserves the right to adjust the allotted waiver capacity and waiver allocated budgets.

Waiver Capacity Commitment

The number of participants the AE may enroll in a specified waiver at any given point in time during a fiscal year, as approved by the department.

Waiver Capacity Commitment Letter

A notification that designates the department's current approved maximum number of participants within the jurisdiction of the AE that may be enrolled in each waiver at any given point in time. There are two numbers designated in the letter, reflecting the number of participants that may be enrolled in the Consolidated, CL, and P/FDS waiver.

Resource B

Acronym Guide

AAA
Area Agency on Aging

AAC
Augmentative and Alternative Communication

AAW
Adult Autism Waiver

AAIDD
American Association on Intellectual and Developmental Disabilities

ABA
Applied Behavioral Analysis

ACAP
Adult Community Autism Program

ACRE
Association of Community Rehabilitation Educators

ADA
Americans with Disabilities Act

ADL
Activities of Daily Living

AE
Administrative Entity

AEOA
Administrative Entity Operating Agreement

ANE
Abuse, Neglect, Exploitation

APC
Approved Program Capacity

APS
Adult Protective Services

APSE
Association of People Supporting Employment First

ARB
Architecture Review Board

ARC
Administrative Review Committee

ASD
Autism Spectrum Disorder

ASERT
Autism Services, Education, Resources, and Training (Collaborative)

ASL
American Sign Language

AT
Assistive Technology

AWC
Agency with Choice

BCS
Bureau of Community Services

BFO
Bureau of Financial Operations

BFS
Base-funded Services

BHA
Bureau of Hearings & Appeals

BH MCO
Behavioral Health Managed Care Organization

BIS
Bureau of Information Systems

BPE
Business Planning Estimate

BPQM
Bureau of Policy and Quality Management

BS
Behavioral Specialist

BSASP
Bureau of Supports for Autism and Special Populations

BSP
Behavior Support Plan

CAO
County Assistance Office

CAP
Corrective Action Plan

CAR
Communication Assessment Report

CART
Communication Access Realtime Translation

CBI
Capacity Building Institute

CBT
Cognitive Behavioral Therapy

CDI
Certified Deaf Interpreter

CDS
College of Direct Support

CES
College of Employment Services

CESP
Certified Employment Support Professional

CHC
Community HealthChoices

CI
Certified Investigator or Certified Investigation

CIR
Certified Investigator Report

CIS
Client Information System

CIT
Certified Investigator Training

CLA
Community Living Arrangement

CLS
Certification and Licensing System

CLW
Community Living Waiver

CMS
Centers for Medicare and Medicaid Services

CSL
Customer Service Line

CO
Change Order (PROMISe™)

CO
Central Office

COMPASS
Commonwealth of Pennsylvania Application for Social Services

CoP
Community of Practice

CPS
Community Participation Support

CPS
Child Protective Services

CRR
Community Reassessment Report

CtLC
Charting the LifeCourse

CW
Consolidated Waiver

DCAP
Directed Corrective Action Plan

DD
Developmental Disability or Dual Diagnosis

DDTT
Dual Diagnosis Treatment Team

DHHDB
Deaf, Hard of Hearing, DeafBlind

DHS
Department of Human Services

DNA
Data not available

DOH
Department of Health

DRP
Disability Rights Pennsylvania

DSP
Direct Support Professional

eCIS
Electronic Client Information System

ECM
Enterprise Case Management

ECS
Enhanced Communication Services

EDE
Essential Data Elements (Survey)

EDL
Everyday Lives

EDLC
Everyday Lives Conference

EDL: VIA
Everyday Lives: Values in Action

EDW
Enterprise Data Warehouse

EI
Early Intervention

EIM
Enterprise Incident Management

EPSDT
Early Periodic Screening, Diagnosis or Treatment

ESC
Error Status Code (in PROMISe™)

EVV
Electronic Visit Verification

FAI
Functional Assessment Interview

FAST
Functional Assessment Screening Tool

FBA
Functional Behavioral Assessment

FEA
Functional Eligibility Assessment

FFP
Federal Financial Participation

FMAP
Federal Medicaid Assistance Percentage

FMS
Financial Management Services

FPIG
Federal Poverty Income Guidelines

FY
Fiscal Year

GAS
Goal Attainment Scale

HCBS
Home and Community-Based Services

HCL
Health Care Level

HCQU
Health Care Quality Unit

HCSIS
Home and Community Services Information System

HHS DC
Health and Human Services Delivery Center

HIPAA
Health Insurance Portability and Accountability Act

HLE
High Level Estimate

HLR
High Level Review

HRST
Health Risk Screening Tool

HSRI
Human Services Research Institute

IADL
Instrumental Activities of Daily Living

ICF/ID
Intermediate Care Facility/Intellectual Disability

ICF/IDD
Intermediate Care Facility/Individuals with Intellectual and Developmental Disabilities

ICF/ORC
Intermediate Care Facility/Other Related Conditions

ICN
Internal Control Number

ID
Intellectual Disability

ID/A
Intellectual Disability and Autism

IDEA
Individuals with Disabilities Education Act

IEP
Individualized Education Program

IM
Incident Management

IM4Q
Independent Monitoring for Quality

IM4Q AST
Independent Monitoring for Quality Annual Statewide Training

IM4Q LP
Independent Monitoring for Quality Local Program

IOD
Institute on Disabilities (Temple University)

IRRC
Independent Regulatory Review Commission

ISAC
Information Sharing and Advisory Committee

ISP
Individual Support Plan

IU
Intermediate Unit

LEAP
Life Experience Appraisal Protocol

LIS
Licensing Inspection Summary

LOC
Level of Care

MA
Medical Assistance

MAR
Medication Administration Record

MAS
Motivational Assessment Scale

MAWD
Medical Assistance for Workers with Disabilities

MCI
Master Client Index

MCO
Managed Care Organization

MedAdmin
Medication Administration

MFP
Money Follows the Person

MH/DD
Mental Health/Developmental Disabilities

MHFA
Mental Health First Aid

MH/ID
Mental Health/Intellectual Disabilities

MMIS
Medicaid Management Information System (PROMISe™)

MPI
Master Provider Index

MyODP
Office of Developmental Programs' Resource and Training Website

NADD
National Association for the Dually Diagnosed

NASDDDS
National Association of State Directors of Developmental Disabilities Services

NCI
National Core Indicators

NCI AFS
National Core Indicators Adult Family Survey

NCI FGS
National Core Indicators Family Guardian Survey

NCI IPS
National Core Indicators In-Person Survey

NCI SoTW
National Core Indicators State of the Workforce Survey

NEAT
Needs Exception Allowance Tool

NL/NG
Needs Level/Needs Group

NPI
National Provider Identifier

OA
Operating Agreement

OBRA
The Omnibus Budget Reconciliation Act

OCDEL
Office of Child Development and Early Learning

OCYF
Office of Children, Youth & Families

ODEP
Office of Disability Employment Policy

ODP
Office of Developmental Programs

OHCDS
Organized Healthcare Delivery Service

OLTL
Office of Long-term Living

OMAP
Office of Medical Assistance Programs

OMHSAS
Office of Mental Health and Substance Abuse Services

OVR
Office of Vocational Rehabilitation

PADDC
Pennsylvania Developmental Disabiliities' Council

P/FDS
Person/Family-Directed Support Waiver

PADES
Pennsylvania Disability Employment and Empowerment Summit

PAO
Provider Applicant Orientation

PA Plus
Supplemental questions for Pennsylvania that accompany the SIS™

PASSR
Pre-Admission Screening and Resident Review

PATC
Pennsylvania Autism Training Conference

PaTTAN
Pennsylvania Training and Technical Assistance Network

PBS
Positive Behavioral Support

PCP
Person-centered Planning

PCT
Person-centered Thinking

PDE
Pennsylvania Department of Education

PDS
Participant-directed Services

PECS
Picture Exchange Communication System

POC
Plan of Correction

PPECC
Prescribed Pediatric Extended Care Center

PPR
Plan to Prevent Recurrence

PPS
Prospective Payment System

PRE
Periodic Risk Evaluation

PROMISe™
Provider Reimbursement and Operation Management Information System (in electronic format)

PUNS
Prioritization of Urgency of Need for Services

QA
Quality Assurance

QA&I
Quality Assessment and Improvement

QDDP
Qualified Developmental Disability Professional

QI
Quality Improvement

QIP
Quality Improvement Plan

QM
Quality Management

QMP
Quality Management Plan

QPN
Quarterly Progress Notes

QPRO
QuestionPro

RCA
Root Cause Analysis

RH
Residential Habilitation

RM
Risk Management

RON
Report of Need

RPM
Regional Program Manager

RPO
Regional Program Office

SC
Supports Coordinator

SCO
Supports Coordination Organization

SEEP
Social, Emotional, and Environmental Support Plan

SH
Supplemental Habilitation

SIS
Supports Intensity Scale

SLC
Service Location Code

SME
Subject Matter Expert

SNF
Skilled Nursing Facility

SPU
Special Populations Unit

SSA
Social Security Administration

SSD
Services and Supports Directory

SSDI
Social Security Disability Income

SSI
Supplemental Security Income

TBI
Traumatic Brain Injury

TDTS
Training Data Tracking System

TSM
Targeted Support Management (6100s)

UAT
User Acceptance Testing

VF/EA
Vendor Fiscal/Employer Agent

VOH
Virtual Office Hours

VTT
Virtual Targeted Training

WCM
Waiver Capacity Management

WO
Work Order

WIOA
Workforce Innovation and Opportunity Act

Resource C

At-a-Glance Home and Community-Based Services

HCBS at a Glance

The Social Security Act, as amended in 1981, allowed states to create Medicaid Home and Community-Based Services (HCBS) programs that would pay for home-based services for elderly or disabled individuals. States' HCBS programs must be approved by the Centers for Medicare and Medicaid Services (CMS) in a process known as a 1915(c) waiver.

HCBS programs are sometimes called waiver programs because certain requirements of the Medicaid program do not apply (are waived). For example, a state must offer Medicaid services equally to all eligible people in the state regardless of their disabling condition. Under these rules, a state couldn't run a Medicaid program that paid for prescriptions for physical conditions but not prescriptions for mental conditions. However, with a waiver, a state can create an HCBS program that offers benefits to a certain population that it wants to assist, so it could offer HCBS benefits to individuals with physical conditions but not to individuals with mental conditions.

You can access a guide through the Autistic Self Advocacy Network.

Waivers in Pennsylvania

In Pennsylvania, there are four waivers offered by the Office of Developmental Programs (ODP) for people with autism, an intellectual disability, or a developmental disability.

- Adult Autism Waiver (AAW);
- Consolidated Waiver;
- Person/Family Directed Support (P/FDS) Waiver; and
- Community Living (CL) Waiver.

These waivers are designed to help individuals live more independently in their homes and their communities. We are able to provide a variety of person-centered services promoting independence.

HCBS Services Offered

Some of the supports and services offered through the Consolidated, P/FDS, and CLW are (see the ODP Service Chart by Waiver on pages 34-36 or the Service Delivery Chart in Resource F on pages 139-140 for a full list of services):

- Behavioral Support – Individuals 21 and older.

- Community Participation Supports (CPS) – Individuals 18 and older; connects an individuals talents and interests with community opportunities through skill building supports.
- Supported Employment – Individuals 16 and older; includes job finding, job coaching and support, and career assessment.
- Transportation – Trip to/from a participant's home, a waiver service, activity in the community or resource, including to/from a competitive employment opportunity.
- Small Group Employment – Individuals 16 and older; support transition to competitive integrated employment (for example, mobile workforce)
- Therapy Services - Individuals 21 and older; includes physical, occupational, speech/language, and orientation, mobility, and vision therapy.
- In-Home and Community Support (IHCS) – Provides counseling or training with unpaid family members or caregivers to strengthen relationships, provide support in developing and increasing the individual's skills, and to successfully return home and/or live in his/her own home.

Some of the supports and services of the AAW for Individuals 21 and older are (see the ODP Service Chart by Waiver on pages 34-36 or the Service Delivery Chart in Resource F on pages 139-140 for a full list of services):

- Speech and Language Therapy.
- Specialized Skill Development – Behavioral Specialist services, Systematic Skill Building, and Community Support.
- Behavioral Specialist Services (BSS)
- Systematic Skill Building (SSB) – Provides support to acquire independence skills and to become a more integral part of their community.
- Community Support – Assist individuals in acquiring, retaining, and improving communication, socialization, self-direction, self-help, and other adaptive skills.
- Career Planning – Develop a plan for competitive integrated employment at or above minimum wage.

- Supported Employment – Can be direct or indirect for the benefit of the individual such as working with an employer to help resolve an issue.
- Small Group Employment – Supports transition to competitive integrated employment (for example, mobile workforce).
- Transportation – Trip to/from a participant's home, a waiver service, activity in the community or resource including to/from a competitive employment opportunity.

How do I know if my loved one is eligible for waiver services?

For someone to be eligible for any of these waiver services, they must have:

- IQ of 70 or below, or a diagnosis of autism spectrum disorder;
- Medical evaluation (ex. MA 51) recommending ICF/ID or ICF/ORC (Other Related Conditions);
- Standardized assessment of adaptive functioning showing deficits in three or more areas;
- Testing/clinical judgment records or Standard Diagnostic Tool showing diagnosis of ID or ASD prior to age 22; and
- There is no age limit for individuals with ID or ASD. Individuals with a developmental disability with a high probability of resulting in an ID or ASD are eligible from age 0-8.

Referrals for waiver services should come from a Supports Coordinator.

Financial eligibility:

- For Medicaid Programs, the person's income can be no greater than 300 percent of the Supplemental Security Income (SSI) federal benefit. Through Medical Assistance for Workers with Disabilities (MAWD), individuals who are employed can have more income and keep their eligibility.
- For ACAP, the person must meet MA eligibility requirements.
- For county MH/ID base funded services, there is no asset or income limit.

Resource D

Step-by-Step Waiver Application

Step-by-Step Summary of Applying for Services

1. Register for services with your local county office (MH/ID)

    - Individuals interested in more information regarding eligibility for intellectual services may contact ODP by calling the Intellectual Disabilities Services Customer Service Line at 1-888-565-9435 or by contacting their local County Mental Health/Intellectual Disabilities (MH/ID) Program Office.

    Necessary documents:

    - Proof of current address (required);
    - Social Security card if you have one;
    - Medicaid card if you have one;
    - Birth certificate or copy; and
    - Copy of psychological evaluation with IQ score; school evaluation with the adaptive scale is acceptable.

You must be notified within 30 days if you are eligible for ID/A services and supports. Determination must be made by the county within 14 days of the receipt of all required documents and information.

2. Apply for Medicaid with the county assistance office (CAO).

    - Medicaid Customer Service Center 1-877-895-8930.

The CAO must determine eligibility within 30 days of submission of your application.

3. Complete application for the Medicaid Waiver and Service Delivery Preference with assistance of your Supports Coordinator (SC).

    - Waiver application and Service Delivery Preference Form, a form that expresses your choice of HCBS in place of ICF/ID services.

You must be notified within 20 calendar days of submitting completed forms if you are eligible for HCBS services. Always request a copy of documents that you complete and/or sign.

4. If a waiver opportunity is not available immediately, you will complete a Prioritization of Urgency of Need for Services (PUNS), a standard instrument to determine the urgency of each person's need for services. Based on your questions, you will be placed in one of three categories that defines the urgency of your support needs:

    - Emergency - in need of services immediately or within six months;
    - Critical - in need of services within two years; or
    - Planning - in need of services within two to five years.

Resource E

How do I get started?

ODP SERVICES

A quick guide to the Office of Developmental Programs (ODP) and services for Individuals with an Intellectual Disability, Autism, and Children with a Developmental Disability in Pennsylvania

What is ODP?

The Office of Developmental Programs (ODP) within the Department of Human Services is responsible for the oversight of intellectual and developmental disability services in Pennsylvania.
Local County MH/ID Programs' verify program eligibility for services through ODP.

Program Eligibility

Must have a diagnosis of one of the following:

- Intellectual disability with a full scale IQ of 70 or below that occurred prior to the age of 22.
- Autism diagnosis based on diagnostic tools that occured prior to the age of 22.
- Developmental disability between age 0 through 8 with a high probability of an intellectual disability or autism.
- Medically complex condition between age 0 through 21 with a current medical evaluation from a licensed medical provider.

And also have:

- Substantial adaptive skill deficits in three or more of these major life activities: self-care, understanding and use of receptive and expressive language, learning, mobility, self-direction, capacity for independent living.
- Intermediate care facility (ICF) level of care.
- Medicaid eligibility (required for most services).

Where do I begin?

1. Make an appointment with your local County Office of Mental Health and Intellectual Disabilities (MH/ID). If you need help locating your local county office, call ODP Customer Service Hotline at 1-888-565-9435.
2. Take documents to the appointment that will help establish that you are eligible for services.
   Some examples are medical, psychological, and school records.

What Happens Next?

Once program eligibility is determined, the County Office of Mental Health and Intellectual Disabilities (MH/ID) will offer a choice of Supports Coordination Organizations (SCOs). SCOs will assign a Supports Coordinator to help determine what services are needed and what resources are available to help plan for a good life, an everyday life.

More information available at dhs.pa.gov/compass, and MyODP.org.

Resource F

Service Delivery Charts

Service	Consolidated Waiver	Community Living Waiver	P/FDS Waiver	Adult Autism Waiver
American Sign Language (ASL) - English Interpreter Service	X	X	X	X
Assistive Technology	X	X	X	X
Behavioral Support	X	X	X	X
Benefits Counseling	X	X	X	
Career Planning				X
Communications Specialist	X	X	X	
Community Participation Support/ Day Habilitation	X	X	X	X
Community Supports				X
Community Transition Services				X
Companion Services	X	X	X	
Consultative Nutritional Services	X	X	X	X
Education Support	X	X	X	
Family/Caregiver Training and Support	X	X	X	
Family Medical Support Assistance	X	X	X	
Family Support				X
Home Accessibility Adaptations/ Home Modifications	X	X	X	X
Homemaker/Chore Services	X	X	X	
Housing Transition and Tenancy Sustaining Services	X	X	X	
In-Home and Community Support	X	X	X	
LifeSharing	X	X		X

Service	Consolidated Waiver	Community Living Waiver	P/FDS Waiver	Adult Autism Waiver
Music, Art, and Equine Assisted Therapy	X	X	X	
Participant Goods and Services	X	X	X	
Remote Supports	X	X	X	X
Residential Habilitation	X Licensed & unlicensed	X Unlicensed		X Licensed
Respite	X	X	X	X
Shift Nursing	X	X	X	
Small Group Employment	X	X	X	X
Specialized Supplies	X	X	X	
Specialty Telehealth and Assessment Team	X	X	X	
Supported Employment	X	X	X	X
Supported Living	X	X		
Supports Broker	X	X	X	
Supports Coordination	X	X	X	X
Systematic Skill Building				X
Temporary Supplemental Services				X
Therapy services	X	X	X	
Therapy – Speech/Language				X
Therapy – Counseling				X
Transportation	X	X	X	X
Vehicle Accessibility Adaptations	X	X	X	X

Resource G

ODP and DHS Overview

Office of Developmental Programs (ODP)

ODP is one of eight offices that are part of the Department of Human Services (DHS). ODP's mission is to support Pennsylvanians with developmental disabilities to achieve greater independence, choice, and opportunity in their lives. The office seeks to continuously improve an effective system of accessible services and supports that are flexible, innovative, and person-centered.

Everyday Lives: Values in Action is the guide for ODP as it develops policy and designs programs. Providers of services use these recommendations to support individuals and their families to achieve everyday lives.

The foundation of *Everyday Lives: Values in Action* is two statements.

- We value what is important to people with disabilities and their families, who are striving for an everyday life.
- People with disabilities have a right to an everyday life, a life that is no different than that of all other citizens.

ODP administers the Commonwealth's intellectual disability (ID) and autism programs consisting of state-operated Intermediate Care Facilities (ICF/ID), known as "state centers," private ICF/IDs, and Home and Community-based Services (HCBS) for individuals with an ID and/or autism. ODP administers federal Medicaid HCBS programs in partnership with County/Administrative Entities (AE).

ODP primarily supports children and adults with ID and autism through services and supports available in the following HCBS programs:

- Adult Autism Waiver (AAW);
- Community Living (CL) Waiver;
- Consolidated Waiver;
- Person/Family Directed Support (P/FDS) Waiver;
- Adult Community Autism Program - Available for adults with autism living in Dauphin, Lancaster, Cumberland, and Chester counties in Pennsylvania; and
- ODP programs are funded through federal and state funds.

The intellectual and developmental disability service system is based on a flexible and dynamic system of supports and services close to home and community. The system is tailored to the

needs of the person living in their home and community which include community residential and day support services. Community residential options include community homes, single apartments with a roommate, or a family living setting. Individuals can also be provided supports in their family homes or their own home.

ODP, in collaboration with the several other DHS program offices, supports a larger DHS initiative to support children with complex medical conditions to have the services necessary to live at home with family. ODP recently amended program eligibility and created new services to provide families with children with medically complex conditions the support they need to care for their child on their own.

Bureau of Supports for Autism and Special Populations – Provides administration and program support for ODP's two programs for adults with autism: the Adult Autism Waiver, and the Adult Community Autism Program. This bureau also provides training, resources, and technical assistance related to supporting special populations (i.e. deaf/hard of hearing, children with medical complexities).

Bureau of Financial Management and Program Support – Prepares budgets and budget revisions, county allocations, and federal expenditure reports. The bureau provides fiscal management for the private ICFs for persons with intellectual disabilities program and Targeted Services Management program.

Bureau of Policy and Quality Management – Develops and publishes policies and regulations, develops applications for federal funding, and evaluates the effectiveness of programs in meeting goals and providing quality services. The bureau also provides and coordinates training and manages communications related to ODP policy and programs.

Bureau of Community Services – Responsible to direct the program planning, management, and oversight of the community-based ID and autism programs. These programs consist of the Consolidated Waiver, the CL Waiver, and the P/FDS Waiver. Additionally, this bureau participates in the planning and placement of individuals moving from facilities, public, and private ICFs.

Bureau of State Operated Facilities – Responsible for the fiscal and program planning, management, and oversight of all state operated ICFs for individuals with intellectual/developmental disabilities, including the health and safety of all persons living there. This bureau is also responsible for planning and placement of individuals transitioning from the state operated ICFs to the community in collaboration with the Bureau of Community Services.

Pennsylvania Department of Human Services (DHS)

DHS exists to help Pennsylvanians lead safe, healthy, and productive lives through equitable, trauma-informed, and outcome-focused services while being an accountable steward of Commonwealth resources. DHS serves more than three million Pennsylvanians through services and programs the agency oversees. Our work extends even more broadly by providing the opportunity to empower our communities and support individuals and families across the Commonwealth.

Office of Administration (OA)

OA's mission is to create partnerships to deliver quality service to customers through collaboration, consultation, and supports. Services provided by OA include administrative appeals/hearings, administrative services, equal opportunity in DHS programs, financial operations, fraud and abuse recoveries in Medicaid and third-party recoveries, procurement, and contract management.

Executive Support Services – Ensures that DHS provides prompt public access to its public records while abiding by exemptions and protections in the Right-to-Know Law (RTKL) to safeguard certain information, including confidential personal information of department clients and other third persons. The Director of Transformation also reports to this office, creating a culture of continuous quality improvement incorporating Lean principles. Finally, according to the Out-of-state Travel Policy, DHS employees planning to travel outside Pennsylvania must obtain approval from the DHS Deputy Secretary for Administration and the Governor's Office prior to booking travel.

Bureau of Administrative Services – Plans, directs, and coordinates DHS's administrative support activities, including forms and publications, printing services, mailroom operations, signature authorization, agency records coordination, automotive fleet operations, guardianship programs, management of facilities and property, leasing and space, the surplus equipment warehouse, emergency planning, environmental safety, and continuity of operations.

Bureau of Equal Opportunity (BEO) – Provides technical assistance to DHS program offices and investigates civil rights complaints by clients, residents, patients, or students receiving services through programs administered by or through DHS. BEO also manages the DHS Limited English Proficiency Program, working with program offices to meet federal and state requirements.

Bureau of Financial Operations – Provides financial and audit oversight, coordination, and support to executive management in the operation of its programs. These activities include the resolution of federal and other external audits; DHS-operated facility support providing technical assistance on finances to county and provider human services programs; and conducting performance audits and reviews of DHS-operated and funded programs.

Bureau of Hearings and Appeals – Functions as the DHS entity charged with conducting administrative hearings and timely adjudicating appeals filed in accordance with state and federal regulations. It covers nearly 280 different areas, including the denial, suspension, termination, or reduction of any DHS-issued benefit.

Bureau of Procurement and Contract Management – Responsible for actively supporting the goals of DHS and its program offices by purchasing and acquiring essential goods and services. This bureau also manages solicitations and the review and award process for grant agreements.

Bureau of Program Integrity – Ensures MA recipients receive quality medical services and that Medicaid recipients do not abuse their use of medical services; applies administrative sanctions; refers cases of potential fraud to the appropriate enforcement agency; and evaluates medical services rendered by medical providers and managed care organization provider networks.

Office of Child Development and Early Learning (OCDEL)

OCDEL's mission is to provide families with access to high quality services to prepare children for school and life success. OCDEL focuses on creating opportunities for the Commonwealth's youngest children to develop and learn to their fullest potential. This goal is accomplished through a framework of supports and systems that help ensure children and their families have access to high-quality services. OCDEL is jointly overseen by DHS and the Department of Education.

Bureau of Certification Services – Responsible for the regulation of all child care centers, group child care homes, and family child care homes in Pennsylvania. The Bureau of Certification Services conducts inspections of child care facilities and supports providers to better meet and understand regulations.

Bureau of Early Intervention Services and Family Supports (BEISFS) – Oversees the Early Intervention (EI) Program for infants, toddlers, and children from birth to school age, through their work with local administrators. BEISFS assures that all eligible children from birth to five with developmental delays receive services and supports that maximize their development, so they are successful in any early childhood education setting. Family Support Programs include, but are not limited to, Evidence-Based Home Visiting (EBHV) programs and Family Centers.

Bureau of Early Learning Policy and Professional Development – Develops and implements standards for early childhood education programs and professionals to improve the quality of early learning for young children and provides financial support and technical assistance for programs and professionals. The bureau is also responsible for establishing and maintaining the rules, regulations, and procedures for the subsidized child care program, Child Care Works.

Bureau of Early Learning Resource Center Operations and Monitoring – Provides oversight and technical assistance to Early Learning Resource Centers (ELRCs). The bureau is responsible for monitoring ELRC grantee program integrity and accountability, proper use of funds, and accurate application of program rules and procedures. ELRCs provide a single point-of-contact for families, early learning providers, and communities to gain information and access services that support high-quality child care and early learning programs.

Bureau of Finance, Administration, and Planning – Provides fiscal oversight for OCDEL's budget, systems development for quality data, and human resources planning for alignment and integration.

Business Partners

- Early Intervention Technical Assistance (EITA) - EITA is part of the Pennsylvania Training and Technical Assistance Network and is administered through the Tuscarora Intermediate Unit. EITA works on behalf of BEISFS to provide training and technical assistance to local Infant/Toddler and Preschool EI agencies.
- Pennsylvania Key (PA Key) - The PA Key is administered by the Berks County Intermediate Unit. Created in 2007 by OCDEL, the PA Key implements the work and supports the policies developed and managed by OCDEL. Some of the services provided in support of OCDEL's mission include the Professional Development Registry, Infant and Early Childhood Mental Health Consultation, Program Quality Assessments for early childhood settings, contract management, and administrative support.

Office of Children, Youth, and Families (OCYF)

OCYF's vision is that all children and youth grow up in a safe, loving, nurturing, permanent family and community. OCYF's mission is to support the provision of quality services and best practices designed to ensure the safety, permanency, and well-being of Pennsylvania's children, youth, and families. The child welfare system in Pennsylvania is administered through 67 county children and youth agencies under the supervision of the state through OCYF.

In 2012, through collaboration with partners across the child welfare system, OCYF established the Pennsylvania Child Welfare Practice Model which focuses on children, youth, families, child welfare representatives, and family service partners working as a team with shared community responsibility to achieve the following:

- Safety from abuse and neglect.
- Enduring and certain permanence and timely achievement of stability, supports, and lifelong connections.
- Enhancement of the family's ability to meet their child/youth's well-being, including physical, emotional, behavioral, and education needs.
- Support families within their own homes and communities through comprehensive and accessible services that build on strengths and address individual trauma, needs, and concerns.
- Strengthened families that successfully sustain positive changes that lead to safe, nurturing, and healthy environments.
- Skilled and responsive child welfare professionals, who perform with a shared sense of accountability for assuring child-centered, family-focused policy, best practice, and positive outcomes.

OCYF provides regulatory guidance, oversight, and support for the operation of the county children and youth agencies and private providers who offer direct services to children and families. These services include child abuse prevention and treatment, in-home family support and preservation services, foster care, and services to support older youth in transitioning to adulthood and adoption. OCYF provides direct services to delinquent children and youth through the operation of three secure youth development centers and two youth forestry camps. OCYF conducts its operations through the following four bureaus.

Bureau of Budget and Fiscal Supports – Provides support functions for OCYF and county child welfare agencies including invoices for state and federal revenue, budgeting, personnel, management of federal grants and revenue, fulfillment of needs-based budget mandates, and administrative, financial, and operational support.

Bureau of Children and Family Services – Responsible for regulatory oversight and monitoring of the delivery of services by county and private children and youth social service agencies, including foster care agencies, adoption agencies, residential treatment facilities, and supervised independent living facilities throughout the Commonwealth.

Bureau of Juvenile Justice Services – Responsible for the management, operations, program planning, and oversight of all the youth development center/youth forestry camp facilities. These facilities are designed to provide state-of-the-art treatment, care, and custody services to Pennsylvania's most at-risk youth.

Bureau of Policy, Programs, and Operations – Responsible for the development and publishing of policies, procedures, and directives governing child welfare activities in the Commonwealth and the administration of several grant programs that support the child welfare service delivery system. The bureau also operates the 24/7 child abuse reporting hotline, ChildLine, and processes child abuse history clearance and FBI fingerprint results.

Office of Income Maintenance (OIM)

OIM's mission is to improve the quality of life for Pennsylvania's individuals and families. OIM promotes opportunities for independence through trauma-informed services and supports while demonstrating accountability for taxpayer resources. Assistance programs administered by OIM service over 3 million Pennsylvanians, many of whom are elderly, disabled, and/or children.

OIM is responsible for the oversight of the Temporary Assistance for Needy Families (TANF) cash assistance program, Medicaid, Supplemental Nutrition Assistance Program (SNAP), which is the name for the food stamp program, home heating assistance (LIHEAP), employment and training services, and child support. All these programs are administered locally at the county assistance offices found across Pennsylvania, with the exception of child support, which is operated by the County Courts of Common Pleas.

OIM's programs work to fight food insecurity, improve the health and well-being of our residents, provide opportunities for children and families to thrive, and promote quality of life in Pennsylvania.

- SNAP - Helps Pennsylvanians offset their food budget. People in eligible, low-income households can obtain more nutritious diets, as their food purchasing power is increased at grocery stores and supermarkets with SNAP.

- TANF (also referred to as cash assistance) - Provides a financial stipend to support pregnant women, dependent children and their parents, and children who live with other qualified relatives.
- Medicaid - Is a joint federal/state program that provides health care coverage to an estimated 3.1 million eligible Pennsylvanians.
- LIHEAP - Helps families living on low incomes pay their heating bills in the form of cash and crisis grants.
- Child Support - Helps custodial parents establish child support orders and ensure reliable financial support for children. It also helps non-custodial parents through employment services and payment arrangements.
- Children's Health and Insurance Program (CHIP) - Joint federal/state program established to provide coverage to uninsured children in families whose incomes are too high to qualify for Medicaid.
- Employment & Training Services - Designed to help individuals start and succeed on their career pathway through education and training services to help remediate barriers to family sustaining employment.

Deputy Secretary's Office – Oversees each bureau and the entirety of programs administered by OIM. The DSO also includes a branch of OIM communications. The OIM Communications Team identifies needed communications, develops plans for communications initiatives, and creates content for communications received by individuals, the public, stakeholders, and DHS staff.

Bureau of Child Support Enforcement – Administers the Child Support Enforcement Program for Pennsylvania in accordance with Title IV-D of the Social Security Act, as amended. The Child Support Enforcement Program determines paternity when necessary and establishes and enforces child support obligations on behalf of custodial parents and their children, including those who receive cash assistance benefits from DHS. Federal and state law require that court-ordered child support be assigned to the department up to the amount of assistance paid for custodial parents and their children if they are receiving cash assistance. The Commonwealth's Child Support Enforcement Program is nationally recognized as a leader in program performance and ranks first among the largest states in overall performance outcomes. The Commonwealth's Title IV-D program exceeds all federal performance standards, which include establishment of paternity and court orders for child support and collection of child support obligations.

Bureau of Operations – Responsible for the management of the CAOs whose staff members work to determine eligibility for programs designed to assist Pennsylvania's most vulnerable citizens. The programs that are managed by the CAOs include TANF, Medicaid, SNAP, LIHEAP, and Employment & Training services. The bureau also has the primary responsibility for training new employees through a network of staff development sites as well as CAOs and providing training to all staff in the CAOs and district offices. The bureau operates offices in all 67 counties so that Pennsylvania's vulnerable citizens have a place where they can apply for benefits, renew existing benefits, and request supportive services. The bureau also operates a network of customer service centers that are designed to assist clients across the Commonwealth over the phone via a toll-free number. The bureau resolves client problems and answers questions received on the telephone hotline, in person, or in letters and electronic mail from clients, legislators, and the public.

Bureau of Policy – Develops, introduces, and clarifies policies and procedures, and manages the public assistance programs administered by OIM. The bureau is responsible for developing and maintaining the policies that are needed for OIM to function consistently across the program office and consistent with federal and state laws and guidelines. The bureau publishes these policies in handbooks and publishes supporting regulations, state plans, operations memorandum, policy clarifications, forms, and other documents. They also assist in system development to ensure policy is applied correctly in the system.

Bureau of Program Evaluation – Monitors and evaluates the accuracy of eligibility decisions in CAOs, analyzes problem areas, and prepares plans to correct deficiencies in CAOs performance. The bureau is also responsible for satisfying major state and federal reporting requirements and ensuring accurate quality control and monitoring procedures. In addition, the bureau is responsible for the submission of TANF work participation data through the federal TANF Data Report, which includes efforts to ensure maximum hours of participation are recorded, to meet the federal work participation requirement.

Bureau of Program Support – Provides administrative support to the other bureaus within OIM and serves as the liaison between those bureaus and other DHS offices. The bureau is responsible for budget and fiscal analysis, personnel, administration, acquisition planning, space and equipment management, contract and grant monitoring, resolution of audits, management of the Electronic Benefits Transfer (EBT) System, and EBT risk management. The bureau conducts detailed financial monitoring and analyses and produces statistical monthly reports needed to support program administration decisions. The bureau is also responsible for the development, monitoring, and maintenance of OIM's automated information systems.

Bureau of Employment Programs (BEP) – Manages DHS efforts to help public assistance recipients to prepare for, secure, and retain employment. The bureau manages a portfolio of programs designed to transition SNAP and TANF recipients to family sustaining wages through intensive barrier remediation services and customized education and training. These programs are administered through contracted partners, and fall into three broad categories: 1) workforce development programs including Employment Advancement & Retention Network (EARN), SNAP EARN, Work Ready, SNAP 50/50, and Contracted Partner Program; 2) education programs including Keystone Education Yields Success (KEYS), SNAP KEYS, Education Leading to Employment and Career Training (ELECT), and TANF Youth Development; and 3) supportive service programs including PA Workwear, Allegheny Transportation Initiative, PLAN Legal Services, and special allowances (SPALs). SPALs are available for persons or families for special needs such as transportation to medical appointments, or technology needed to participate in employment and training programs. BEP also manages the Commonwealth's Refugee Resettlement Program, which helps refugees successfully integrate into communities through public assistance and education and training activities. As of August 2022, this program is 100% federally funded.

Office of Long-Term Living (OLTL)

OLTL is committed to serving more people in communities rather than in facilities, giving them the opportunity to work, spend more time with their families, and experience an overall better quality of life.

Major program areas include:

- Managed Long-Term Services and Supports (MLTSS) provided through Pennsylvania's Community Health Choices (CHC) program and Nursing facilities services;
- Medicaid funded Home and Community-Based Services (HCBS);
- State funded ACT 150 HCBS Program;
- Living Independently for the Elderly (LIFE), known nationally as the Program for All-Inclusive Care for the Elderly;
- Personal Care Home and Assisted-Living Residences licensing programs; and
- Adult Protective Services for those adults living with disabilities ages 18-59.

OLTL is responsible for the statewide administration of Pennsylvania's Medicaid funded long-term services and supports programs. As of April 2022, OLTL serves a population of 405,718 lives through its various Long Term Services and Supports (LTSS) programs to include Omnibus Budget Reconciliation Act (OBRA), Act 150, LIFE, and CHC. Bureau of Human Services Licensing's (BHSL) licensed facilities serve over 67,000 individuals across Pennsylvania. In addition, program responsibilities include assessing and improving the quality of services received by participants in various long-term living settings and monitoring fiscal and regulatory compliance.

Bureau of Fee-for-Service Programs (BFFSP) – Manages provider focused activities and functions in OLTL. The bureau is responsible for Medicaid provider enrollment activities under provider code 03 and provider code 59 in coordination with the Office of Medical Assistance Program claims management in fee-for-service (FFS) programs such as the Act 150, as well as other waiver programs, manages the financial management contract, which provides payroll assistance to participants of the self-directed model of care; and manages and coordinates the ventilator dependent and durable medical equipment exception programs. The bureau also directs the Quality Management Efficiency Teams that audit and analyze the quality and efficiency of services delivered by providers who are participants in OLTL waivers and CHC MCO program to ensure compliance with state and federal regulations. BFFSP also manages the operations of seven field offices that conduct quarterly on-site clinical and financial reviews of nursing facilities enrolled in the Medicaid program, to ensure that utilization of Medicaid services and reimbursements are appropriate and consistent with regulations, and prepares statistical and other reports related to the utilization of Medicaid services for senior management consumer advocates, and other parties.

Bureau of Quality Assurance and Program Analytics – Responsible for ensuring that valid statistical and procedural methodologies are used to collect and analyze compliance with federal and state regulations. The bureau manages data analysis to measure the effectiveness of program design and operations, and ensures required reports are provided to CMS and other regulatory entities, supports OLTL management in the development and implementation of internal and external training to improve service delivery, oversees the analysis of data obtained through consumer satisfaction surveys and provider performance measures, and oversees internal and external activities of OLTL monthly and quarterly review meetings reviewing waiver assurance.

Bureau of Finance – Manages and monitors OLTL's appropriations and operating budget of approximately $13 billion. The bureau serves as liaison to the DHS budget office and the Governor's budget office. The bureau develops and manages related fiscal activities including managed care and fee-for-service rate setting, cost reporting, budget reporting and submissions, audits, and fiscal management of grants and contracts.

Bureau of Policy Development and Communication Management – Supports the strategic policy and communication goals across all bureaus and the deputy secretary's office. The bureau plans, coordinates, evaluates, and develops policies and procedures across OLTL, and coordinates internal and external communication with stakeholders. The bureau serves as a liaison with other DHS programs and policy offices and other Commonwealth agencies, supports all bureaus in the development of consistent policy, evaluating impact, and improving strategic directions. The bureau also serves as the liaison with DHS's right-to-know law office and submits the state plan and waiver documents to the federal government's Centers for Medicare and Medicaid Services (CMS).

Bureau of Human Services Licensing (BHSL) – Responsible for the overall management and coordination of Personal Care Home and Assisted Living Residences licensing programs administered by DHS in the Central, Northeast, Southeast, and Northwest regions. Responsibilities include the management, planning, direction, oversight, design, development, and administration of licensing statutes, licensing regulations and policy licensing enforcement policy, licensing training, licensing research, and licensing data systems for more than 1,100 out-of-home care settings licensed by the department serving over 67,000 adults with mental illness, developmental disabilities, physical disabilities, behavioral, and/or cognitive disorders.

Bureau of Coordinated and Integrated Services (BCIS) – Responsible for the administration and oversight of the Community Health Choices (CHC) Managed Care Organizations (MCO) that provide managed long-term services and supports to eligible participants. The bureau is also responsible for the development and management of the Living Independence for the Elderly (LIFE) managed care program. BCIS oversees the Medicare Improvements for Patients and Providers Act (MIPPA), Agreements with Medicare Advantage Plans, and Dual Special Needs plans, including enforcement of MIPPA requirements to promote the effective coordination of Medicare, Medicaid, and Behavior Health services. This bureau is also responsible for the oversight of the Independent Enrollment Broker (IEB), incident management, complex case management, and of the Independent Assessment Entity (IAE) contract.

Office of Medical Assistance Programs (OMAP)

OMAP's mission is to promote whole-person health for all Pennsylvanians served by Medicaid and CHIP by modernizing systems and programs, ensuring access to the highest value healthcare available, and dismantling institutional and systemic barriers to equity and wellness.

OMAP administers Pennsylvania's Medicaid program, which is the joint state and federal Medicaid program that provides coverage for health care for eligible Pennsylvania residents. Medicaid provides coverage for health care services through a fee-for-service program as well as through the managed care program that is administered by contracted Managed Care Organizations. OMAP is also responsible for enrolling providers, processing provider claims, establishing rates and fees, contracting, monitoring of managed care organizations, and detecting and deterring providers and recipients' fraud and abuse.

OMAP Programs:

- Two delivery systems, fee-for-service and managed care.
- Medical Assistance Transportation Program (MATP) - Non-emergency medical transportation is a required Medicaid benefit designed to provide transportation to and from medical appointments for enrollees who have no other means of transportation.
- PA eHealth Partnership Program - Responsible for establishing and operating the state's electronic health information exchange, known in Pennsylvania as the PA Patient & Provider Network.

Bureau of Data and Claims Management – Responsible for activities related to Medicaid invoice processing and payments to providers. All claims processing issues that involve the claims processing contractor, the Office of Information Systems, other OMAP bureaus, and other DHS organizations are coordinated and approved by this bureau.

Bureau of Fee-for-Service Programs – Responsible for the operational components of OMAP's Fee-for-Service health care delivery program.

Bureau of Fiscal Management – Responsible for the administration and oversight of fiscal operations for both Fee-for-Service and Physical Health Managed Care delivery systems.

Bureau of Managed Care Operations – Responsible for the administration and oversight of mandatory managed care program known as HealthChoices that provides Medicaid benefits to eligible recipients in Pennsylvania.

Bureau of Policy, Analysis, and Planning – Responsible for the policy and program development for all inpatient, outpatient, and ancillary Medicaid services in both the fee-for-service and managed care delivery systems, as well as managing the functions of planning and data analysis for OMAP.

Office of Mental Health and Substance Abuse Services (OMHSAS)

OMHSAS' goal is to transform the children's behavioral health system to a system that is family and youth guided, implement services and policies to support recovery and resiliency in the adult behavioral health system, and assure that behavioral health services and supports recognize and accommodate the unique needs of older adults. Every individual served by the Mental Health and Substance Abuse Service system will have the opportunity for growth, recovery, and inclusion in the community, have access to culturally competent services and supports of their choice, and enjoy a quality of life that includes family members and friends.

Bureau of Children's Behavioral Health Services – Promotes the emotional well-being of children and works to ensure that children with emotional and behavioral challenges live, learn, work, and thrive in their communities. The bureau supports the objective of OMHSAS that is specifically related to the behavioral health needs of children and adolescents: to transform the children's behavioral health system to a system that is trauma-informed, family-driven, and youth-guided.

Bureau of Community and Hospital Operations – Responsible for the oversight of county mental health programs, contract oversight of HealthChoices managed behavioral health program, and operation and oversight for the state hospitals and South Mountain Restoration Center.

Bureau of Financial Management and Administration – Responsible for the development, implementation, oversight, and continual improvement of all OMHSAS administrative, financial, budgetary and personnel policies, procedures, regulations, and performance standards. Specific activities include budget planning, allocation, and monitoring; HealthChoices behavioral health capitation rate setting, analysis, and negotiation; capitation contract development and negotiation; management of the Medicaid fee-for-service program; personnel management, including labor relations; contract management and procurement; coordination of statewide training activities. The bureau director is a member of the OMHSAS Executive Staff Council.

Bureau of Policy, Planning, and Program Development – Responsible for performing a full range of behavioral health system and service planning as well as grant-funded program management functions. This includes managed care design and development, service system design and development, policy and program development, state and county planning and human resource development. Commonly identified as "OMHSAS Policy," the bureau coordinates legislative analysis, bulletin creation, regulation development, and the issuance of regulatory waivers of mental health program licensing regulations and bulletins.

Bureau of Quality Management and Data Review – Supports the department's goal of public accountability. By using proven methodologies and evidenced based practices, the bureau works to ensure that adults and children with mental illness and/or substance use disorders, and their families, receive high quality services from DHS. Additionally, the bureau works to ensure that those in our care are provided a voice in the oversight of the services they receive.

Resource H

County Assistance Office and County Mental Health/Intellectual Disabilities Office Contact Information

Pennsylvania County Assistance Offices

Call Center 1-877-395-8930

COMPASS HHS Home

County Assistance Offices

Adams 717-334-6241

Allegheny – Headquarters 412-565-2146

Allegheny – Alle-Kiski District 724-339-6800

Allegheny – Liberty District 412-565-2652

Allegheny – Three Rivers District. 412-565-7755

Allegheny – Southeast District . . . . . .412-664-6800 or 6801

Allegheny – Southern District 412-565-2232

Allegheny – Greater Pittsburgh East District . . . .412-645-7400 or 7401

Armstrong 724-543-1651

Beaver 724-773-7300

Bedford 814-623-6127

Blair 1-866-812-3341

Bradford 570-265-9186

Bucks 215-781-3300

Butler 724-284-8844

Cambria 814-533-2491

Cameron 814-486-3757

Carbon. 610-577-9020

Centre 814-863-6571

Chester 610-466-1000

Clarion 814-226-1700

Clearfield. 814-765-7591

Clinton 570-748-2971

Columbia. 570-387-4200

Crawford 1-800-527-7861

Cumberland 717-240-2700

Dauphin 717-787-2324
Delaware – Crosby District 610-447-5500
Delaware – Darby District 610-461-3800
Elk. 814-776-1101
Erie 814-461-2000
Fayette. 724-439-7015
Forest 814-755-3552
Franklin 717-264-6121
Fulton 717-485-3151
Greene. 724-627-8171
Huntingdon 814-643-1170
Indiana 724-357-2900
Jefferson. 814-938-2990
Juniata. 717-436-2158
Lackawanna 570-963-4525
Lancaster 717-299-7411
Lawrence 724-656-3000
Lebanon 717-270-3600
Lehigh 610-821-6509
Luzerne – Wilkes-Barre District 570-826-2100
Luzerne – Hazleton District 570-459-3800
Lycoming. 570-327-3300
McKean 814-362-4671
Mercer. 724-983-5000
Mifflin 717-248-6746
Monroe 570-424-3030
Montgomery – Norristown District 610-270-3500
Montgomery – Pottstown District 610-327-4280
Montour 570-275-7430
Northampton. 610-250-1700
Northumberland 570-988-5900

Perry 717-582-2127
Philadelphia – Headquarters 215-560-7226
Philadelphia – Boulevard District 215-560-6500
Philadelphia – Chelten District 215-560-5200
Philadelphia – Delancey District 215-560-3700
Philadelphia – Elmwood District 215-560-3800
Philadelphia – Glendale District 215-560-4600
Philadelphia – Liberty District 215-560-4000
Philadelphia – Somerset District 215-560-5400
Philadelphia – South District 215-560-4400
Philadelphia – Unity District 215-560-6400
Philadelphia – West District 215-560-6100
Pike 570-296-6114
Potter 814-274-4900
Schuylkill 570-621-3000
Snyder 570-374-8126
Somerset 814-443-3681
Sullivan 570-946-7174
Susquehanna 570-278-3891
Tioga 570-724-4051
Union 570-524-2201
Venango 814-437-4341/4342
Warren 814-723-6330
Washington 724-223-4300
Washington – Valley District 724-379-1500
Wayne 570-253-7100
Westmoreland 724-832-5200
Westmoreland – Donora/Valley District 724-379-1500
Wyoming 570-836-5171
York 717-771-1100

Intellectual/Developmental Disabilities/Autism Offices

ODP Customer Service Line 1-888-565-9435

RA-customerservice@pa.gov

York/Adams	717-771-9618
Allegheny	412-253-1399
Armstrong/Indiana	724-548-3451
Beaver	724-847-6225
Bedford/Somerset	814-443-4891
Berks	610-478-3271
Blair	814-693-3023
Bradford/Sullivan	570-265-1760
Bucks	215-442-0760
Butler	724-284-5114
Cambria	814-534-2800
Cameron/Elk	814-772-8016
Carbon/Monroe/Pike	570-421-2901
Centre	814-355-6782
Chester	610-344-6265
Clarion	814-226-1080
Clearfield/Jefferson	814-371-5100
Clinton/Lycoming	570-326-7895
Columbia/Montour/Snyder/Union	570-275-5422
Crawford	814-724-8380
Cumberland/Perry	717-240-6325
Dauphin	717-780-7050
Delaware	610-713-2400
Erie	814-451-6800
Fayette	724-430-1370
Forest/Warren	814-726-2100
Franklin/Fulton	717-264-5387

ASERT & Aid in PA
877-231-4244

Temple Institute on Disabilities
215-204-1356

PA Family Network
844-723-2645

Disability Rights Pennsylvania
800-692-7443 (Intake number)

Pennsylvania
Department of Human Services

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