Guidelines for developing Person-Centered Service Plan (PCSP)

Components to incorporate through interdisciplinary participation

- **Registrant will lead the person-centered planning process where possible**
  - Care plan team includes people chosen by registrant
  - Registrant representative should have participatory role as needed and as defined by registrant
  - Registrant directs the process to the maximum extent possible and is enabled to make informed choices and decisions
- **Care plan process**
  - Care plan is timely (every six months, whenever there is a change in condition, at the request of the registrant) and occurs at times and locations of convenience to registrant
  - Reflects cultural considerations of the registrant and is conducted in "plain language" and in the language the registrant prefers
  - Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants
  - Offers informed choices to the individual regarding the services and supports they receive and from whom
  - Includes a method for the registrant to request updates to the plan as needed
  - Records the alternative home and community-based setting that were considered by the registrant
- **Care plan requirements**
  - Must reflect the services and supports that are important for the registrant to meet the needs identified through UAS-NY
  - Must reflect the services and supports that are important ***to*** the registrant
  - Must reflect that the setting in which the registrant resides is chosen by the registrant
  - Must reflect the registrant's strengths and preferences
  - Must reflect clinical and support needs as identified through UAS-NY
  - Must include goals and outcomes (identified by registrant)
  - Must include services and supports (paid and unpaid) that will assist the registrant to achieve identified goals and the providers (paid/unpaid) of such services
  - Must reflect risk factors and measures in place to minimize them
  - Must be understandable to the registrant and representative: plain language, language preferred by registrant, accessible to people with disabilities
  - Identify the individual responsible for the PCSP
  - Must be finalized and agreed to, with consent of the registrant in writing and signed by all individuals and providers responsible for its implementation
  - Must be distributed to registrant and other people involved in the care plan