An Important Message from

The Texas Health and Human Services Commission (HHSC)

Recording Available for 'New & Revised Forms: STAR+PLUS HCBS & Community First Choice' Training

Background:

HHSC delivered the *New and Revised Forms: STAR+PLUS HCBS and Community First Choice* training on Aug. 15, 2025 via webinar. This training supports the Sept. 1, 2025 implementation of revised program requirements and is meant for STAR+PLUS MCO service coordinators that facilitate, document, and monitor the individual service plan for members eligible for or receiving Community First Choice (CFC) services and STAR+PLUS Home and Community-Based Services (HCBS).

This training reviews the new and revised versions of the following STAR+PLUS forms:

- 1701, Support Plan Narrative
- H1700-2, Individual Service Plan – Addendum
- H1700-3, Individual Service Plan – Signature Page
- H6516, CFC Assessment

Key Details:

A recording of the training can be viewed using this link.

Additional Information:

This training is part of a larger initiative to comply with the Centers for Medicare and Medicaid Services HCBS Settings Rule requirements for the person-centered planning process and the person-centered plan. Included in this initiative are a new person-centered service planning form; revisions to existing service planning forms; STAR+PLUS Handbook revisions; STAR+PLUS contract amendments; training and monitoring to support the revised program requirements.

A document containing responses to questions submitted during the webinar will be sent in a future MCO Notice.

Resources:

Policy or Operational Documents:	STAR+PLUS Handbook Revision 25-3, effective Sept. 1, 2025

Attachments:	1701, Support Plan Narrative and instructions H1700-2, Individual Service Plan – Addendum and instructions H1700-3, Individual Service Plan – Signature Page H6516, CFC Assessment and instructions

Other:	Training Recording Link
	
	Code of Federal Regulations Requirements for:
	
	• STAR+PLUS HCBS
	  ○ Person-Centered Service Planning Process
	  ○ The Person-Centered Service Plan
	  ○ Review of the Person-Centered Service Plan
	  ○ Home and Community-Based Settings
	
	• Community First Choice
	  ○ Person-Centered Service Planning Process, the Person-Centered Service Plan, and Reviewing the Person-Centered Service Plan
	  ○ Home and Community-Based Settings
	
	Access Rule

Questions?
For additional questions, please contact **UnitedHealthcare Customer Service at 888-887-9003, 8 a.m.–6 p.m. CT, Monday–Friday.**

Instructions

Updated: 9/2025

Note: A member as defined in 15 Texas Administrative Code (TAC) Section 353.2 is referred to as a person in this form. A Medicaid applicant is also referred to as a person in this form.

Purpose

Form 1701 is completed for a person being assessed for either the STAR+PLUS Home and Community Based Services (HCBS) program or Community First Choice (CFC) services. The form collects narrative information about the person to inform the services and supports he or she receives.

A person enrolled in the Home and Community-based Services (HCS), Texas Home Living (TxHmL), Community Living Assistance and Support Services (CLASS) and Deaf Blind with Multiple Disabilities (DBMD) waivers will not use this tool. Existing tools used in these waivers are used to assess for CFC services.

Form 1701 is:

- developed through a person-centered planning process;
- completed with the support of others chosen by the person, with support from the legally authorized representative (LAR) if applicable; and
- completed in a way that accommodates the person's style of interaction, communication and preferences for time and setting.

Form 1701 is used to:

- identify the person’s strengths, preferences, support needs and goals;
- identify what is important to the person;
- identify and document the person’s current and preferred living arrangement;
- identify natural supports available to the person;
- identify any needs, requests or considerations staff should know when supporting this person;

- describe how to meet the person's needs and whom to contact in case of an emergency;
- determine if the person's current living situation meets the federal requirements for HCBS settings; and
- document any modifications to the HCBS settings requirements for a person receiving services in provider owned or controlled settings.

Procedure

When to Prepare or Update

Form 1701 is part of the STAR+PLUS HCBS individual service plan (ISP). For a person applying for STAR+PLUS HCBS the MCO completes it. For a person eligible for CFC services and at least annually for a person receiving STAR+PLUS HCBS or CFC services the MCO or LIDDA completes it. The form is also updated whenever the person's needs have substantially changed.

Moving forward, assessor is the MCO or LIDDA completing the form.

The information in this form is obtained through an information gathering conversation called the discovery process. It is about the person's abilities, preferences and goals, in line with person-centered planning principles. The assessor should move through the various sections of the form following the natural flow of the conversation with the person and LAR, if applicable, and should re-visit completed sections if more information emerges as the discovery process continues.

The assessor must ask the person or LAR, if applicable, every question that appears on Form 1701 unless otherwise indicated on Form 1701 or in the form instructions. The assessor's observations cannot be substituted for the person's response but can be recorded in Section 9: Service Coordinator Comments. If the person does not use words to communicate, the assessor must facilitate communication sufficient for the person to respond to the questions on Form 1701. Every field on Form 1701 must be completed unless otherwise indicated on the form or in the form instructions. If a person or LAR does not know the information requested or declines to answer, document that in the space provided.

Form Retention

Each MCO must keep Form 1701 per the retention requirements found in all Medicaid managed care contracts and federal regulations. Keep all originals or electronic copies of this form in the applicant's or member's folder or electronic record for five years after services are denied or terminated.

The LIDDA must keep the original copy of the form in the individual's case record and provide a copy to the MCO.

The LIDDA must keep Form 1701 per the retention requirements found in the LIDDA Performance Contract and state and federal regulations.

Detailed Instructions

My Legal Name - Enter the person's legal name.

I Like to Be Called - Enter the name or nickname the person prefers to be called, if different from his or her legal name.

Person's Medicaid No. – Enter the person's nine-digit Medicaid number.

Date of Birth – Enter the person's date of birth.

Date of Completion – Enter the date the form is completed.

Event Type – Indicate if this narrative is initial, a renewal or a revision.

Section 1 – Individual Strengths and Preferences

Discuss the questions with the person and record their answers. Use the prompts on the form as a starting point for further conversation. The service coordinator can also record input from the LAR, if applicable, or others the person has invited to participate in the service planning meeting.

Insert Photo Here (optional) – If available, insert one or two recent photos of the person or photos of people, places or things that are important to him or her. This is optional but provides more information about the person.

What people like and admire about me – Document what the person likes about him or herself, as well as what others say they like about him or her. Document what the person wants others to know about him or her.

What's important to me – **Important to** reflects what is important from the person's perspective and is based on conversation with or observation of the

person. The information might include important relationships, how the person prefers to interact, things the person likes to do or not do, preferred routines, relevant background information and what the person wants to do in the future. Remember the person's response is limited to the knowledge and experiences he or she has to date. Effort should be made to increase the person's awareness of more possibilities and experiences to increase his or her options of choice.

What others need to know and do to support me – **Important for** reflects information that is important for the service provider to know and understand about health, safety and any supports necessary for the person to live the life he or she wants and be a valued member of the community. Document how the person communicates and prefers others to communicate with him or her. Enter information such as health needs, supervision requirements, specific behavioral needs, and special instructions for those who support the person. This section includes contraindications and special justifications for deviating from typical routines or activities. For example, this could include day activity health services three days a week, four hours a day, or a job four days a week, five hours a day. Things identified **as important for** are not usually included as **important to** the person.

What the people are like who support me best – Document the characteristics and traits that the person finds most supportive. Some examples are someone with a gentle voice who enjoys the same activities as the person or preference of a male or female attendant. Also document traits that the person finds unsupportive. Provide any information that may be important to a successful match between the person and the service provider.

How I like to spend my day - Document what the person prefers to do during the day, including but not limited to:

- daily routines and rituals;
- places he or she likes to go;
- how he or she relaxes;
- holidays he or she likes to celebrate; and
- any other activities he or she enjoys.

Also document other activities the person would like to start or do more often.

Other things about myself – Record biographical information about the person here. Also use this space to record any other information the person

says is important to know about him or her that is not captured by the questions above.

Section 2 – Goals or Desires

This section documents the person's goals or desired outcomes and the strategies and supports needed to achieve each goal.

Goal or Desired Outcome: Goals or desired outcomes are identified by and unique to the person. They can be medical or nonmedical, including personal, educational and social goals or outcomes, and can be short- or long-term. The assessor can use the terms goal or outcome interchangeably depending on what is most meaningful, understandable and useful to the person.

Examples of goals and outcomes include:

- Learning how to play the guitar
- Meeting new people in the community
- Getting a job at a beauty supply shop
- Staying out of the hospital
- Learning to use the city bus system and riding the bus alone
- Maintaining close friendships from the person's school days
- Taking a trip to the Grand Canyon

As the assessor, person and LAR, if applicable complete other parts of this form, information and patterns may emerge that indicate a goal or outcome needs to be recorded. For example, if the person states in Section 4 that he or she currently lives with a relative but wants to move into his or her own apartment, the assessor should record this as a goal in Section 2. The assessor and person can and should move freely between sections of the form to record any goals identified when discussing other subjects.

Example Form 1701 entry: I want to get a job in the next year.

Barriers to Achieving Goal or Desired Outcome: Identify any barriers that must be addressed for the person to achieve his or her goal or desired outcome. Barriers include, but are not limited to:

- Transportation
- Communication
- Awareness of options

- Access to and use of technology
- Health factors
- Community factors

Example Form 1701 entry:

Goal: I want to get a job in the next year.

Barriers:

- I do not know what kind of jobs I would like to do or be good at doing.
- I need help to apply for jobs online because I sometimes have trouble using the computer.
- I do not have a mode of transportation because I cannot drive a car or ride a bicycle.

Strategies: Work with the person to define strategies that will lead to achieving each goal or desired outcome. Strategies:

- Are specific.
- Detail actionable steps and assign responsibilities to specific people within the Medicaid applicant or member's support system to take towards meeting the goal.
- Identify the actions the service coordinator will take to help the person achieve each goal.
- Specify what the person and his or her support system need to observe to track progress.
- Are tailored to the person's preferences and capabilities.
- Provide clear criteria for tracking progress, ensuring both the person and his or her support system can effectively monitor advancements over time, and make adjustments based on changing circumstances.

Example Form 1701 entry:

Goal: I want to get a job in the next year.

Strategies:

- My service coordinator and I will complete the Employment First Discovery Tool together to determine what types of jobs I will apply for.

- My service coordinator will help me:
    - get approved for employment assistance services;
    - invite Michael, my mother and Ellen to my service planning meeting and discuss how they will support me in finding a job; and
    - find bus routes to the Texas Workforce Commission office and job interviews.
- I will contact the Texas Workforce Commission in the next month to get help applying for a job.
- I will apply for one job a week for the next three months.
- I will meet with my primary support person every two weeks to monitor my progress in getting a job.

Supports Needed to Achieve Goal or Desired Outcome: List people and other supports who will help the person reach this goal or outcome, including the service coordinator's role. Other supports can include community programs, resources through the person's school and religious groups. Document any barriers that might make meeting goals difficult for the person such as community or health factors, and how they can be overcome.

Example Form 1701 entry:

Goal: I want to get a job in the next year.

Supports Needed:

- My friend Michael will help me use the computer to apply for jobs online.
- My mother Delores will help me mark down job interviews on my calendar.
- My CDS employment assistance provider Ellen will meet with me every two weeks to monitor my progress in getting a job and will contact Vanessa if needed.
- My service coordinator Vanessa will check in with Michael, Ellen, my mother and me monthly and answer any questions we have.
- The Texas Workforce Commission will advise me on different career paths and open job postings.
- The city bus will be my mode of transportation to the Texas Workforce Commission office and job interviews.

Detail the plan to assess progress toward meeting established goals, including a time frame for follow-up to communicate with the

person: Together with the person, create a plan to follow up on progress towards each goal or desired outcome. The time frame for follow up:

- May differ between goals, even for the same person, due to factors including:
    - The person's priorities
    - External deadlines
    - Strategies used to meet the goal
    - Individualized barriers to meeting the goal
- Includes dates the service coordinator follows up with the person to discuss progress made toward achieving the goal.
- May be more frequent, but no less frequent, than the annual re-evaluation of the ISP.

Section 3 – Important People in the Person's Life

Does the person have a legally authorized representative (LAR)? Check the box showing if the Medicaid applicant or member has an LAR. If he or she has an LAR, document the type of legal authority this person has, if there is current legal paperwork on file, and the expiration date of the paperwork. If current legal paperwork is not on file, document the reason for this.

Current Providers: List the names and contact information for the person's currently known providers including primary care provider, individual or company providing home health, personal assistance service, physical therapy, occupational therapy, adult day care, respite care, meal delivery and transportation services.

People Who Are Important to Me*:* List the people the Medicaid applicant or member is close to and cares about. This will help the provider determine whom to speak with in certain situations. It will also help to ensure that the Medicaid applicant or member does not lose contact with important people in his or her life.

Also use this table to document current and future availability of paid or unpaid caregiver supports provided by family, friends, and other community members. This includes people who will assist the applicant or member with activities of daily living (ADLs) and instrumental activities of daily living (IADLs).

Additional rows may be added if necessary.

Name — Enter the name of a person who is important to the Medicaid applicant or member or who will provide help or services to the Medicaid applicant or member during the ISP period.

Relationship — Enter the relationship between the Medicaid applicant or member and the person who is important to him or her or will provide help or services to him or her during the ISP period.

Phone Number, Address and Email — Enter the area code and phone number, address and email address of the person who is important to the Medicaid applicant or member.

Is this person providing informal support(s) in lieu of paid services? — Check the correct box to indicate if the person who is important to the Medicaid applicant or member provides unpaid services or supports that supplement or replace services or supports that would otherwise be paid for.

Important Because —

Document why the person who is important to the Medicaid applicant or member is important to him or her. If the person who is important to the Medicaid applicant or member provides informal unpaid services or supports, document the service(s) provided by the person who is important to the Medicaid applicant or member and document specific detail of what is included in the service(s).

Examples unrelated to unpaid informal services and supports include:

- He is the person's father.
- She is the person's best and oldest friend. They have known each other since pre-school.
- She is the person's favorite teacher.
- He and the person like to go to Sunday brunch together every week.
- The person spends every holiday vacation at his house.

Examples related to unpaid informal services and supports:

- The person's wife reminding the person when to take his medications and at what dosages.
- The person's son visiting for dinner every night to prepare food, help the person eat and prevent the person from choking.

- The person's co-worker giving her a ride to and from work.
- The person's roommate helping her with personal hygiene.
- The person's friend helping the person learn steps to use the washing machine.
- The person wants to attend a regular church event in the future, and the Bible study lead will coordinate a schedule to provide transportation.

Units or Hours per Week — If the person who is important to the Medicaid applicant or member provides informal unpaid services or supports, enter the units or hours per week the service(s) will be provided. A single number indicating the total units or hours per week of all services provided is sufficient. Units and hours do not need to be broken down by individual service.

Involved in Development of Plan? — Check the appropriate box to indicate if the person who is important to the Medicaid applicant or member was involved in the development of the plan.

Check this box if no informal unpaid support is available — Check the box if no informal unpaid support is available. The term available refers to informal unpaid support that a person can access for help. If there are friends, family members or community members who are willing and able to provide help with daily activities or other care needs without compensation, then that support is considered available. If such informal support does not exist, or if there are individuals who could provide support but are unwilling to do so, check the box showing that there is no informal unpaid support available.

Section 4 – Living Situation

Current Residence – Check the most appropriate box from the list to show where the person currently lives.

Own Home or Apartment

- Alone – Check this box if the person lives alone. This includes a person living alone who receives in-home services.
- With spouse, partner or relative – Check this box if the person lives in his or her own home with a spouse, partner or relative. If the person lives with a spouse, partner or relative who is being paid, this box should be checked.

- With non-relatives or roommates – Check this box if the person lives with a non-relative or with other roommates. This includes if the person lives with a caregiver who is paid or unpaid, or if the person lives in a dorm or community living situation.

Someone Else's Home or Apartment

- Relative – Check this box if the person lives in a relative's home. The relative may be a paid or unpaid support providing services such as personal care to the person.
- Non-relative – Check this box if the person lives with a non-relative who may also be the person's caregiver who is paid or unpaid but is not living in the person's own home or relative's home.

Residential Setting

- Assisted Living Facility (ALF) – Check this box if the person lives in an ALF.
- Adult Foster Care (AFC) – Check this box if the person lives in an AFC home.

Institution

- Nursing Home – Check this box if the person lives in a nursing home as his or her permanent residence. If the person is currently in a hospital or nursing home for rehabilitation, but maintains a home elsewhere, do not select this box. For example, if the person is in the nursing facility for rehabilitation but has an apartment that he or she intends to return to, then the apartment is the current residence. The person's permanent living arrangement should be indicated rather than the temporary setting.
- Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) – Check this box if the person lives in an ICF/IID facility. This includes state supported living centers (SSLCs).
- Institution for Mental Disease (IMD) – Check this box if the person is currently living in an IMD, including a state psychiatric facility.

Other Living Arrangements

- No Permanent Residence – Check this box if the person does not have a permanent residence and specify the person's living arrangement. For

example, check this box if the person lives in an emergency shelter. A hotel or motel would go under no permanent residence if it is a temporary arrangement. If the hotel or motel serves as the person's permanent residence, select one of the options under the Own Home or Apartment category.

- Other–Specify – Check this box only if no other box is appropriate and specify the person's living arrangement.

Is this living situation:

- Permanent – Check this box if the person plans to stay in this living arrangement for the foreseeable future and if this living arrangement is available to the person for the foreseeable future.
- Temporary – Check this box if the person's current living arrangement will not be available to him or her in the future or if he or she is currently in the process of changing his or her living arrangement. Record the end date of the person's current living arrangement. If the exact date is unknown, provide the most accurate timeframe possible.

If you need to provide more information about the person's living arrangement, document this in Section 9: Service Coordinator Comments rather than choosing other when an existing option would be appropriate.

Who chose your current living arrangement? Ask the person if he or she chose his or her current living arrangement by himself or herself, or if someone else helped or chose for him or her. Check the appropriate box to show the person's answer. If someone else helped or chose for the Medicaid applicant or member, record that person's name.

Were you given a choice between all the residence types listed above? Ask the person if he or she, or the person who chose his or her current living situation, was offered a choice between all the residence types listed in the Current Residence sub-section under the:

- Own Home or Apartment;
- Someone Else's Home or Apartment;
- Residential Setting;
- Institution; and
- Other Living Arrangements headings.

Check the appropriate box to show the person's answer. If the person answers no, record the reason.

Were you given the option to live in a non-disability specific residence? Ask the person if he or she, or the person who chose his or her current living situation, was given the option of a non-disability specific living arrangement. Check the appropriate box to show the person's answer. If the person answers no, record the reason.

Prefers to Live – Check the appropriate box or boxes from the list to show the person's preference about where he or she lives. The Prefers to Live question asks for the person's own stated preference. It is used to determine if the person lives where he or she wants to live and to track changes over time. **Note: Record where the person would like to live, not where anyone else wants the person to live, and not where others think is realistic.** Explain each different type of living arrangement to help the person understand his or her options.

Own Home or Apartment

- Alone – Check this box if the person wants to live alone. This includes a person who prefers wants to live alone and who may receive in-home services.
- With spouse, partner or relative – Check this box if the person wants to live in his or her own home with a spouse, partner or relative. This could be with a spouse, partner or relative who is being paid.
- With non-relatives or roommates – Check this box if the person wants to live with a caregiver who is paid or unpaid, or to live in a dorm or community living situation.

Someone Else's Home or Apartment

- Relative – Check this box if the person wants to live in a relative's home.
- Non-relative – Check this box if the person wants to live with a non-relative who may also be the person's paid or unpaid caregiver but is not in the person's own home or relative's home.

Residential Setting

- Certified or Licensed Group Home – Check this box if the individual wants to live in a group home. This includes if the individual prefers to live in a three- or four-person residence operated by a certified HCS program provider.
- Assisted Living Facility (ALF) – Check this box if the person wants to live in an ALF.
- Adult Foster Care (AFC) – Check this box if the person wants to live in an AFC home.

Other Living Arrangements

- No Permanent Residence – Check this box if the person wants a non-permanent residence and specify the person's preferred living arrangement. For example, check this box if the person prefers living in an emergency shelter.
- Other–Specify – Check this box only if no other box is appropriate and specify the person's preferred living arrangement.
- Unable to determine person's preference for living arrangement – Check this box if you cannot determine the person's living preference due to such things as challenges with communication or cognitive ability.

If you need to provide more information about the person's preferred living arrangement, document this in Section 9: Service Coordinator Comments rather than choosing other when an existing option would be appropriate.

What is the LAR's preference for living arrangements for this person? – Check the appropriate box or boxes from the list to show the LAR's preference for where the person lives.

- Not applicable – There is no relative or LAR, or the relative or LAR does not have any preferences around the person's place of residence.
- Stay at current residence
- Move to own home or apartment which includes living with spouse or relative, non-relatives and caregivers
- Move to an ALF which includes all size ALFs
- No consensus among multiple parties
- Someone else's home including the home of a relative, non-relative or caregiver

Is there anything else you want to tell me about your living arrangement? Record the person's answer.

Is there anything you want to change about your living arrangement? Record the person's answer.

Are there any of the following home safety risks? Ask the person if any of the safety risks listed on the form are present in his or her home. The service coordinator can include his or her own observations along with the person's stated answer. Specify if the home safety risks are permanent or temporary, and document the end date, if known. Document details of all home safety risks in Section 9: Service Coordinator Comments.

Section 5 – How I Spend My Day

Discuss paid employment, volunteerism, retirement or unemployment, education and other activities with the person. Use the prompts on the form to encourage and guide discussion. If the person does not currently do one of the activities being discussed and does not want to, record this in the corresponding box. If the person states he or she currently works or would like to work, the box for retirement and unemployment will not be completed, and vice-versa. The service coordinator may insert information documented on Form 8401, Employment First Discovery Tool where appropriate and if the person has already completed it.

Section 6 – Emergency Plan

Describe the details of the emergency plan or back-up plan — Enter specific detail of how the person's needs will be met if there is an emergency. Emergencies include but are not limited to:

- a behavioral health crisis;
- serious injury;
- extreme weather;
- the provider not able to physically access the person due to physical obstructions;
- temporary or permanent loss of caregiver.

The emergency plan includes actions to take in a weather emergency, such as required use of a ventilator and power generator backup and required

emergency medication such as insulin and EpiPen. It also includes a listing of any life-threatening conditions the person has.

Include an emergency plan in the event the caregiver or the paid provider is unavailable. Because this situation is possible for any person, every person will have an emergency plan addressing, at minimum, actions to take if the caregiver or paid provider is unavailable.

Emergency contacts — Enter the name, relationship, area code and phone number of the people the Medicaid applicant or member would like the service coordinator to contact in an emergency. Emergency contacts could include family members or a trusted person who does not live with the Medicaid applicant or member.

The service coordinator must ensure the person has a physical copy of the emergency contact information described above. The physical copy given to the person must also include, at a minimum, the name and direct phone number of the service coordinator and appropriate provider staff to contact in an emergency.

Section 7 – HCBS Settings Requirements

Ask the person the questions in this section and record his or her responses.

Section 8 – Provider Owned and Controlled Settings

This section is only completed for a person receiving STAR+PLUS HCBS program services in provider owned and controlled settings, including but not limited to adult foster care (AFC) and assisted living facilities (ALF).

Provider Owned and Controlled HCBS Settings Requirements: Ask the person the questions in this sub-section and record his or her responses.

Modifications: HCBS settings requirements can only be modified for a person receiving services in a provider owned and controlled setting, and in those cases, only the requirements under 42 CFR 441.301(c)(4)(vi)(A) through 42 CFR 441.301(c)(4)(vi)(D) can be modified. Modifications must be applied to one person only. They cannot, for example, be enacted for all persons living in a single residential setting. Modifications can be enacted only with consent of the person or LAR. If a person is subject to multiple modifications, each is recorded and consented to separately.

If a modification will be enacted, select the checkbox showing this.

Clearly state the specific modification to the HCBS Settings Rule: Specify what action needs to be taken to ensure the person's health and safety.

Identify which right this modification restricts: Select the checkbox corresponding to which right the modification restricts.

Identify the specific and individualized assessed need: Enter the person's specific need prompting the modification. Do not enter a diagnosis.

How was the need assessed? Specify the mode in which the need was identified. This includes observations, assessment tools, or other modes. If a specific assessment tool was used, enter the name of the tool here.

Describe the health and safety risk caused by the assessed need: Describe the adverse result for the person if the modification is not approved.

Document the positive interventions and supports used before any modifications: Describe analytic methods and behavioral interventions implemented to help reduce challenging behaviors and to support and reinforce the learning of new, more appropriate behavioral skills.

Document less intrusive methods of meeting the need that have been tried but did not work. Explain why they did not work: Elaborate on analytic methods and behavioral interventions implemented to help reduce challenging behaviors and to support and reinforce the learning of new, more appropriate behavioral skills.

Describe how data will be collected and reviewed regularly to measure the ongoing effectiveness of the modification. Specify what data points will be collected: The person and service planning team will create a plan for collecting and monitoring data. Data can be both quantitative and qualitative. The data collection or monitoring plan should include:

- Frequency of data collection
- Method of data collection
- Who will collect the data
- The source of the data
- Methodology for data monitoring

- What data would need to be observed to minimize or lift the modification
- A plan to adjust if the data shows the modification is not effective

What is the frequency of review to determine if the modification is necessary? Enter the time intervals for the service planning team to review progress and determine if the modification is still necessary. These time frames are determined by the service planning team. Time frames may happen more often, but not less, than the annual re-evaluation of the ISP.

Describe how the provider will mitigate the impact of the intervention on the person: List:

- specific actions the provider will take to lessen the impact of the modification on the person's rights and daily life;
- ways that individual safety is considered; and
- if the person had choice in determination of the modification.

Informed consent of the person: Review the statement of informed consent together with the person and LAR, if applicable. Answer any questions the person has. Ensure the person knows he or she is not required to consent to the modification and will not be subject to retaliation if he or she does not consent. Also explain to the person that not consenting to the modification may mean not being able to receive his or her current services safely in his or her current living arrangement. He or she may need to select a different living arrangement or different services.

If the person or LAR agrees with the statement and consents to the modification, select the checkbox indicating this. The person or LAR consents to and initials each modification separately.

Section 9 – Service Coordinator Comments (if applicable)

Document any other information the person would like the service coordinator, service providers, informal supports, and others to know to best support him or her.

TEXAS Health and Human Services

Form 1701
September 2025

Support Plan Narrative

Section 1 – Individual Strengths and Preferences

My Legal Name	I Like to Be Called	Insert Photo Here (Optional)
Medicaid No.	Date of Birth	
Date of Completion	Event Type ◯ Initial ◯ Renewal ◯ Revision	

What people like and admire about me: The assessor asks the person what he or she likes about himself or herself and what others say they like about him or her. Ask what he or she wants others to know about him or her.

What's important to me: The assessor asks the person what he or she enjoys most and wants more of in his or her life. Include his or her preferences for routines and other parts of everyday life.

What others need to know and do to support me:

What the people are like who support me best: The assessor asks the person what qualities he or she looks for in a person who supports him or her, and if there are any traits that would not be helpful in supporting him or her.

How I like to spend my day: The assessor asks the person:

- about his or her preferred daily routine and rituals;
- places he or she likes to go;
- how he or she relaxes;
- holidays he or she celebrates; and
- other activities he or she enjoys. Include routines, rituals, and activities he or she would like to start or do more often.

Other things about myself: The assessor records biographical information about the person here. The assessor also uses this space to record any other information he or she says is important to know about him or her that is not captured by other questions in this section.

Section 2 – Goals

The assessor records information about the person's goals or desired outcomes below. These may be medical or nonmedical, including personal, educational, and social goals or outcomes.

Goal or Desired Outcome	Barriers to Achieving Goal or Desired Outcome	Strategies	Supports Needed to Achieve Goal or Desired Outcome	
				X

Add Row

The assessor details the plan to assess progress toward meeting established goals. The assessor includes a time frame for follow-up to communicate with the person.

Section 3 – Important People in the Person's Life

Does the person have a legally authorized representative (LAR)? ◯ Yes ◯ No

If the person has an LAR:

List type of LAR.

Is a current copy of LAR paperwork on file? ◯ Yes ◯ No

If yes, list the expiration date of the LAR paperwork.

If no, explain.

Current Providers

Provider Name	Provider Type	Contact Information	
			X

Add Row

People Who Are Important to Me

The assessor lists the people the person says they are close to and who know and care about him or her. It gives an idea of whom the assessor might want to talk to later. Include contact information.

Family

Name	Relationship	Area Code and Phone No.
Street Address, City, State and ZIP Code	Email	
Is this person providing informal support(s) in lieu of paid services? ◯ Yes ◯ No		
Important because:		
Units or Hours per Week	Involved in development of plan? ◯ Yes ◯ No	

Add Family Member | Remove Family Member

Friends

Name	Relationship	Area Code and Phone No.
Street Address, City, State and ZIP Code	Email	

Is this person providing informal support(s) in lieu of paid services? ◯ Yes ◯ No

Important because:

Units or Hours per Week	Involved in development of plan? ◯ Yes ◯ No

Add Friend | Remove Friend

School, Work or Other

Name	Relationship	Area Code and Phone No.
Street Address, City, State and ZIP Code	Email	

Is this person providing informal support(s) in lieu of paid services? ◯ Yes ◯ No

Important because:

Units or Hours per Week	Involved in development of plan? ◯ Yes ◯ No

Add School, Work or Other | Remove School, Work or Other

Community, Other

Name	Relationship	Area Code and Phone No.
Street Address, City, State and ZIP Code	Email	

Is this person providing informal support(s) in lieu of paid services? ◯ Yes ◯ No

Important because:

Units or Hours per Week	Involved in development of plan? ◯ Yes ◯ No

Add Community or Other | Remove Community or Other

☐ Check this box if no informal unpaid support is available.

Section 4 – Living Situation

Current Residence – Check applicable boxes.

Own Home or Apartment

☐ Alone – includes person living alone who receives in-home services

☐ With spouse, partner or relative

☐ With non-relatives or roommates

Someone Else's Home or Apartment

☐ Relative

☐ Non-relative

Residential Setting

☐ Assisted Living Facility (ALF) – STAR+PLUS HCBS only

☐ Adult Foster Care (AFC)

Institution

☐ Nursing Home

☐ Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID)

☐ Institution for Mental Disease (IMD)

Other Living Arrangements

☐ No Permanent Residence, such as an emergency shelter – Specify: _____

☐ Other – Specify: _____

Is this living situation:

◯ Permanent

◯ Temporary – Specify end date: _____

Who chose your current living arrangement?

◯ Me

◯ Me, together with someone else

Who helped you choose your current living arrangement? _____

◯ Someone else

Who chose your current living arrangement? _____

Were you given a choice between all the residence types listed above? ◯ Yes ◯ No

If no, explain reason.

Were you given the option to live in a non-disability specific residence? ◯ Yes ◯ No

If no, explain reason.

Prefers to Live – Check applicable boxes. Explain all options to the person.

Own Home or Apartment

☐ Alone – includes person living alone who receives in-home services

☐ With spouse, partner or relative

☐ With non-relatives or roommates

Someone Else's Home or Apartment

☐ Relative

☐ Non-relative

Residential Setting

☐ Certified or Licensed Group Home

☐ Assisted Living Facility (ALF)

☐ Adult Foster Care (AFC)

Other Living Arrangements

☐ No Permanent Residence, such as an emergency shelter – Specify: _____

☐ Other – Specify: _____

☐ Unable to determine person's preference for living arrangement

What is the legally authorized representative's (LAR's) preference for living arrangements for this person? Check applicable boxes.

☐ Not applicable

☐ Stay at current residence

☐ Move to own home or apartment. Includes living with spouse or relative

☐ Move to an ALF

☐ No consensus among multiple parties

☐ Someone else's home

Is there anything else you would like to tell me about your living arrangement?

Is there anything you would like to change about your current living arrangement? Or would you like to learn more about a different living arrangement?

Are there any of the following home safety risks?

☐ Home fall risk

☐ Bathroom safety

☐ Chemical hazards

☐ Food preparation safety

☐ Crime

☐ No home safety risks exists

Note: Document details of all home safety risks in Section 9, Service Coordinator Comments.

Are these risk(s)

◯ Permanent

◯ Temporary – Specify end date: _____

Section 5 – How I Spend My Day

If the person does not currently work or do an activity and does not want to, assessor indicates this in the corresponding box. Ask the person why he or she is not interested in this activity and document his or her response.

Work

Assessor asks the person:

- if he or she currently has paid employment, and if not, if he or she wants to;
- where he or she currently works or wants to work;
- his or her current or desired work schedule;
- things he or she likes and dislikes about his or her current or desired job or working in general;
- how he or she gets to work or wants to get to work; and
- anything he or she wants help with including Employment Assistance, Supported Employment and other program services.

Volunteering

Assessor asks the person:

- if he or she volunteers, and if not, if he or she wants to;
- where he or she currently volunteers or wants to volunteer;
- his or her current or desired volunteering schedule;
- what he or she likes and dislikes about his or her current or desired volunteer role or volunteering in general;
- how he or she gets to or wants to get to the place he or she volunteers or wants to volunteer; and
- anything he or she wants help with.

Retirement or Unemployment

Assessor asks the person:

- if he or she is retired or unemployed, and if not, if he or she wants to be;
- what he or she likes and dislikes about being retired or unemployed or would like and dislike;
- his or her current or desired schedule; and
- anything he or she wants help with.

Education

Assessor asks the person:

- about his or her educational background and what level of education he or she has completed;
- if he or she is currently in school, and if not, if he or she wants to enroll;
- what he or she currently studies or wants to study;
- where he or she currently attends or wants to attend school;
- his or her current or desired school schedule;
- what he or she likes and dislikes about school;
- how he or she gets to or wants to get to school; and
- anything he or she wants help with.

Other Activity

Assessor asks the person what other activities he or she likes to do or wants to do;

- where the activities take place;
- his or her current or desired activity schedule;
- things he or she likes and dislikes about the current or desired activities;
- how he or she gets to his or her current or desired activities; and
- anything he or she wants help with.

Section 6 – Emergency Plan

Describe the details of the emergency plan or back-up plan.

X

Add Row

Emergency Contacts – Name, Relationship and Area Code and Phone No.

X

Add Row

Section 7 – HCBS Settings Requirements

1. Do you have the chance to leave your home and do activities you enjoy? If not, why?

2. Can you access your money when you want and spend your money when and how you want? Does someone else help you manage your money or manage your money for you? If so, who?

3. Does your provider respect your choices about when and how your services are delivered? For example, when and what you eat or doing things on your own schedule instead of the provider's schedule?

4. Does your provider respect your privacy? For example, do they knock before they come into your room or into your house? Is your personal information kept private?

5. Do you feel like your provider gives you freedom to choose your daily routine and activities? For example, when and where you go out, where and when you eat your meals and snacks and take smoke breaks? Do you feel like you must do things the way the provider wants them on their schedule? Has anyone tried to stop or discourage you from doing the things you want to do? Are you spending the day in a way you like? If not, what would you change?

6. Has your provider ever restrained you?

Section 8 – Provider Owned and Controlled Settings

This section will only be completed for a person receiving STAR+PLUS HCBS program services in provider owned and controlled settings, including but not limited to adult foster care (AFC) and assisted living facilities (ALF).

8a. Provider Owned and Controlled HCBS Settings Requirements

1. Do you have a signed lease agreement with your provider?

2. If you have a roommate, were you given a choice about your roommate?

3. Were you given the opportunity to decorate and furnish your unit?

4. Does your living unit have a lock on the door, and do you have the key?

5. Do you have access to food at any time? For example, can you get food outside of regular mealtimes? Do you have to eat whenever everyone else is served?

6. Are you able to have visitors at any time?

7. Can you do activities you want to do when you would like to? Can you come and go as you would like? For example, is there a curfew?

8. Are you able to get around in your residence without help? **Note:** the assessor can record observations about physical accessibility in addition to the person's response.

8b. Modifications

Will any of the HCBS settings requirements under 42 CFR 441.301(c)(4)(vi)(A) through 42 CFR 441.301(c)(4)(vi)(D) be modified for this person? ◯ Yes ◯ No

Modification [number]

Clearly state the specific modification to the HCBS Settings Rule:

Identify which right this modification restricts:

◯ Lease or legally enforceable agreement for unit or dwelling

◯ Privacy in sleeping or living unit: Entrance doors lockable by person, with only appropriate staff having keys to doors

◯ Privacy in sleeping or living unit: Choice of roommates for persons sharing units

◯ Privacy in sleeping or living unit: Freedom to furnish and decorate sleeping or living units within requirements of lease or other agreement

◯ Freedom and support to control own schedules and activities

◯ Freedom and support to access food at any time

◯ Persons can have visitors of their choosing at any time

Identify the specific and individualized assessed need:

How was the need assessed?

Describe the health and safety risk caused by the assessed need:

Document the positive interventions and supports used before any modifications:

Document less intrusive methods of meeting the need that have been tried but did not work. Explain why they did not work:

Describe how data will be collected and reviewed regularly to measure the ongoing effectiveness of the modification. Specify what data points will be collected.

What is the frequency of review to determine if the modification is necessary?

Describe how the provider will mitigate the impact of the intervention on the person:

By initialing below, I agree to the following:

- I will be subject to the modification described above.
- I understand how this modification will affect me.
- I understand what will need to happen for this modification to be removed.
- I have discussed this modification with my service coordinator, family, friends, peers, or others of my choosing, if I wished to do so.
- All my questions about this modification have been answered.
- I understand I will not be subject to retaliation if I do not consent to this modification.
- I understand that if I do not consent to this modification, my service providers may not be able to ensure I can receive my current services safely in my current living arrangement.
- I can withdraw my consent at any time, and I will talk to my service coordinator if I wish to do so.
- By initialing below, I am consenting only to the modification described in the section directly above. If I am subject to multiple modifications, my service coordinator and I will discuss each one separately, and I will consent to each one separately.

I consent to the modification described above: ◯ Yes ◯ No

Printed Name of Member or Legally Authorized Representative (LAR)	Initials	Date

Add Modification | Remove Modification

Section 9 – Service Coordinator Comments

Instructions

Updated 9/2025

Purpose

Use this form to document the STAR+PLUS Home and Community Based Services (HCBS) program benefits provided to the applicant or member and to establish the medical need and rationale for all items or services included on Form H1700-1, Individual Service Plan. The service coordinator also documents on Form H1700-2 all other resources and supports, available and projected, that the applicant or member will use during the individual service plan (ISP) period.

Procedure

When to Prepare

The managed care organization (MCO) service coordinator completes Form H1700-2, or an alternate form of documentation that includes the same information. Form H1700-2 documents all other resources and supports, available and projected, that the applicant or member will use during the individual service plan (ISP) period. Form H1700-2 is completed at the initial assessment, reassessment or for a change in condition.

Form Retention

The managed care organization (MCO) must keep a copy of Form H1700-2 or any alternate document in the member's case record per the retention requirements found in all Medicaid managed care contracts and federal regulations. Provide a copy of Form H1700-2 to the applicant or member on request. After service termination, the MCO must keep all originals and electronic copies of Form H1700-2 in the member's case record for five years.

Detailed Instructions

Individual Service Plan Dates — MCO staff enter the begin and end date of the ISP using mm/dd/yyyy format. For initial assessments, the MCO must use the ISP dates listed on Form H2065-D, Notification of Managed Care Program Services, received from HHSC Program Support Unit (PSU) staff.

Revision Date — Enter the date the ISP was revised if any changes were made during the ISP period. This line is left blank during the initial assessment and annual reassessment.

Applicant or Member Name — Enter the name of the applicant or member.

Medicaid ID No. or Applicant Social Security No. — Enter the applicant's or member's Medicaid number or Social Security number if a Medicaid number is not available.

Section 1 – Medical Information

Describe why the STAR+PLUS HCBS program item or service is necessary and how it benefits the applicant or member:

Item or Service — Enter the STAR+PLUS HCBS program item or service requested on the ISP by the applicant or member or identified as a need by the service coordinator. Each item or service should be entered on a separate line. More lines may be added, if needed.

Rationale — Enter specific information detailing why the requested STAR+PLUS HCBS program item or service is necessary and exactly how it will benefit the individual medically, functionally or in terms of rehabilitation. The rationale should demonstrate how the member meets waiver eligibility of having an unmet need for waiver services. For paid attendant care, include any nursing tasks or health maintenance activities that have been delegated to the attendant.

Section 2 – Payors

A. Medicare and Other Payors – include Medicare, VA, TRICARE, private insurance and other payors — Enter the following information for each non-Medicaid payor listed.

Resource — Enter the name of the non-Medicaid payor providing services to the applicant or member during the ISP period.

Policy No. — Enter the policy number, if available.

Service Type and Detail — Enter the service provided. Document specific detail of what is included in the service.

Units or Hours per Week — Enter the units or hours per week the service is provided.

Not Applicable Box — Check the Not Applicable box if the applicant or member does not receive services from Medicare or other payors.

B. Medicaid State Plan Services – include Medicaid Home Health, DAHS, and CFC — Enter the following information for each state plan service listed.

Resource — Enter the name of the state plan service to be provided to the applicant or member during the ISP period.

Service Type and Detail — Enter the service provided. Document specific detail of what is included in the service. For paid attendant care, include any nursing tasks or health maintenance activities that were delegated to the attendant.

Units or Hours per Week — Enter the units or hours per week the service is provided.

Not Applicable Box — Check the Not Applicable box if the applicant or member does not receive any Medicaid State Plan Services.

C. Services Provided in an Educational Setting — Enter the information for services provided in an educational setting.

Resource — Enter the name of the educational facility that provides services to the applicant or member during the ISP period.

Service Type and Detail — Enter the service provided. Document specific detail of what is included in the service and the beginning and end date of the service. The dates must be within the From and To dates as documented on Form H1700-1, Individual Service Plan. Enter Unknown for an unknown begin date.

Units or Hours per Week — Enter units or hours per week the service is provided.

Not Applicable Box — Check the Not Applicable box if the applicant or member does not receive services in an educational setting.

D. Value-added Services — Enter the following information if it is anticipated the applicant or member will use MCO Value-added Services (VAS) during the ISP period. Include only waiver benefits offered as VAS items or services such as dental services, emergency response services, respite or home-delivered meals. VAS are not required to be used before waiver service. VAS vary by MCO. The service coordinator is responsible for knowing the VAS applicable for the applicant or member.

Service Type and Detail — Enter the service provided. Document specific detail of what is included in the service.

Units or Hours per Week — Enter units or hours per week the service will be provided.

Not Applicable Box — Check the Not Applicable box if the applicant or member does not receive VAS.

E. Additional Follow-up — Enter any other follow-up referral or assessments needed. A referral can be generated for a specific service or item such as:

- physical therapy, personal care service or durable medical equipment (DME); or
- for an assessment for a service such as a referral for a behavioral health assessment to determine specific services an individual may need.

Item or Service — Enter any other identified item or service the applicant or member was assessed as needing but does not have a current authorization.

Action — Enter the action steps needed for the item or service to be authorized and the party or entity responsible for completing the follow-up or assessment. If no action is needed, enter No action required. Document the reason why.

Not Applicable Box — Check the Not Applicable box if the applicant or member does not have any other follow-up needs.

Section 3 – Follow-up Schedule

Enter the information for the applicant’s or member’s follow-up schedule.

Service Coordinator follow-up schedule — Enter the service coordinator's plan to follow up and communicate with the applicant or member during the ISP period.

Section 4 – Service Coordinator Comments if Applicable

The service coordinator can provide additional documentation of the applicant's or member's needs from Section 3 - Follow-up Schedule section in this section. Any other needs and how the needs are met may also be listed. Enter comments relevant to the applicant's or member's medical or functional status not documented elsewhere.

TEXAS Health and Human Services

Form H1700-2
September 2025

Individual Service Plan – Addendum

Individual Service Plan Begin Date	Individual Service Plan End Date	Revision Date

Applicant or Member Name	Applicant or Member Medicaid ID No. or Social Security No.:

Section 1 – Medical Information

Describe why the STAR+PLUS HCBS program item or service is necessary and how it benefits the applicant or member:

Item or Service	Rationale	
		X
		X
		X
		X

Add Row

Section 2 – Payors

A. Medicare and Other Payors – include Medicare, VA, TRICARE, private insurance and other payors. ☐ Not Applicable

Resource	Policy No.	Service Type and Detail	Units or Hours per Week	
				X
				X
				X
				X

Add Row

B. Medicaid State Plan Services - include Medicaid Home Health, DAHS, CFC ☐ Not Applicable

Resource	Service Type and Detail	Units or Hours per Week	
			X
			X
			X
			X

Add Row

C. Services Provided in an Educational Setting ☐ Not Applicable

Resource	Service Type and Detail	Units or Hours per Week	
			X
			X
			X
			X

Add Row

D. Value-added Services	☐ Not Applicable	
Service Type and Detail	**Units or Hours per Week**	
		X
		X
		X
		X
		Add Row

E. Additional Follow-up	☐ Not Applicable	
Item or Service	**Action**	
		X
		X
		X
		X
		Add Row

Section 3 – Follow-up Schedule

Service Coordinator follow-up schedule:

	X
	X
	X
	X
	Add Row

Section 4 – Service Coordinator Comments If Applicable

TEXAS Health and Human Services

Form H1700-3
September 2025

Individual Service Plan – Signature Page

Individual Service Plan Begin Date	Individual Service Plan End Date	Revision Date
Applicant or Member Name	Applicant or Member Social Security No.	Applicant or Member Medicaid ID No.

Freedom of Choice: I understand that the STAR+PLUS Home and Community Based Services (HCBS) program may be an alternative to nursing facility services. I was informed about the program and its limitations and I freely choose services through the STAR+PLUS HCBS program.

Acknowledgement and Acceptance of the Individual Service Plan: I, the applicant, member or authorized representative, completed Form 1701, Support Plan Narrative, together with my service coordinator. I acknowledge review of the waiver services shown on Form H1700-1, Individual Service Plan and agree that they match the goals I identified for myself on Form 1701. I also acknowledge review of the program items or services identified on Form H1700-2, Individual Service Plan – Addendum. I accept my person-centered service plan as appropriate to meet my assessed medical, functional and cognitive needs and to help me achieve my goals. I understand the state of Texas will not pay for the services on the plan until all eligibility decisions are made and waiver services are authorized by Texas Health and Human Services Commission.

Applicant, Member or Authorized Representative:

Printed Name	**Signature**	**Date**

Witness, if applicable:

Printed Name	**Signature**	**Date**

Service Coordinator Verification: I verify assessment of the applicant or member to establish or maintain eligibility for the STAR+PLUS HCBS program. Medical need and rationale were established on Form H1700-2, Individual Service Plan – Addendum. The waiver services identified are based on the goals the applicant or member identified for himself or herself on Form 1701, Support Plan Narrative. The waiver services identified are also necessary and appropriate to meet the applicant or member's needs.

Service Coordinator:

Printed Name	**Signature**	**Date**

Instructions

Updated: 9/2025

Purpose

Form H6516 is completed for applicants or individuals being assessed for Community First Choice (CFC) services. The form helps collect and document essential information to determine the functional needs of applicants or individuals 21 and over for CFC services.

Individuals in the Home and Community-based Services (HCS), Texas Home Living (TxHmL), Community Living Assistance and Support Services (CLASS) and Deaf Blind with Multiple Disabilities (DBMD) waivers will not use this tool. Existing tools used in these waivers are used to assess for CFC services.

For the remainder of the instructions, the term individual is defined as an applicant or member requesting CFC services.

Form H6516:

- is developed through a person-centered planning process;
- occurs with the support of a group of people chosen by the individual and the legally authorized representative (LAR) on the individual's behalf; and
- accommodates the individual's style of interaction, communication and preferences regarding time and setting.

Use Form H6516 to:

- determine the Habilitation (HAB), Personal Assistance Services (PAS), Emergency Response Services (ERS) and Support Management needs of an individual;
- assess the individual's needs, functional impairments, ability to perform activities of daily living (ADLs), instrumental activities of daily living (IADLs) and health-related tasks;
- document the individual’s preferences for when to receive CFC services;
- document the risks to the individual’s health and safety, as well as a plan to mitigate those risks;

- identify any special needs, requests or considerations staff should know when supporting this individual; and
- document the individual's unmet needs.

Procedure

When to Prepare or Update

Form H6516 is completed by the local intellectual and developmental disability authority (LIDDA) or managed care organization (MCO) in its entirety when an individual applies for CFC services and at least annually for individuals receiving CFC services. The form is also updated whenever the individual's needs have substantially changed, or at the request of the individual or LAR, if applicable.

Assessor from this point forward refers to the LIDDA or MCO completing the form.

If an individual or LAR does not know the information requested or refuses to answer, document that in the space provided.

Form Retention

The LIDDA must keep the original copy of the form in the individual's case record and provide a copy to the MCO.

The LIDDA must keep Form H6516 per the retention requirements found in the LIDDA Performance Contract and state and federal regulations.

The MCO must keep the form for five years after the case is closed, per record retention requirements.

Detailed Instructions

Individual's Name - Enter the individual's name. Required on each page of the assessment.

Medicaid No. – Enter the individual's nine-digit Medicaid number.

Date of Birth – Enter the individual's date of birth.

Date of Assessment – Enter the date this assessment is completed.

Sex – Select Male or Female to indicate the individual's sex.

Employment Status – Check the appropriate box to indicate the individual's employment status: employed, unemployed or retired.

Education Level - Check the appropriate box to indicate the individual's education level. If none of the boxes apply to the individual's education level, select other and document the individual's education level.

Participants – List each person who participated in this assessment.

Type of Assessment – Check the type of assessment being conducted: initial, renewal or revision.

Note: The information in this form is about the individual's abilities, preferences and goals, in line with person centered planning principles. It is obtained through an information gathering conversation called the discovery process.

Section 2 – Needs Assessment Questionnaire and Task and Hour Guide

The Needs Assessment Questionnaire and Task and Hour Guide is comprised of three sections:

- Part A – Functional Assessment. This part is used to assess an individual's level of support needs, who currently provides the service and if the individual needs that service purchased.
- Part B – Task and Hour Guide. When a task needs to be purchased, the Task and Hour Guide details how much time is needed to provide either the PAS or HAB service.
- Part C – Subtasks and PAS Minute Ranges. This section is used to indicate the subtasks the individual needs help or training with when a task is purchased.

Note: The Task and Hour Guide must be completed for each purchased task. Each purchased task must have subtasks indicated in Part C.

Part A – Functional Assessment

The functional assessment is comprised of the support level and service arrangement.

Support Level (SL)

The support level is designed to assess an individual's capacity for self-care. Score each item per this capacity for self-care and not per the individual's access to a resource to help with the task. In scoring each item, use the individual's response, plus any observations or knowledge of the individual from other sources. The support level is not required for an individual receiving only habilitation.

Each PAS task has an associated question to help score the support level. The first time an item is addressed, use the wording of the question as written. Then, explain or paraphrase, if necessary. Ask follow-up questions if there is a need to verify the first response. PAS task items 1-23 must be given a support level.

For PAS activities only, score the individual per the following scale:

Score	Score Details
0	None. No functional impairment. The individual can conduct activities without difficulty and has no need for assistance.
1	Mild. Minimal or mild functional impairment. The individual can conduct activities with minimal difficulty and needs minimal help.
2	Severe. Extensive or severe functional impairment. The individual has extensive difficulty carrying out activities and needs extensive help.
3	Total functional impairment. The individual is completely unable to carry out any part of the activity.

An individual has an impairment with respect to a particular activity if he or she is limited, either physically or mentally, in his or her ability to carry out that activity. An impairment could also be a behavioral challenge resulting in difficulty accomplishing the task.

Numbers 0 and 3 are absolutes because they indicate no functional impairment or total dependency. **Example:** If an individual can perform any of the dressing tasks for himself or herself, a 3 is not appropriate. If he or she can perform the dressing task completely without difficulty, a 0 is appropriate.

Enter a score for each question in the Support Level column.

Use the following examples for each item to help differentiate between scores of 1 and 2. An individual may score 1, but not request help with a task. The following are only examples of appropriate scores based on the individual's abilities. If an example is appropriate for an individual, but the score for that example is not, give the appropriate score and explain your choice.

Tasks	1 = Minimal or Mild Impairment	2 = Extensive or Severe Impairment
1. Bathing	Individual can bathe self, but needs supplies laid out. Individual can bathe self but needs help drawing and testing the temperature of the water. Individual needs standby help for safety or reminding and monitoring. Individual needs minimal help getting in and out of tub or shower. Individual may accomplish bath for self by using a chair or other adaptive device for assistance. Individual requires partial supervision or cueing. Individual requires help bathing but can be left alone to soak in the tub. Individual refuses to bathe without multiple prompts.	Individual needs extensive help getting in and out of tub or shower. Individual needs hands-on help with actual bathing and drying of body. Individual must always use adaptive devices and needs help arranging adaptive devices for the bath. Individual can only manage sponge baths due to disabilities. Individual requiring a bed bath can help with some part of the task. Individual always requires cueing or ongoing supervision while bathing. Individual gets out of the tub multiple times while bathing due to behavioral challenges such as fear of water, or cognitive ability such as not understanding reason for showering.

Tasks	1 = Minimal or Mild Impairment	2 = Extensive or Severe Impairment
2. Dressing	Individual needs occasional help with zippers, buttons or putting on shoes and socks. Individual may need help laying out or selecting clothes. Individual needs reminding or monitoring for completion of dressing. Individual occasionally refuses to get dressed.	Individual always needs help with zippers, buttons or shoes and socks. Individual needs help getting into garments. This includes putting arms in sleeves, legs in pants or pulling up pants. Individual may dress totally inappropriately without help or would not finish dressing without physical help. Individual needs help dressing because he or she routinely undresses him or herself.
3. Exercising	Not scored.	
4. Eating	Individual may need standby help but only occasional physical help. Individual needs verbal reminders or encouragement. Individual eats with adaptive devices but requires help with applying and positioning. Individual can feed self but occasionally smears food on table due to behavioral challenges or cognitive ability.	Individual usually needs extensive hands-on help eating. Individual may hold eating utensils but needs continuous help during meals and would not complete meal without continual help. Spoon feeding of most foods is required, but individual can eat some finger foods. Individual needs constant supervision because he or she has Prader Willi Syndrome, pica disorder or polydipsia. Individual requires constant

Tasks	1 = Minimal or Mild Impairment	2 = Extensive or Severe Impairment
		supervision during eating due to risk of choking.
5. Grooming	Support level is based on the highest level of support level needed on any grooming task in (5a-5b).	
5a. Shaving, Oral Care and Nail Care	Individual can manage grooming, but needs supplies laid out or handed to him and needs standby for safety and help with grooming tools. Individual can accomplish grooming but needs reminding or monitoring. Individual occasionally refuses to complete grooming tasks.	Individual cannot adequately shave face or under arms and legs because of inability to see well, to reach or to successfully use equipment. Individual cannot adequately brush teeth and perform oral care. Individual cannot adequately care for nails. Individual routinely refuses to complete grooming tasks.
5b. Routine Hair and Skin Care	Individual can manage hair and skin care but needs supplies laid out. Individual needs reminding to do tasks. Individual needs help to comb or brush hair. Individual needs help applying non-prescription lotion to skin.	Individual cannot adequately perform washing and shampooing hair, drying hair, or setting, rolling or braiding hair. Individual cannot adequately wash hands and face or apply makeup. Individual refuses to complete tasks or has moderate behaviors surrounding these tasks.

Tasks	1 = Minimal or Mild Impairment	2 = Extensive or Severe Impairment
	Individual sometimes requires prompting to complete tasks. Individual pushes hands away when hair is brushed.	Individual always needs help because he or she screams when face gets wet. Individual always requires prompting to complete tasks.
6. Toileting	Individual has instances of urinary incontinence and occasionally needs help because of this. Fecal incontinence does not occur unless caused by a specific illness episode. Individual may need help with supplies or equipment. Individual needs some help with clothing during toileting. Individual needs standby help. Individual may have catheter or colostomy bag, and occasionally needs help with management.	Individual often cannot get to the bathroom on time to urinate or has occasional episodes of fecal incontinence. Individual may wear incontinence products to manage the problem and needs help with them. Individual usually needs help with catheter or colostomy bag. Individual needs help with a bedpan or urinal, or with emptying a catheter bag or changing an external catheter or colostomy bag. Individual needs diapers changed or needs help with feminine hygiene products.
7. Hygiene in Toileting	Individual can usually manage cleaning self after toileting except on	Individual often needs help with cleaning after toileting because of difficulty in

Tasks	1 = Minimal or Mild Impairment	2 = Extensive or Severe Impairment
	occasional days when bending or moving is particularly difficult, or when incontinence occurs. Individual may have catheter or colostomy bag, and occasionally needs help with management. Individual occasionally needs help toileting due to cognitive ability such as lack of understanding of hygiene, or due to behavioral challenges such as fecal smearing.	reaching, or due to incontinence problems. Clothes are sometimes soiled and odorous. Individual usually needs help with catheter or colostomy bag. Individual routinely needs help toileting due to cognitive ability such as lack of understanding of hygiene, or due to behavioral challenges such as fecal smearing.
8. Transfer	Individual usually can get out of bed or chair with minimal or standby help. Individual may accomplish transfer without help but needs standby assistance for safety. Individual needs some help adjusting or changing position in a bed or chair, called positioning. Individual may sometimes need prompting to complete transfers.	Individual usually needs hands-on help when rising to a standing position or moving into a wheelchair to prevent losing balance or falling. Individual can help with the transfer by holding on and supporting him or herself. Individual can help some with non-ambulatory movement from one stationary position to another, called a transfer. This task does not include carrying. Individual usually needs help

Tasks	1 = Minimal or Mild Impairment	2 = Extensive or Severe Impairment
		transferring due to behavioral challenges or cognitive ability.
9. Walking (Ambulation)	Individual walks alone without help for only short distances. Individual can walk with minimal difficulty using an assistive device or by holding onto walls or furniture. Individual needs help positioning for use of a walking apparatus or putting on and removing leg braces and prostheses for ambulation. Individual may need repeated prompts while ambulating.	Individual has considerable difficulty walking even with an assistive device. Individual can walk only with help from another person and never walks alone outdoors without help. Individual may use a wheelchair periodically. Individual needs help with wheelchair ambulation. Wheelchair ambulation is defined as pushing the wheelchair for the individual. Individual needs help walking due to behavioral challenges or cognitive ability.
10. Cleaning	Individual can do most tasks around the house, like picking up, dusting, washing dishes, sweeping, straightening the bed, carrying out trash, light vacuuming or cleaning sinks. Individual cannot move heavy furniture or do extensive scrubbing or	Individual can do only very light housework like dusting, washing a few dishes or straightening up magazines or newspapers. Individual cannot see well enough or does not have the strength or flexibility to sweep floors, change bed linens or carry heavy objects.

Tasks	1 = Minimal or Mild Impairment	2 = Extensive or Severe Impairment
	mopping. Individual may be capable of cleaning but may refuse or sometimes require repeated prompts to complete tasks.	Individual may excessively collect items or neglect to pick up after themselves. Individual may be capable of cleaning but routinely refuses or requires repeated prompts to complete tasks.
11. Laundry	Individual does hand washing but has difficulty wringing and hanging heavy laundry to dry. Individual can do most laundry tasks but needs minimal help to put clothes in machines, sort clothes, fold them and put them away. Individual may have strength but may not be able to see or turn washer dials or, may require supervision or instruction to use a washer. Individual may be capable of doing laundry activities but may refuse or require repeated prompts to complete tasks.	Individual may do light hand washing but cannot bend or lift or carry loads of clothes to manage most laundry, and cannot hang clothes out at all or get them off a line, but may fold them and help put them away. Individual may not be able to wring out clothes without help. If a laundromat is used, the individual has considerable difficulty getting there. Individual has special laundry needs due to incontinence or other physical problems and needs laundry more frequently than once a week.
12. Meal Preparation	Individual can do some meal preparation but has some difficulty. Individual can prepare simple foods or warm up food like frozen meals or	Individual cannot cook meals due to physical impairment and can only do minimal preparation of simple cold foods like sandwiches or cereal.

Tasks	1 = Minimal or Mild Impairment	2 = Extensive or Severe Impairment
	food prepared by others. Individual may have difficulty with cutting meats or other foods. Individual can prepare foods but needs help with meal planning or minimal help preparing meals. Individual may need help carrying food items or meal preparation items. Individual needs help with hygienic and safe practices around food preparation and storage.	Individual has difficulty opening cans and preparing fresh foods for cooking. Individual regularly has difficulty seeing or turning burners on and sometimes forgets to turn them off. Individual needs prepared meals pureed or ground up for serving. Individual may be fearful or unable to use kitchen appliances safely due to behavioral challenges or cognitive ability.
13. Escort	Not scored.	
14. Shopping	Individual decides what to buy but needs help preparing a shopping list. Individual can shop if someone goes along to help. This could be prompting or help using money to purchase items. Individual may shop by phone but needs help carrying or storing groceries. Individual can do most shopping, but needs extra	Individual may still decide what to buy, but seldom, if ever, goes to a store and needs shopping for all items and picking up medications. Individual may not be able to shop by phone because of communication difficulties. Individual cannot regularly carry or store most of the purchases without help. Individual may wander off during shopping due to cognitive ability or yell or cry

Tasks	1 = Minimal or Mild Impairment	2 = Extensive or Severe Impairment
	items picked up between shopping trips.	during shopping trips due to behavioral challenges.
15. Help with Medications	Individual can self-direct* medications, but occasionally needs help with opening the containers. Individual may need to be reminded to take medications. *Self-direct means the individual can: • identify the proper medication by name or sight including color and shape; • identify the purpose of the medication such as for my heart, for pain, for allergies; • determine the correct dosage is being taken such as one pill; and • identify the time medication is needed for example morning or lunchtime.	Individual or LAR can self-direct* medications but needs help opening containers or needs the medication brought within reach. Individual or LAR can self-direct * medications but has a visual impairment and may not be able to read labels. Individual or LAR can self-direct* medications but must be reminded to ensure that medications are taken as prescribed. Unless medication is a delegated task, it cannot be purchased if the score for medication is 3. Total help indicates the individual cannot self-direct medications and requires either skilled assistance or supervision from informal support. Total help indicates the individual can self-direct medications, but due to a functional limitation, is unable to self-administer medications, or due to cognitive limitations where the

Tasks	1 = Minimal or Mild Impairment	2 = Extensive or Severe Impairment
		individual refuses to take medications.
16. Trim Nails	Individual can trim his or her own fingernails but may have difficulty doing his or her toenails by him or herself. Individual may be capable of trimming nails but refuses or is unable due to behavioral challenges or cognitive ability.	Individual trims fingernails only when no one is available to help. Individual cannot reach and trim toenails and has difficulty using scissors or clippers. Individual may be capable of helping but refuses or is unable due to behavioral challenges or cognitive ability.
Note: A diagnosis of diabetes does not automatically indicate a score of 3. Many people with diabetes can trim their nails. If a medical practitioner has instructed an individual with diabetes not to trim the nails, score the task 3.		
17. Balance	Individual occasionally gets dizzy or needs to steady him or herself by holding onto furniture or a person and may need to hold someone's arm to go up and down stairs. Individual may have experienced an occasional fall because of imbalance or the individual's movement is restricted because of fear of falling.	Individual usually experiences some imbalance and needs to hold onto a support when he or she first stands up to steady him or herself. Individual suffers from dizziness that affects his or her balance and would likely fall if help was not available.

Tasks	1 = Minimal or Mild Impairment	2 = Extensive or Severe Impairment
18. Open Jars, Cans and Bottles	Individual can open some containers but may have difficulty with very large jars, special medicine caps or containers that require special opening instructions or procedures. Individual may use an assistive device.	Individual cannot open large jars or new bottles or jars without help or an assistive device. Individual may be able to open small jars and bottles that have been previously opened.
19. Phone	Individual can use phone but may have difficulty hearing or getting to the phone quickly when it rings. Individual may need to go out of the home to use the phone but can do so without much difficulty.	Individual may be able to answer or talk on the phone but may not be able to dial the correct number. Individual is sometimes not able to get to a phone when necessary. Individual may be able to use the phone but may require repeated prompting and monitoring to use appropriately. For example, the individual is susceptible to being taken advantage of by telemarketers.

Items 20-23 are assessed for PAS only.

On Items 20 and 21, the assessor can use information other than the individual's perception of him or herself only if:

- the individual provides inaccurate information because of his or her physical or mental impairment;
- there are inconsistencies between the information the individual is providing and the assessor's observation of the individual; or

- there is conflicting information provided by a family member present during the interview.

To properly score these questions, if the assessor is unsure of the information given by the individual, he or she will:

- get as much information as possible from the individual;
- contact a third party such as a family member or friend, who is aware of the individual's cognitive abilities; or
- use his or her judgment to score the question if no one is available who knows the individual's cognitive abilities.

20. Initial scoring: These questions are based on the individual's perception of self.

- 0 – If the answer to both questions is No, stop here.

Final scoring:

- 1 – If the answer to all four questions is No.
- 2 – If the answer to any one of these four questions is Yes.
- 3 – If the answer to at least two of these four question is Yes.

21. Scoring instructions: This question is based on the individual's perception of self. Does the individual indicate he or she has trouble concentrating and has memory lapses? Does the individual indicate he or she needs help making decisions?

- 0 – If the answer to the question is not at all.
- 1 – If the answer to the question is occasionally or a couple times.
- 2 – If the answer to the question is frequently, more than a couple times but not every day.
- 3 – If the answer to the question is every day.

22. Scoring instructions: This question is based on someone's observation of the individual. This may be a family member, relative, caregiver or the person who called in the intake. Information from home health attendants or assessor observation can be used to score this question, but only as a last resort. The assessor must make every effort to contact a third party to provide the information. There should be documented attempts in the case record to contact other resources. If no other source is available, and the assessor feels

the information provided by the attendant is accurate, he or she can score the information based on the attendant's knowledge and observation of the individual.

- 0 = The answer to the question is the individual makes consistent and reasonable decisions independently. For example, he or she pays bills and makes financial decisions, keeps own medical appointments, and maintains own household.
- 1 = The answer to the question is the individual makes simple decisions without help. For example, he or she decides what to wear, what to buy at the grocery store, and when to do housekeeping chores.
- 2 = The answer to the question is the individual makes poor decisions and needs cues or supervision for most decisions.
- 3 = The answer to the question is the individual is severely impaired and rarely makes his own decisions.

23. Scoring instructions: This question is based on someone's observation of the individual. This may be a relative, caregiver or the person who called in the intake. Information from home health attendants or assessor observation can be used to score this question, but only as a last resort. The assessor must make every effort to contact a third party to provide the information. There must be documented attempts in the case record to contact other resources. If no other source is available, and the assessor feels the information provided by the attendant is accurate, he or she can score the information based on the attendant's knowledge and observation of the individual.

- 0 = The answer to the question is No.
- 1= The answer to the question is the individual has some short-term memory problems and can perform tasks for himself with occasional reminders.
- 2 = The answer to the question is the individual has memory lapses resulting in frequently not performing tasks even with reminders.
- 3 = The answer to the question is the individual has memory lapses resulting in inability to perform routine daily tasks.

Service Arrangement (SA) – Enter the following codes to show the service provider for PAS and HAB activities.

Code	Details
S	Self. Use S if the Individual performs the task without any help.
C	Caregiver. Use C when all of the task is being performed by or training is being provided by an unpaid relative, neighbor or friend regularly.
P	Purchased. Use P if any part of the task will be purchased all the time or at times when another service arrangement type is not available to help. For PAS only, if the functional score is 3, a service arrangement code of P should only appear under Item 15, Assistance with Medications, if it is a delegated task. Unless delegated, since 3 indicates total inability to perform any aspect of the task, only a licensed nurse or designated informal support or caregiver may fulfill this need. Habilitation may still be provided, if appropriate, for an individual with a functional score of 3.
P/C	Purchased or Caregiver. Use P/C when the caregiver is helping with, performing a purchased task or training the individual on how to perform the task during the time the attendant is present. Document in the Preferences and Special Considerations section the part of the task the caregiver performs or provides training on. **Example 1:** The caregiver helps with bathing by laying out supplies but needs the attendant to help with the bath. **Example 2:** The individual requests a five-day plan and the daughter, who is the caregiver, works Monday, Wednesday and Friday. The daughter helps the individual with bathing on Tuesday and Thursday during the time the attendant is present performing other tasks. When the caregiver is not available during the time purchased tasks are delivered and helps only in the evenings or on weekends, a general comment may be entered in the Comments section. The tasks are not coded as P/C, but P only for purchased tasks. **Example 3:** The individual requests a five-day plan and the caregiver works full time. The caregiver will help in the evenings and on the weekend but does not help with tasks during the time the attendant is present. A comment, Caregiver (use name and relationship) helps in the evenings and on weekends in the

Code	Details
	Preferences and Special Considerations section is adequate documentation. Code the task as P. **Example 4:** The caregiver packs breakfast and lunch for the individual but the attendant provides training to the individual on meal preparation for dinner. **Example 5:** The caregiver helps the individual on and off the toilet but the attendant teaches the individual about toileting hygiene.
A	Other agency. Use A when a non-contracted agency is performing the task.
P/A	Purchased/Agency. Use P/A when another agency is available to perform the task on some days, but not other days. Document in the Preferences and Special Considerations section the part of the task the other agency performs.
NA	Not Applicable or None Available. Not Applicable: The only tasks that can be not applicable are Walking and Assistance with Medications. Use NA when the individual cannot perform any part of the walking task, exercise task or assistance with medications task, and there is no caregiver or other agency totally performing the task. For example, an individual is a double amputee and cannot walk or use wheelchair ambulation. No time will be allotted for the task. Explain in the Preferences and Special Considerations section the task is not applicable.

Additional Habilitation Activities

The information below includes examples of habilitation activities. You may use them to determine if an individual needs habilitation training in these specific tasks.

Information about the service arrangement is below the examples.

Service Arrangement (SA)	Example
24. Money Management	Individual may need help counting money, learning how to budget and paying for items, among other things.
25. Interpersonal Communication	Individual may need help communicating with others in person, on the phone or on the computer.
26. Community Integration	Individual may need help finding, participating in and accessing community activities.
27. Reduction of Challenging Behaviors to allow individuals to accomplish ADLs, IADLs, and health-related tasks	Individual may have challenging behaviors that can be reduced through behavior support plans, prompting, rewards or redirection, among others.
28. Accessing Leisure Time and Recreational Activities	Individual may need help finding activities he or she wants to participate in during leisure time or accessing those activities.
29. Self-Advocacy	Individual may need help learning how to advocate for him or herself. Advocating for oneself could include asserting preferences or requesting needed services.
30. Socialization and Development of Relationships	Individual may need help with development and maintenance of relationships or appropriate social behaviors.
31. Personal Decision Making	Individual may need help making decisions for him or herself. This includes help assessing what is important to that individual, pros and cons, as well as consequences.

Service Arrangement (SA)	Example
32. Accessing Community Resources	Individual may need help finding, participating in, and accessing community resources such as free meal programs, churches, parks, self-advocacy training or events.
33. Use of Augmentative Communication Devices	Individual may need help operating, learning to use, or accessing an augmentative communication device.
34. Other	Include other activities when the individual may have a need for habilitation training in the other category if it does not fit in an existing category.
35. Other	Include other activities when the individual may have a need for habilitation training in the other category if it does not fit in an existing category.

Part B – Task or Hour Guide Column

Minutes Per Day – To have each task authorized as PAS, enter the daily number of minutes needed to conduct that task, based on the support level and the minute range for that task shown in Part C. Times must be shown in five-minute increments and, if needed, rounded up to the next five-minute increment. For each task to be authorized as HAB, enter the daily number of minutes needed to provide training on that task.

The time allotted for PAS must be within the range shown in Part C for the support level and cannot be higher or lower, except in the following situations:

- If an individual has a compelling reason for not wanting any of the subtasks under the appropriate support level, but only wants subtasks listed in a lower support level, document the individual's request and allocate minutes in the minute range for the subtasks selected. Document the reason and no supervisory approval is required. **Example:** The individual scores 2 on bathing. She needs help with drying. However, when discussing subtasks, she states she wants standby help for safety and drawing of water, all under the support level

of 1. She states her skin is very sensitive and she would not allow help with drying as she is afraid it would hurt her. The subtasks checked are all under the support level of 1, so ten minutes is allowed. Documentation is required to explain the variance. No supervisory approval is required.

- If an individual has a caregiver or other agency performing part of a task and only subtasks in a lower support level are needed, the assessor must document the individual's request and allocate minutes in the minute range for the subtasks selected. Document the reason and no supervisory approval is required. **Example:** The individual scores 2 for bathing, but only wants help laying out supplies and drawing water because her daughter provides all hands-on help with the bathing task. The task is marked P/C. The subtasks under the support level of 1 are checked and ten minutes is allowed for the subtasks to be purchased. Documentation is required to explain the variance. No supervisory approval is required.

A task may be purchased if it is performed at least once a month by the provider. Time allotted for the task must be prorated into a weekly amount. **Example:** Escort 1 time a month × 120 minutes ÷ 4.33 = 28 minutes per week. Round up to the next five-minute increment to equal 30 minutes per week.

Escort may be shown as PRN, as needed, if it occurs less than once a month and no time is allocated.

Note: Get supervisory approval if:

- the individual has extenuating circumstances, other than the exceptions listed above; and
- requires time outside the range, either more or less, for the subtasks within the appropriate support level.

Do not change the support level to adjust the minutes or for the convenience of a provider or attendant. For supervisory approval, document the individual's extenuating circumstances and justify the need for minutes outside the range. The request must be in writing and the supervisor's approval or disapproval must be in writing. Documentation of the request and the approval or disapproval must be filed in the case record. Supervisory approval is required for the adjustment of time outside the ranges to specific tasks and to combinations of tasks that have ranges.

Companion Cases – For PAS only. Check the box in each companion case eligible section to show if there is a companion case. For general household tasks, including cleaning, shopping and meal preparation, use the companion minute range rather than the individual range. Time is assigned per individual based on the individual's support level. Check the box(es) in the Total Minutes Per Week column for cleaning, meal preparation or shopping to show that time is authorized for these tasks to the companion case. In situations where there are more than two companions in the household, assign time based on the individual's support level using the companion minute ranges.

- **Example 1:** On cleaning, Mr. Jones scores 3 and Mrs. Jones scores 1. Mrs. Jones can do some light housekeeping, but due to her husband's incapacity, he needs all cleaning tasks performed in his area. Mrs. Jones is allowed the maximum of 45 minutes under support level 1 in the companion range. Mr. Jones is allowed the maximum of 180 minutes under support level 3 in the companion range.
- **Example 2:** On meal preparation, Mr. and Mrs. Smith both score 2. However, they have different schedules and need some meals shared and others on an individual basis. Calculate everyone's time based on the meals needed within the impairment range. Use the time in the companion minute range for shared meals and time in the individual range for non-shared meals. Use the Optional Meal Preparation Chart as a tool for calculating time.

Optional Meal Preparation Chart for a Varied Meal Schedule – This is an optional chart to help calculate time for meals for individuals who have a varied schedule. There is no requirement for this chart to be completed as it is a tool only to help calculate times. Enter the time for each meal by the number of days the meal is needed for the total minutes for each type of meal. Use the individual or companion range, as appropriate, and check the box. Total the minutes for the Total Minutes per Week.

Divide the Total Minutes per Week by the number of days per week meals will be authorized for the Average Daily Minutes. If needed, round this amount up to the next five-minute increment. Enter this amount in Part B, Minutes Per Days for the task of Meals. In Days Per Week, enter the highest number of days meals are prepared, even if not all meals are prepared daily.

Days Per Week – For each task to be authorized as PAS or HAB, enter the number of days per week the attendant will conduct that task. Enter in the Preferences and Special Considerations section if the task is performed less

than once a week. For the task of Feeding, enter the total number of meals per week.

Sub-Total Minutes Per Week –- Multiply the minutes per day by the days per week to get the Sub-Total Minutes Per Week for each PAS or HAB task.

Part C – Subtasks and PAS Minute Ranges

Note: The minute ranges in this section only apply to PAS activities. Indicate using the checkbox if habilitation is needed for any of the subtasks, but when completing the Task and Hour Guide for habilitation, do not use the minute ranges indicated in Part C.

The subtasks in Part C must be checked to show specifically what the individual needs. An individual scoring of 2 or 3 may need all subtasks under the support level for 1 and additional subtasks under the support level of 2.

Preferences or Special Considerations

Indicate preferences or special considerations identified during the discovery process in the space provided for each activity. This could include the individual's preference to take baths over showers, or factors such as behaviors that result in higher scores. Additionally, any comments regarding each task can also be documented in this space.

Calculating Total PAS and Habilitation Hours

Total PAS Minutes Per Week - Add the subtotal minutes for each task 1-19 to get the Total PAS Minutes for all tasks.

Total PAS Hours Needed Per Week –Divide the Total PAS Minutes by 60 to determine the weekly total in hours. Round the weekly number of hours to the next highest quarter hour to determine the total hours to authorize. **Example:** If an individual needs 7 hours and 10 minutes of service each week, enter 7.25 in Hours Needed. This field is NA for HCBS STAR+PLUS Waiver.

Total Habilitation Minutes Per Week – Add the subtotal HAB minutes for each task 1-19, and 24-36 to get the Total HAB Minutes for all tasks.

Total Habilitation Hours Needed Per Week – Divide the Total HAB Minutes by 60 to determine the weekly total in hours. Round the weekly number of hours to the next highest quarter hour to determine the total hours to

authorize. **Example:** If an individual needs 7 hours and 10 minutes of service each week, enter 7.25 in Hours Needed.

Total Combined PAS and Habilitation Hours Per Week - Enter the total weekly hours that can be authorized. Do this by adding together the Total PAS Hours Per Week and the Total HAB Hours Needed Per Week. Round the time up to the next highest quarter hour.

Section 3 – Health-Related Tasks Screening Tool

The Health-Related Tasks Screening Tool is used to determine if the individual may have nursing tasks when the individual or his or her LAR is requesting CFC PAS/HAB. The assessor asks the individual or LAR and then records his or her answer. The assessor is not expected to answer these questions for the individual or LAR.

A. Physician Delegation - Answer Yes or No to the question about physician delegation. Physicians may delegate medical acts to an unlicensed person when the unlicensed person can carry out the act properly and safely. As the physician remains responsible for the medical act performed, delegation is made to a specific person and does not encompass any person who is caring for the individual. Writing an order for an individual's care does not constitute delegation to an unlicensed person. If the answer is Yes, skip to Section C.

B. Medication Administration – Check Yes or No to the question about medication administration. If the answer is Yes, check all the routes of medication administration that are currently used.

C. Special Procedures – Answer Yes or No to the questions about special procedures.

D. Eating - Answer Yes or No to the questions about eating.

E. Bathing – Answer Yes or No to the question about bathing.

F. Toileting – Answer Yes or No to the questions about toileting.

G. Mobility – Answer Yes or No to the questions about mobility.

H. Health-Related Task Screening Tool Review – Review the Yes responses in Section B-G. Make a referral to the MCO to take further action if any tasks are shown to need to be delegated tasks or HMAs.

Section 4 – Emergency Response Service (ERS)

Check Yes or No to show if the individual needs ERS. If Yes, describe how the individual will benefit from ERS in the space provided. Any more comments about special considerations or preferences should also go in this space.

Section 5 – Information and Referrals

Check the box or boxes from the list to show the referrals appropriate for the individual.

- STAR+PLUS Home and Community Based Services (STAR+PLUS HCBS)
- Waiver Interest List (Community Living Assistance and Support Services (CLASS), Deaf Blind with Multiple Disabilities (DBMD), Medically Dependent Children Program (MDCP), Texas Home Living (TxHmL), Home and Community Based Services (HCS))
- State Supported Living Center crisis diversion slot
- Preadmission Screening and Resident Review (PASRR) crisis diversion slot
- Other Medicaid services, such as durable medical equipment, augmentative communication systems, seating and positioning systems, power or custom mobility equipment, nursing and therapy services
- Other non-Medicaid or community service
- Housing options which refers to housing-only services such as Section 8 housing assistance and other independent or subsidized housing arrangements that are affordable, integrated and accessible
- Community living options which refers to services and programs that support community living, including in-home nursing, attendant and habilitation services, minor home modifications, respite, and adaptive aids, among others
- Other – Specify any other referrals that are appropriate for the individual

Notes: Provide any additional information about information and referrals for the individual. For example, show why the individual was or was not referred for a service.

Section 6 – Support Management

1. Check Yes or No to show if the individual is currently receiving support management.
2. Check Yes or No to show if the individual wants to receive support management.

If Yes for 1 or 2, complete 3.

1. Identify any needs, requests or considerations specific to this service necessary for the staff to know when supporting the individual to achieve his or her outcomes.

Section 7 – Service Delivery Options

For initial assessment: Check Yes or No to show if the individual is interested in self-directing CFC services.

For renewal: Check the appropriate box to show what service delivery option the individual is currently using. The service delivery options are Agency, Consumer Directed Services or Service Responsibility Option. Check Yes or No to show if the individual wants to change his or her service delivery option.

Section 8 – Summary of Recommended Community First Choice Services

Community First Choice PAS/HAB Recommended Total Hours – Show the total combined recommended CFC PAS/HAB hours as listed at the end of Section 2.

Support Management: Check Yes or No to indicate the response given in Section 6.

ERS – Check Yes or No to indicate the response given in Section 4.

Health-Related Tasks indicated in Section 3 – Indicate Yes or No if there are health-related tasks indicated in Section 3.

Section 9 – Acknowledgement

Signing this page affirms:

- The hours suggested on Form H6516 are informed by the goals the individual has identified for themselves on Form 1701, Support Plan Narrative.
- The individual, LAR, representative or assessor participated in the service planning process.
- The individual, LAR, representative and assessor understand that this document and the hours listed on this plan are only a recommendation and not a guarantee of services to be provided. However, this recommendation will be used to guide the approval and provision of services for CFC.

Signature of Individual or Legally Authorized Representative and Date – The individual or LAR must sign and date Form H6516 after completion. Any updates to the form must be initialed and dated by the individual or LAR. If the individual or LAR refuses to sign the form, the assessor should notate this on the signature line of the form.

Printed Name of Individual or LAR – Print or enter the individual or LAR's name.

Signature of Assessor and Date – The assessor must sign and date Form H6516 after completion. Any updates to the form must be initialed and dated by the assessor.

Printed Name of Assessor – Print or enter the assessor's name.

Signature of Representative and Date – If a representative participates in the completion of the assessment, he or she must sign and date Form H6516 after completion. Any updates to the form must be initialed and dated by the representative, if applicable.

Printed Name of Representative – Print or enter the representative's name.

Signature of Other Person and Date – If there is another person who participates in the completion of the assessment, he or she must sign and date Form H6516 after completion.

Printed Name of Other Person – Print or enter the other person's name.

Signature of MCO Staff and Date – If there is an MCO staff other than the assessor who participates in the completion of the assessment, he or she must sign and date Form H6516 after completion.

Printed Name of MCO Staff – Print or enter the MCO staff's name.

TEXAS Health and Human Services

Form H6516
September 2025

Community First Choice Assessment

Section 1 – Individual's Information and Type of Assessment

Individual's Name	Medicaid No.	Date of Birth

Date of Assessment	Sex	Employment Status
	◯ Male ◯ Female	◯ Employed ◯ Unemployed ◯ Retired

Education Level

◯ Less than high school (HS) ◯ HS diploma or equivalence ◯ Some College ◯ College degree

◯ Master's or higher ◯ Other: _____

Participants

Type of Assessment: ◯ Initial ◯ Renewal ◯ Revision

Section 2 – Needs Assessment Questionnaire and Task and Hour Guide

Scoring the Support Level for Personal Assistance Services (PAS)

Score the individual per the following scale:

Score	Description
0 = None	No functional impairment. The individual can conduct activities without difficulty and has no need for help.
1 = Mild	Minimal or mild functional impairment. The individual can conduct activities with minimal difficulty and needs minimal help.
2 = Severe	Extensive or severe functional impairment. The individual has extensive difficulty carrying out activities and needs extensive help.
3 = Total	Total functional impairment. The individual cannot carry out any part of the activity.

Task, Minute, and Subtask Guide

General – The minute range for each PAS task and score is the minimum and maximum time that may be allowed for the task at that score level. Times must be shown in 5-minute increments and if needed, rounded up to the next highest 5-minute increment. Check each subtask the individual requires. If there is more than one individual residing in the home, use the companion range for common household tasks (cleaning, meal preparation and shopping). If the individual has a caregiver or other agency doing part of a task, so that the service arrangement is coded Purchased/Caregiver (P/C) or Purchased/Agency (P/A), less time may be allowed for the purchased part of the task without supervisory approval.

Specific Tasks – Each task has one or more activities or subtasks that form the overall purchased task. When calculating PAS times, carefully consider which activities will be purchased. An individual with an impairment score of 2 may need subtasks listed under impairment score 1, or an individual with an impairment score of 3 may need subtasks listed under impairment score 1 and 2. Check all subtasks that apply for the individual's specific circumstances to specify the type of help provided and support the time allocated for that task.

Supervisory Approval is required to authorize any PAS minutes outside these guidelines. The need for more minutes or fewer minutes within a specific impairment score must be documented and justified when requesting supervisory approval. Refer to the form instructions for exceptions and procedures for requesting supervisory approval.

Support Level (SL): 0 = None **1** = Mild **2** = Severe or **3** = Total
Service Arrangement (SA): C = Caregiver **P** = Purchased **NA** = Not Applicable **S** = Self or **A** = Other Agency
Boxes related to priority factors are in bold.

1. Bathing

Part A – Functional Assessment	SL	Part B – Task and Hour Guide: SA	Min. Per Day	Days Per Week	Sub-Total Min. Per Week
1.a. Do you have any problems taking a bath or shower? PAS time needed for bathing				x _____ = PAS	
1.b. Habitation (HAB) time needed for bathing				x _____ = HAB	

Part C – Subtasks and PAS Minute Ranges

PAS Support Level 1 Minute Range 5-10	Habilitation?	PAS Support Level 2 Minute Range 15-30	Habilitation?	PAS Support Level 3 Minute Range 35-45	Habilitation?
☐ Minimal help in or out of tub or shower	☐	☐ Extensive help in or out of tub or shower	☐	☐ Total help with bathing	☐
☐ Laying out supplies	☐	☐ Tub or shower bathing	☐		
☐ Drawing water	☐	☐ Sponge bathing	☐		
☐ Standby help for safety	☐	☐ Bed bathing	☐		
☐ Reminding or monitoring	☐	☐ Drying	☐		

☐ If hauling and heating water are required, add an extra 30 minutes for all support levels.

Preferences and Special Considerations:

2. Dressing

Part A – Functional Assessment	SL	Part B – Task and Hour Guide: SA	Min. Per Day	Days Per Week	Sub-Total Min. Per Week
2.a. Can you dress yourself? PAS time needed for dressing				x _____ = PAS	
2.b. Habilitation time needed for dressing				x _____ = HAB	

Part C – Subtasks and PAS Minute Ranges

PAS Support Level 1 Minute Range 5-10	Habilitation?	PAS Support Level 2 Minute Range 15-20	Habilitation?	PAS Support Level 3 Minute Range 25-30	Habilitation?
☐ Laying out clothing	☐	☐ Always requires help with zippers, buttons, socks or shoes	☐	☐ Total help dressing	☐
☐ May require occasional help with zippers, buttons, putting on socks or shoes	☐	☐ Requires help getting into and out of garments	☐		
☐ Reminding or monitoring	☐				

Preferences and Special Considerations:

Individual's Name: _____

3. Exercise

Part A – Functional Assessment		Part B – Task and Hour Guide				
		SA	Min. Per Day	Days Per Week		Sub-Total Min. Per Week
3.a. Walking only - maximum 30 minutes				x	= PAS	
3.b. Habilitation time needed for exercise				x	= HAB	

Preferences and Special Considerations:

4. Eating

Part A – Functional Assessment		Part B – Task and Hour Guide				
		SA	Min. Per Meal	Meals per Week		Sub-Total Min. Per Week
4.a. **Can you feed yourself?** Enter score of 3 if individual requires total help. If tube fed or gastrostomy feeding, **do not purchase.**	Enter 0-3			x	= PAS	
4.b. Habilitation time needed for eating				x	= HAB	

Part C – Subtasks and PAS Minute Ranges

PAS Support Level 1 Minute Range 5-10	Habilitation?	PAS Support Level 2 Minute Range 15-20	Habilitation?	PAS Support Level 3 Minute Range 25-30	Habilitation?
☐ Verbal reminders or encouragement	☐	☐ Spoon feeding	☐	☐ Total help with feeding	☐
☐ Standby help	☐	☐ Bottle feeding	☐		
☐ Applying adaptive devices	☐				

Preferences and Special Considerations:

5. Grooming

Part A – Functional Assessment		Part B – Task and Hour Guide				
5.a. **Can you shave yourself, brush your teeth, shampoo and comb your hair? Use the higher score of 5b or 5c.**	SL					
		SA	Min. Per Day	Days Per Week		Sub-Total Min. Per Week
5.b. Shaving, oral care, nail care				x	= PAS	
5.c. Routine hair and skin care				x	= PAS	
5.d. Habilitation time needed for grooming				x	= HAB	

Part C – Subtasks and PAS Minute Ranges

Shaving, Oral Care, Nail Care

PAS Support Level 1 Minute Range 5-10	Habilitation?	PAS Support Level 2 Minute Range 15-20	Habilitation?	PAS Support Level 3 Minute Range 25-30	Habilitation?
☐ Laying out supplies	☐	☐ Shaving	☐	☐ Total help grooming	☐
☐ Verbal reminders	☐	☐ Brushing teeth	☐		
		☐ Shaving legs, underarms	☐		
		☐ Caring for nails	☐		

Routine Hair and Skin Care

PAS Support Level 1 Minute Range 5-10	Habilitation?	PAS Support Level 2 Minute Range 15-30	Habilitation?	PAS Support Level 3 Minute Range 35-45	Habilitation?
☐ Laying out supplies	☐	☐ Washing hair	☐	☐ Total help with routine hair and skin care	☐
☐ Verbal reminders	☐	☐ Drying hair	☐		
☐ Combing hair	☐	☐ Setting, rolling, or braiding hair	☐		
☐ Applying non-prescription lotion	☐	☐ Washing hands and face	☐		
		☐ Applying makeup	☐		

Preferences and Special Considerations:

6. Toileting

Part A – Functional Assessment

6.a. Do you have any problems getting to the bathroom and using the toilet?

6.b. Habilitation time needed for toileting

Part B – Task and Hour Guide

	SA	Min. Per Day		Days Per Week		Sub-Total Min. Per Week
6.a.			x		= PAS	
6.b.			x		= HAB	

7. Hygiene in Toileting

Do you have trouble cleaning yourself after using the bathroom? SL

Part C – Subtasks and PAS Minute Ranges

PAS Support Level 1 Minute Range 5-10	Habilitation?	PAS Support Level 2 Minute Range 15-20	Habilitation?	PAS Support Level 3 Minute Range 25-30	Habilitation?
☐ Preparing toileting supplies or equipment	☐	☐ Helping on or off bedpan	☐	☐ Total help with toileting	☐
☐ Helping with clothing during toileting	☐	☐ Help using the urinal	☐		
☐ Occasional help with cleaning self	☐	☐ Help with toileting hygiene	☐		
☐ Occasional help with catheter or colostomy care	☐	☐ Help with feminine hygiene needs	☐		
☐ Standby help	☐	☐ Changing diapers	☐		
		☐ Changing external catheter	☐		
		☐ Emptying catheter bag	☐		
		☐ Changing colostomy bag	☐		

Preferences and Special Considerations:

8. Transfer

Part A – Functional Assessment	SL	Part B – Task and Hour Guide: SA	Min. Per Day	Days Per Week	Sub-Total Min. Per Week
8.a. Can you get in and out of your bed or chair?				x = PAS	
8.b. Habilitation time needed for transferring				x = HAB	

Part C – Subtasks and PAS Minute Ranges

PAS Support Level 1 Minute Range 5-10	Habilitation?	PAS Support Level 2 Minute Range 15-20	Habilitation?	PAS Support Level 3 Minute Range 25-30	Habilitation?
☐ Helping with positioning - adjusting or changing position	☐	☐ Non-ambulatory movement from one stationary position to another	☐	☐ Total help positioning or transferring from bed to chair	☐
☐ Minimal help rising	☐	☐ Hands-on help rising from a sitting to a standing position	☐		
☐ Standby help	☐	☐ Extensive help positioning or turning	☐		

Preferences and Special Considerations:

9. Walking

Part A – Functional Assessment	SL	Part B – Task and Hour Guide: SA	Min. Per Day	Days Per Week	Sub-Total Min. Per Week
9.a. Can you walk without help?				x = PAS	
9.b. Habilitation time needed for walking				x = HAB	

Part C – Subtasks and PAS Minute Ranges

PAS Support Level 1 Minute Range 5-10	Habilitation?	PAS Support Level 2 Minute Range 15-20	Habilitation?	PAS Support Level 3 Minute Range 25-30	Habilitation?
☐ Standby help with walking	☐	☐ Steadying in walking or using steps	☐	☐ Total help with wheelchair ambulation	☐
☐ Help putting on and removing leg braces	☐	☐ Help with wheelchair ambulation	☐		

Preferences and Special Considerations:

10. Cleaning

Part A – Functional Assessment		Part B – Task and Hour Guide			
10.a. Can you clean your house, including sweeping, dusting, washing dishes, and vacuuming? ☐ Check if companion case, use range for companion.	**SL**	**SA**			**Sub-Total Min. Per Week** = **PAS**
10.b. Can you clean your house, including sweeping, dusting, washing dishes, and vacuuming?		**SA**	**Min. Per Day**	**Days Per Week** x _____ = **HAB**	**Sub-Total Min. Per Week**

Part C – Subtasks and PAS Minute Ranges

Support Level 1 Min Range: Individual 60-90, Companion 30-45	Habilitation?	Support Level 2 Min Range: Individual 95-235, Companion 50-180	Habilitation?	Support Level 3 Min Range: Individual 240-300, Companion 50-180	Habilitation?
☐ Minimal help cleaning	☐	☐ Cleaning up after personal care tasks	☐	☐ Total help with cleaning	☐
☐ Making bed	☐	☐ Cleaning floors of living area used by individual	☐		
☐ Straightening areas	☐	☐ Dusting	☐		
		☐ Cleaning bathroom	☐		
		☐ Changing bed linens	☐		
		☐ Cleaning stove top, counters, washing dishes	☐		
		☐ Cleaning refrigerator and stove	☐		
		☐ Emptying and cleaning bedside commode	☐		
		☐ Carrying out trash, setting out garbage for pickup	☐		

Preferences and Special Considerations:

11. Laundry – Washer and Dryer

Part A – Functional Assessment		Part B – Task and Hour Guide			
11.a. Can you do your own laundry?	**SL**	**SA**			**Sub-Total Min. Per Week** = **PAS**
11.b. Habilitation time needed for laundry		**SA**	**Min. Per Day**	**Days Per Week** x _____ = **HAB**	**Sub-Total Min. Per Week**

Part C – Subtasks and PAS Minute Ranges

PAS Support Level 1 Minute Range: 30	Habilitation?	PAS Support Level 2 Minute Range: Below in parentheses	Habilitation?	PAS Support Level 3 Minute Range: Below in parentheses	Habilitation?
☐ Minimal help	☐	Individual has no special laundry needs and has:	☐	Individual has no special laundry needs and has:	☐
☐ Light hand washing	☐	☐ Washer and dryer **(60)**		☐ Washer and dryer **(60)**	
☐ Gathering and sorting	☐	☐ Washer or dryer only **(90)**		☐ Washer or dryer only **(90)**	
☐ Folding and putting away clothes	☐	☐ No washer and no dryer **(120)**		☐ No washer and no dryer **(120)**	
		Individual has special laundry needs and has:	☐	Individual has special laundry needs and has:	☐
		☐ Washer and dryer **(120)**		☐ Washer and dryer **(120)**	
		☐ Washer or dryer only **(180)**		☐ Washer or dryer only **(180)**	
		☐ No washer and no dryer **(240)**		☐ No washer and no dryer **(240)**	

Preferences and Special Considerations:

12. Meal Preparation

Part A – Functional Assessment

Part B – Task and Hour Guide

12.a. Can you fix your meals?	SL	SA	Min. Per Day	Days Per Week	Sub-Total Min. Per Week
☐ Check if companion case, use range for companion.				x _____	= PAS
Purchased: ☐ Breakfast ☐ Lunch ☐ Supper					
12.b. Habilitation time needed for meal preparation				x _____	= HAB

Part C – Subtasks and PAS Minute Ranges

PAS Support Level 1 Minute Range: Individual 10-25 Companion 5-10	Habilitation?	PAS Support Level 2 Minute Range: Individual 30-90 Companion 15-45 Must allow a minimum of 30 minutes whatever the number of meals.	Habilitation?	PAS Support Level 3 Minute Range: Individual 30-90 Companion 15-45 Must allow a minimum of 30 minutes whatever the number of meals.	Habilitation?
☐ Warming, cutting, serving prepared food	☐	☐ Cooking full meal Indicate meals to be cooked. The maximum time per meal is 30 minutes.	☐	☐ Total help with meal preparation	☐
☐ Meal planning	☐	☐ Breakfast			
☐ Helping prepare meals	☐	☐ Lunch			
☐ Light Breakfast	☐	☐ Supper			
☐ Snacks	☐	☐ More time for leftovers. Allow an extra 15 minutes per day for cooking enough for leftovers for the next meal, if needed.			
		☐ Grinding and pureeing food			

Preferences and Special Considerations:

Optional Meal Preparation Chart for a Varied Meal Schedule

Breakfast: Minutes: _____ **X** Days: _____ **=** Total minutes per day: _____ ◯ Individual ◯ Companion

Lunch: Minutes: _____ **X** Days: _____ **=** Total Minutes per Day: _____ ◯ Individual ◯ Companion

Supper: Minutes: _____ **X** Days: _____ **=** Total Minutes per Day: _____ ◯ Individual ◯ Companion

Additional time for leftovers: Minutes: _____ **X** Days: _____ **=** Total Minutes per Day: _____ ◯ Individual ◯ Companion

Total Minutes Per Week: _____

Total Minutes Per Week: _____ **÷ Number of Days Per Week =** **Average Daily Minutes:** 0

Days Per Week: Enter the highest number of days meals are prepared, even if not all meals are prepared daily. Due to rounding, the final total may be higher than the calculations on this page.

13. Escort

Part A – Functional Assessment		Part B – Task and Hour Guide			
		SA	Min. Per Day	Days Per Week	Sub-Total Min. Per Week
13.a. Escort				x _____ = PAS	
13.b. Habilitation time needed for escort				x _____ = HAB	

Part C – Subtasks and PAS Minute Ranges

There is no associated minute range for the escort task.

- ☐ Arranging for transportation
- ☐ Accompanying individual to get medical treatment
- ☐ Waiting with the individual at the site due to individual's condition or distance from home
- ☐ Escort is needed less than once a month
- ☐ Escort is needed at least once a month

Document the specific individual need. If escort occurs at least once a month, time can be allocated and prorated weekly

Preferences and Special Considerations:

14. Shopping

Part A – Functional Assessment		Part B – Task and Hour Guide			
14.a. Can you do your own shopping? ☐ Check if companion case, use range for companion.	**SL**	**SA**	**Min. Per Day**	**Days Per Week** x _____ = **PAS**	**Sub-Total Min. Per Week**
14.b. Habilitation time needed for shopping				x _____ = **HAB**	

Part C – Subtasks and PAS Minute Ranges

PAS Support Level 1 Minute Range: Individual 10-30 Companion 5-15	Habilitation?	PAS Support Level 2 Minute Range: Individual 35-90 Companion 20-45	Habilitation?	PAS Support Level 3 Minute Range: Individual 35-90 Companion 20-45	Habilitation?
☐ Preparing a shopping list	☐	☐ Picking up medications	☐	☐ Total help with shopping	☐
☐ Picking up extra items	☐	☐ Putting items away	☐		
		☐ Going to the store and shopping for all items	☐		

The time allowed for shopping depends on if all shopping is done by the attendant or if someone else does the major shopping and only extra items are picked up. The time also depends on how close the individual is to a store. Time is allowed for traveling to and from the store.

Preferences and Special Considerations:

15. Help with Medication

Part A – Functional Assessment		Part B – Task and Hour Guide			
15.a. Can you take your own medicine?	**SL**	**SA**			
15.b. Habilitation time needed for help with medication		**SA**	**Min. Per Day**	**Days Per Week** x _____ = **HAB**	**Sub-Total Min. Per Week**

Preferences and Special Considerations:

16. Trim Nails

Part A – Functional Assessment		Part B – Task and Hour Guide				
16.a. Trim Nails - Can you trim your nails?	SL	SA				
16.b. Habilitation time needed for trimming nails		SA	Min. Per Day	Days Per Week x	= HAB	Sub-Total Min. Per Week

Preferences and Special Considerations:

17. Balance

Part A – Functional Assessment		Part B – Task and Hour Guide				
17.a. Do you have any problems keeping your balance?	SL	SA				
17.b. Habilitation time needed for balance		SA	Min. Per Day	Days Per Week x	= HAB	Sub-Total Min. Per Week

Preferences and Special Considerations:

18. Open Jars, Cans and Bottles

Part A – Functional Assessment		Part B – Task and Hour Guide				
18.a. Can you open jars, cans and bottles?	SL	SA				
18.b. Habilitation time needed for opening jars, cans and bottles.		SA	Min. Per Day	Days Per Week x	= HAB	Sub-Total Min. Per Week

Preferences and Special Considerations:

19. Phone

Part A – Functional Assessment		Part B – Task and Hour Guide				
19.a. Can you use the phone?	SL	SA				
19.b. Habilitation time needed for using the phone.		SA	Min. Per Day	Days Per Week x	= HAB	Sub-Total Min. Per Week

Preferences and Special Considerations:

Part A – Functional Assessment – More PAS Questions

Items 20-23 are scored only for PAS

	SL
20. During the last month, did you experience little interest or pleasure in doing things? Have you felt down, depressed or hopeless? If the answer to either question is yes, ask the following: **In the last two weeks, most of the day, nearly every day:** **• Have you had problems sleeping?** **• Have you lost the ability to enjoy things that once were fun?** **• Do you feel that you have little value as a person?** **• Have you had a significant change in your appetite?**	
21. During the last two weeks, how many days have you had trouble concentrating or making decisions?	
22. Can the individual make decisions independently?	
23. Does the individual appear to have short-term memory impairment?	

Additional Habilitation Activities	SA	Min. Per Day		Days Per Week		Sub-Total Min. Per Week
24. Money Management			X		=	HAB
Preferences and Special Considerations:						
25. Interpersonal Communication			X		=	HAB
Preferences and Special Considerations:						
26. Community Integration			X		=	HAB
Preferences and Special Considerations:						
27. Reduction of Challenging Behaviors			X		=	HAB
Preferences and Special Considerations:						
28. Accessing Leisure Time and Recreational Activities			X		=	HAB
Preferences and Special Considerations:						
29. Self-Advocacy			X		=	HAB
Preferences and Special Considerations:						
30. Socialization and Development of Relationships			X		=	HAB
Preferences and Special Considerations:						
31. Personal Decision Making			X		=	HAB

Additional Habilitation Activities	SA	Min. Per Day		Days Per Week		Sub-Total Min. Per Week
Preferences and Special Considerations:						
32. Accessing Community Resources			X		=	HAB
Preferences and Special Considerations:						
33. Use of Augmentative Communication Devices			X		=	HAB
Preferences and Special Considerations:						
34. Other:			X		=	HAB
Preferences and Special Considerations:						
35. Other:			X		=	HAB
Preferences and Special Considerations:						

Calculating Total PAS and Habilitation Hours	Total PAS and HAB Minutes and Hours Per Week Round up to next quarter unit.
Total PAS Minutes Per Week	
Total PAS Minutes Per Week ÷ 60 = **Total PAS Hours Needed Per Week**	0
Total Habilitation Minutes Per Week	
Total Habilitation Minutes ÷ 60 = **Total Habilitation Hours Needed Per Week**	0
Total Combined PAS and Habilitation Hours Per Week	0

Section 3 – Health-Related Tasks Screening Tool

A. Physician Delegation

Refer to form instructions for definition of physician delegation.

Has a physician delegated all medical acts that will be completed by unlicensed staff? ◯ Yes ◯ No **If Yes, skip to Section C.**

B. Medication Administration

Does the individual require administration of medication to ensure that medications are received safely? ◯ Yes ◯ No

Includes the following routes of administration:

☐ Oral ☐ Topical ☐ Sublingual, under the tongue

☐ Eye or ear drops ☐ Injections including insulin ☐ Enteral tube or naso-gastric (NG)/gastric (G-tube)

☐ Intravenous (IV) ☐ Nebulizer ☐ Suppositories, rectal or vaginal

☐ Metered dose inhaler by mouth ☐ Nasal

C. Special Procedures

1. Does the individual require help to measure pulse, respiration, blood pressure, temperature, weight, fluid intake or output, oxygen saturation or glucose levels? ◯ Yes ◯ No
2. Does the individual require help to perform sterile procedures such as wound care including bed sores, tracheostomy care and suctioning, urinary catheter placement and care? ◯ Yes ◯ No
3. Does the individual require help to use a CPAP, BiPAP, or other oxygen therapy? ◯ Yes ◯ No

4. Does the individual require help to use a vagal nerve stimulator for seizure control?	◯ Yes ◯ No
5. Does the individual require help to administer as needed medication as necessary to manage behavior?	◯ Yes ◯ No
D. Eating	
1. Does the individual need help with IV nutrition or NG or G-tube feeding, special diets, or additives including thickening agents for oral feeding?	◯ Yes ◯ No
2. Does the individual need someone to intervene due to a history of frequent choking episodes?	◯ Yes ◯ No
E. Bathing	
1. Does the individual require help to bathe using specific bathing techniques because the individual has a chronic condition such as brittle bone disease or history of aspiration or gastric reflux (GERD) that would put the individual at significant risk for injury if the individual helping were not skilled in the specific bathing techniques?	◯ Yes ◯ No
F. Toileting	
1. Does the individual need someone to perform urinary catheterization, either long term or occasionally?	◯ Yes ◯ No
2. Does the individual need someone to intervene due to a history of bowel impaction or chronic constipation or quadriplegia or paraplegia that requires a routine or periodic bowel program?	◯ Yes ◯ No
G. Mobility	
1. Does the individual need someone to change his or her position to prevent skin breakdown?	◯ Yes ◯ No
2. Does the individual need someone to use a mechanical lift to transfer him or her?	◯ Yes ◯ No
3. Does the individual require the use of physical or mechanical restraints by paid staff?	◯ Yes ◯ No
H. Health-Related Tasks Screening Tool Review	
Review the Yes responses in Sections B – G. Make a referral to the managed care organization (MCO) to take further action if any tasks are indicated to need to be delegated tasks or health maintenance activities (HMAs).	

Section 4 – Emergency Response Services (ERS)

Does the individual require ERS? ◯ Yes ◯ No

If yes, describe how the individual will benefit from ERS.

Section 5 – Information and Referrals

- ☐ STAR+PLUS Home and Community Based Services (HCBS)
- ☐ Waiver Interest List
- ☐ State Supported Living Center crisis diversion slot
- ☐ Preadmission Screening and Resident Review (PASRR) diversion slot
- ☐ Other Medicaid services
- ☐ Other non-Medicaid or community service
- ☐ Housing options
- ☐ Community living options
- ☐ Other: _____

Notes:

Individual's Name: _____

Section 6 – Support Management

1. Is the individual currently receiving support management? ◯ Yes ◯ No

2. Would the individual like to receive support management? ◯ Yes ◯ No

3. Identify any needs, requests or considerations specific to this service that are necessary for the staff to know when they support the individual in achieving his or her outcomes.

Section 7 – Service Delivery Options

For initial assessment:

• Is the individual interested in self-directing Community First Choice services? ◯ Yes ◯ No

For renewal:

• What service delivery option is the individual currently using?

☐ Agency ☐ Consumer Directed Services ☐ Service Responsibility Option

• Does the individual want to change his service delivery option? ◯ Yes ◯ No

Section 8 – Summary of Recommended Community First Choice Services

Community First Choice PAS/HAB Recommended Total Hours: _____

• Support Management: ◯ Yes ◯ No

• ERS: ◯ Yes ◯ No

• Health-related tasks shown in Section 3? ◯ Yes ◯ No

Section 9 – Acknowledgement

By signing, I acknowledge that:

• I participated in the service planning process.
• The hours suggested are informed by the goals I identified for myself on Form 1701, Support Plan Narrative.
• The hours suggested are a recommendation, not a guarantee.

Signature of ◯ Individual ◯ Legally Authorized Representative (LAR)

Printed Name of Individual or LAR	**Signature of Individual or LAR**	**Date**
Printed Name of Assessor	**Signature of Assessor**	**Date**
Printed Name of Representative	**Signature of Representative**	**Date**
Printed Name of Other Person	**Signature of Other Person**	**Date**
Printed Name of MCO Staff	**Signature of MCO Staff**	**Date**