

**441—83.87(249A) Service plan.** A service plan will be prepared and utilized for each HCBS BI waiver member. The service plan will be developed by an interdisciplinary team that includes the member, and, if appropriate, the legal representative, member's family, case manager, providers, and others directly involved. The service plan will be stored by the case manager for a minimum of three years. The service plan staffing will be conducted before the current service plan expires.

**83.87(1) Information in plan.** The plan will be in accordance with 441—subrule 24.4(3) and will additionally include the following information to assist in evaluating the program:

- a. A listing of all services received by a member at the time of waiver program enrollment.
- b. For supported community living:
  - (1) The member's living environment at the time of waiver enrollment.
  - (2) The number of hours per day of on-site staff supervision needed by the member.
  - (3) The number of other waiver members who will live with the member in the living unit.
- c. An identification and justification of any restriction of a member's rights, including but not limited to:
  - (1) Maintenance of personal funds.
  - (2) Self-administration of medications.
- d. The names of all providers responsible for providing all services.
- e. All service funding sources.
- f. The amount of the service to be received by the member.
- g. Whether the member has elected the member choices option and, if so:
  - (1) The independent support broker selected by the member; and
  - (2) The financial management service selected by the member.
- h. A plan for emergencies and identification of the supports available to the member in an emergency.

**83.87(2) Use of nonwaiver services.** Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 16 or under that include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the department. The Medicaid case manager will attach a written request for a variance from the limitation on supported community living to intermittent.

**83.87(3) Annual assessment.** The department will assess the member annually and certify the member's need for long-term care services. The department will be responsible for determining the level of care based on the completed information submission tool listed in paragraph 83.82(1) "f" and other supporting documentation as relevant.

- a. The department or the member's MCO will be responsible for annual redetermination of the level of care.
- b. The MCO must submit documentation to the department for all reassessments, performed at least annually, that indicate a change in the member's level of care. The department will make a final determination for any reassessments that indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.

**83.87(4) Service file.** The Medicaid case manager must ensure that the member service file contains the member's service plan.

[ARC 0318D, IAB 5/27/26, effective 7/1/26]