***Logo

Description automatically generatedText

Description automatically generatedSTEPS (Support and Training for Employing People Successfully)   
Individualized Service Plan***

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| **Member name:** First and last name | | **DOB:** Enter date | | **Primary phone #:** Include area code | | | **Medicaid ID:** Enter # | | |
| **Member address:** Street Address | | **City, State:** City, State | | | | **Zip:** Zip code | |
| **Alternate contact #:** Include area code | | **Email:** Enter email | | | | **PPL ID:** Enter ID | |
| Mailing address same as member street address | | | | | | | |
| **Mailing address:** Mailing Address | | **City, State:** City, State | | | | **Zip:** Zip code | |
|  | | | | | | | |
| **Guardian or**  **Representative:** First and last name | | | | **Phone #:** Include area code | | **Email:** Enter email | | | |
| Guardian/Representative address same as member address | | | | | | | |
| **Guardian address:** Mailing Address | | **City, State:** City, State | | | | **Zip:** Zip code | |
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| **MCO:** Choose | **Care Coordinator:** First and last name | | | | **Phone or email:** Enter contact info | | | |
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| **Community Services Coordinator:** First and last name | | | **CSC Agency:** Enter Agency | | | | |
| **CSC Phone #:** Include area code | | | **CSC Email:** Enter email | | | | |
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|  | | **Service Plan Start Date** | **Service Plan End Date** |
| **Type Example: Annual or Revised** | | **Always the 1st of the month** | **Always the last of the month** |
| ***INITIAL SERVICE PLAN START ON THIS LINE (always keep this row)*** | | Start date | End date |
| Choose type | If not annual, provide explanation | Start date | End date |
| Choose type | If not annual, provide explanation | Start date | End date |
| Choose type | If not annual, provide explanation | Start date | End date |
| Choose type | If not annual, provide explanation | Start date | End date |
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| Choose type | If not annual, provide explanation | Start date | End date |

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| ♦ | ***For this form to work correctly, CSCs MUST use the Tab key to navigate through the yellow highlighted boxes. Once you have entered an amount in the box, use the Tab key to make the form calculate accordingly.*** | ♦ |

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| **Current Service Plan Services** | | | | | | | |
|  | **Service Type** | | **Amount** | **Frequency** | **Provider Name** | **Begin Date** | **End Date** |
|  | **Pre-Vocational Services** | | Hours | Total | Enter Provider | Begin Date | End Date |
|  | **Independent Living Skills Training** | | Hours | Total | Enter Provider | Begin Date | End Date |
|  | **Supported Employment** | | Hours | Per month | Enter Provider | Begin Date | End Date |
|  | **SE Reduction – 1st** | | Hours | Per month | Enter Provider | Begin Date | End Date |
|  | **SE Reduction – 2nd** | | Hours | Per month | Enter Provider | Begin Date | End Date |
|  | **SE Reduction – 3rd** | | Hours | Per month | Enter Provider | Begin Date | End Date |
|  | **SE Reduction – 4th** | | Hours | Per month | Enter Provider | Begin Date | End Date |
|  | **Transportation** (Enter info below) | | Hours | Per month | Enter Provider | Begin Date | End Date |
|  | **Personal Assistance Services**  Agency  Self (List workers below) | | Hours | Per month | Enter Provider | Begin Date | End Date |
|  | **Enhanced Services**  Agency  Self (List workers below) | | Nights | Per month | Enter Provider | Begin Date | End Date |
|  | **Home Delivered Meals** | | Meals | Per month | Enter Provider | Begin Date | End Date |
|  | **Med Minder Install** | | Unit | Total | Enter Provider | Begin Date | End Date |
|  | **Med Minder Monthly** | | Unit | Per month | Enter Provider | Begin Date | End Date |
|  | **PERS Install** | | Unit | Total | Enter Provider | Begin Date | End Date |
|  | **PERS Monthly** | | Unit | Per month | Enter Provider | Begin Date | End Date |
|  | **Community Service Coordination** | | Hours | Total | Enter Provider | Begin Date | End Date |
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| **Transportation – Vendor/Agency invoice, Member reimbursement, or PAS payment based on EVV** | | | | | | | | | | |
| **Enter total # of assessed hours for transportation:** | | | | **Total dollar amount available for transportation costs: $ 0.00** | | | | | | |
| **Vendor/Agency or Member** – Who is to be paid | | **Invoice or reimbursement?** | | | **Description/details of transportation** | | | | | **Monthly Cost** |
| Vendor/Agency and contact info | | Choose method | | | Description | | | | |  |
| Vendor/Agency and contact info | | Choose method | | | Description | | | | |  |
| Vendor/Agency and contact info | | Choose method | | | Description | | | | |  |
| **PAS Transportation** – Use Provider Pay Rates for Service Plan chart for hourly wage | | | **Relationship to the member** | | | **# of hours per month** | **Hourly wage** | **Cost to employer/hr.** | | **Monthly Cost** |
| First and last name, email | | | Choose one. | | |  |  | $15.00 | | $ 0.00 |
| First and last name, email | | | Choose one. | | |  |  | $15.00 | | $ 0.00 |
| First and last name, email | | | Choose one. | | |  |  | $15.00 | | $ 0.00 |
|  | **Total hours:** | | | | | **0** | **Total cost:** | | **$ 0.00** | |

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| **Personal Assistance Services (PAS) – Self-Directed** | | | | | |
| **Enter total # of assessed monthly PA hours:** | | | | | |
| **Name of PA and relationship to the member**  (Use Provider Pay Rates for Service Plan chart for hourly wage) | | **Total hours per month** | **Hourly wage** | **Cost to employer/hr.** | **Total cost per month** |
| First and last name, email | Choose one. |  |  | $16.50 | $ 0.00 |
| First and last name, email | Choose one. |  |  | $16.50 | $ 0.00 |
| First and last name, email | Choose one. |  |  | $16.50 | $ 0.00 |
| First and last name, email | Choose one. |  |  | $16.50 | $ 0.00 |
| First and last name, email | Choose one. |  |  | $16.50 | $ 0.00 |
| First and last name, email | Choose one. |  |  | $16.50 | $ 0.00 |
|  | **Total hours:** | **0** |  | **Total cost:** | **$ 0.00** |

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| **Enhanced Services – Self-Directed** | | | | | |
| **Enter total # of assessed nights per month:** | | | | | |
| **Name of PA and relationship to the member**  (Use Provider Pay Rates for Service Plan chart for nightly rate) | | **Total nights per month** | **Nightly rate** | **Cost to employer/night** | **Total cost per month** |
| First and last name, email | Choose one. |  |  | $92.00 | $ 0.00 |
| First and last name, email | Choose one. |  |  | $92.00 | $ 0.00 |
| First and last name, email | Choose one. |  |  | $92.00 | $ 0.00 |
| First and last name, email | Choose one. |  |  | $92.00 | $ 0.00 |
| First and last name, email | Choose one. |  |  | $92.00 | $ 0.00 |
| First and last name, email | Choose one. |  |  | $92.00 | $ 0.00 |
|  | **Total nights:** | **0** |  | **Total cost:** | **$ 0.00** |

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| **Supplemental Services – Services in place of PAS hours** | | | |
| ♦ **Check the appropriate box for any supplemental services that the member will receive. CSCs must enter the 1-time costs and total cost per month manually** ♦ | | | | | |
| **Category of service** | | **Details of service(s) to be provided** | **Total cost per month** |
|  | *Home-Delivered Meals* | # of meals per month: 0 | $ 0.00 |
|  | *PERS* | 1-time cost? |  |
|  | *Medication Minder* | 1-time cost? |  |
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| **Service Plan Summary** | | |
|  | | **Total Cost** |
| Pre-Vocational Services | | **$ 0.00** |
| Independent Living Skills Training | | **$ 0.00** |
|  | | **Monthly Cost** |
| Supported Employment | | **$ 0.00** |
| * SE Reduction – 1st | | **$ 0.00** |
| * SE Reduction – 2nd | | **$ 0.00** |
| * SE Reduction – 3rd | | **$ 0.00** |
| * SE Reduction – 4th | | **$ 0.00** |
| Transportation | | **$ 0.00** |
| PAS | | **$ 0.00** |
| **Supplemental Services**  (only available with PAS) | * Enhanced Services | **$ 0.00** |
| * Home-Delivered Meals | **$ 0.00** |
| * PERS | **$ 0.00** |
| * Med Minder/Dispenser | **$ 0.00** |
| **1-Time Costs** | | **Total Cost** |
| * PERS Install | | **$ 0.00** |
| * Medication Reminder/Dispenser Install | | **$ 0.00** |

**STEPS Service Plan Agreement**

**I agree:**

* To follow the STEPS Program Policy Manual.
* That I was given information about my provider options for all my STEPS services.
* To make sure all timesheets are correct and approved in time for the pay period. I will be at fault for any mistakes. It could be Medicaid Fraud to approve timesheets that are known to be incorrect.
* To use only the number of self-directed services authorized on this Service Plan. Any hours of self-directed PA Services used over the amount listed in this Service Plan will be my responsibility to pay.
* That Pre-Vocational Services and Independent Living Skills Training are limited to 34 hours each. These services are not on-going and are expected to end.
* That Supported Employment is limited to 13.25 hours per month for the first 15 months of my enrollment in STEPS and will be reduced by a minimum of ¼ on a quarterly basis with a goal of closing this service by the end of the second year.
* To have an accurate Individualized Emergency Backup Plan in the event a provider or Personal Attendant fails to show up.

**I understand:**

* That using services outside of the approved Service Plan and/or confirmed Medicaid Fraud or abuse may lead to involuntary disenrollment from STEPS and I will be barred from participating in the future.
* That if I purchase assistive services/technology that have not received prior approval by the Program Manager I will be responsible for paying for these costs myself.
* Copies of this approved Individualized Service Plan will be shared with the fiscal manager, my MCO, the STEPS Program Manager, KDHE, and all providers that I have chosen to deliver my supports and services.
* My Community Services Coordinator and MCO Care Coordinator are required by Kansas law to report concerns if they feel I am being abused, neglected, exploited, or taken advantage of by someone with power over me.
* All STEPS information about me is private. I allow STEPS to give information about my participation in the program and my Individualized Service Plan to the Centers for Medicaid and Medicare Services, the Social Security Administration, the Kansas Department of Health and Environment, and the Kansas Department for Children and Families.
* All information from surveys and program records will only be about groups of people and will be used for research purposes only.
* No person shall, on the grounds of race, color, national origin, age, disability, religion, or sex, be excluded from participation in, be denied the benefits of or be subject to discrimination under any program or activity of the Department for Children and Families or Kansas Department of Health and Environment.

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| Member/Representative Agreement Signature | Date |

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| MCO Service Plan Approval Signature | Date |