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DEPARTMENTAL MEMORANDUM

MAD-MR: 20-05

DATE: JULY 13, 2020

TO: MEDICAL ASSISTANCE DIVISION

FROM: NICOLE COMEAUX, DIRECTOR, MEDICAL ASSISTANCE DIVISION

THROUGH: SHARI ROANHORSE-AGUILAR, EXEMPT SERVICES AND PROGRAMS BUREAU CHIEF, MEDICAL ASSISTANCE DIVISION

BY: LINDA GILLET, BRAIN INJURY PROGRAM MANAGER, EXEMPT PROGRAMS AND SERVICES BUREAU

SUBJECT: BRAIN INJURY SERVICES FUND (BISF) PROGRAM INDEPENDENT LIVING PLAN - MAD 393 REVISED FEBRUARY 2020



GENERAL INFORMATION

The MAD 393 is for use by the contracted Service Coordination Agency of the Brain Injury Services Fund (BISF) for the purpose of developing an Independent Living Plan (ILP) with each BISF participant. The basis of the ILP is the BISF Service Coordination (SC) Assessment. The ILP serves as an agreement with the participant for the goals that will be worked on to resolve the participant's crises. It also includes expected outcomes, documents progress and lists any steps necessary to prepare the participant for discharge.

- Added form number to bottom left of form.
- ILP interims for "short-term" services were changed from 90 days to 6-month interims.
- The information box at the top, Section II.A "Describing My Crisis", Section II.B "My Goals" section and Section III, Participant Agreement (signature page) are tailored to the perspective of the participant, using the participant's own words, using language in accordance with 6th grade readability standards. All other sections are for completion by the SC.
- A new section on each "Goals" page allows the SC to enter progress updates. This allows for the MAD 389 BISF 90 Day Narrative Review to be retired.
- Sections and references to the SC as a Life Skills Coach ("Independence Coaching") were removed, since SCs no longer provide this service; the service is now only accessed through BISF Home and Community Based Services (HCBS).
- More specificity was provided regarding the types of assistance that the SC may provide.
- "Crisis Interim Services" was replaced with "BISF HCBS".
- New sections include "Services accessed through or referrals made for alternate payer sources", "Services and supports the participant wanted but that were not assessed as a need", and "Past goals that have been met".
- Section III, the signature page includes an acknowledgment that individual services may change or end in the course of an ILP cycle without having to write a new ILP.
- Most content in the instructions was moved to Standard Operating Procedures, limiting the instructions to essential guidance needed to complete the form fields.

FILING INSTRUCTIONS

Please make the following changes to the MAD forms manuals:

INSERT MAD 393 Revised February 2020

DELETE MAD 393 BISF SC ILP 01-14-2015

DELETE / RETIRE MAD 389 Issued 07/01/14 (BISF Program 90-Day Narrative Review)

Please address any questions concerning these guidelines to Linda Gillet, LindaB.Gillet@state.nm.us or call (505) 827-7218.

Attachment: MAD 393 Revised February 2020



Brain Injury Services Fund Program (BISF)
Independent Living Plan (ILP)

Date Developed or Revised: / / Region:
Name: Last 4 SSN: DOB: / /
Service Coordination Agency: Service Coordinator’s Name:
Date of 1st Access to Program: / / Reactivation Date (if applicable): / /
6 Month Interim: (Interim 1) (Interim 2) Approved Extension
ILP Start Date: / / ILP End Date (6 months from start of this ILP): / / Referrals: BISF HCBS

To the BISF participant: Service Coordination helps you resolve “crisis” or urgent needs related to your brain injury. This is so that you can live better in your home and community. The BISF Service Coordination Assessment is used to make choices about which services, goods and/or supports you need to help resolve or end your crisis. It also helps in deciding what should be included in this plan, or ILP. Your ILP helps you to name your crisis needs and your goals. The ILP and the assessment help the Service Coordinator (SC) make referrals for needed services and other supports. This includes BISF Home and Community Based Services (HCBS) that may be paid for by the BISF Program. It also includes community and other supports or payers, when they are available. The BISF SC works to arrange these services and connect you to other community supports. This plan will end in 6 months, or it will end when your crisis ends. With your ongoing participation, the SC can work to make sure that your plan and services go on until your crisis ends.

All goals and supports listed in this ILP are to help you. They should help you live on your own as much as possible in your home and community. It is important that your family help as much as they can. Friends and others who care about you should also help. Your SC helps you name your crises and fill in your ILP goals. This is done in Section II.A. and B. Your SC completes all the other parts of the plan. You and your SC sign the plan in Section III. Your SC can answer any questions you may have. Once the plan is finished, your SC will give you a copy. The instructions at the end help the SC know how to fill in your ILP.

I. PARTICIPANT’S STRENGTHS AND BARRIERS

A. List the Participant’s Strengths in Achieving Goals / Living Independently: This can also include the participant’s readiness to address the crisis and any supports the participant may already have (e.g., family, community, friends who help; Physical Therapy covered by V.A. or I.H.S; Outpatient Mental Health services covered by private insurance or other sources; etc.)

B. List the Participant’s Barriers in Achieving Goals / Living Independently:



Independent Living Plan (ILP)

II. BUILDING MY PLAN WITH MY SERVICE COORDINATOR

In Sections IIA and IIB, my SC will list my concerns and my goals in my words. My SC will use this information to fill out the rest of my plan.

- A. “Describing My Crisis: A crisis means a very difficult time in managing my life with a brain injury. Taking care of myself and my needs has become very hard. Getting help for a while will help me until it gets easier to manage on my own.”

“My crisis needs, in my own words, are listed below. I have also rated them by their importance to me.”

“I need...”	“...because...”	“I have noted with the number ‘1’ my most important goal and rated the next most important goals with numbers 2 – 5.” *

“I am hoping that this help will...” (Complete the sentence in your own words.)

“My Service Coordinator is also recommending the following services and supports to help end my crisis.”

Also needed is...	...because...	The SC’s rating by importance:	Does the participant want this help? (Y/N)

Additional comments by SC:

*NOTE to SC and participant: There are spaces for 5 entries each, but this doesn’t mean there have to be 5 goals. There can be less than 5 or more than 5. If there are more than five, the less important ones can be grouped together on the last line in each of the tables. The crisis needs and goals, according to a mutually agreeable priority, will be listed in order of importance in the sections below.



Brain Injury Services Fund Program (BISF)

Independent Living Plan (ILP)

B. **“My Goals: The pages in this section list all my goals. They list how my SC and I will solve my crisis needs so that the supports I need are there. They list how my SC will help. They also list what I need to do or how others will help me. Some of these goals may require help from BISF HCBS. Sometimes, goals will be met when a non-BISF payer can pay. Any goals I meet will be moved to Section II, Letter I. This section helps me see the progress that I have made with the help of my SC and BISF HCBS.”**

“My Service Coordinator and I agree that this is my first priority.”

One crisis need I have is:

Goal 1:

Action steps (what we need to do and who does it):

1)

By when:

2)

By when:

3)

By when:

What we hope will happen as we work toward the goal (be specific):

Additional notes / Progress Notes for Interim Reassessments:

For the participant: In this section, the SC lists the progress I have made. The SC also lists anything that is getting in the way of meeting my goal. This helps us to know if the help I am getting should go on. It may also help us to know if the help should end.

For the SC: Using dates, the SC will note ongoing progress and/or ongoing barriers to reaching goals. The SC will list solutions and adjustments to goals as justification to continue or discontinue this help.

Outcome/Results:

“We just got started.” (not prepared for discharge)

“We’re making progress.” (not prepared for discharge)

“We’re almost there!” (preparing for discharge)

“We met the goal!” (prepared for discharge) Date: / /



Brain Injury Services Fund Program (BISF)
Independent Living Plan (ILP)

“My Service Coordinator and I agree that this is my second priority.”

Crisis Issue/Need:

Goal 2:

Action steps (what we need to do and who does it):

1)

By when:

2)

By when:

3)

By when:

What we hope will happen as we work toward the goal (be specific):

Additional notes / Progress Notes for Interim Reassessments:

For the participant: In this section, the SC lists the progress I have made. The SC also lists anything that is getting in the way of meeting my goal. This helps us to know if the help I am getting should go on. It may also help us to know if the help should end.

For the SC: Using dates, the SC will note ongoing progress and/or ongoing barriers to reaching goals. The SC will list solutions and adjustments to goals as justification to continue or discontinue this help.

Outcome/Results:

“We just got started.” (not prepared for discharge)

“We’re almost there!” (preparing for discharge)

“We’re making progress.” (not prepared for discharge)

“We met the goal!” (prepared for discharge) Date: / /



Brain Injury Services Fund Program (BISF)
Independent Living Plan (ILP)

“My Service Coordinator and I agree that this is my third priority.”

Crisis Issue/Need:

Goal 3:

Action steps (what we need to do and who does it):

1)

By when:

2)

By when:

3)

By when:

What we hope will happen as we work toward the goal (be specific):

Additional notes / Progress Notes for Interim Reassessments:

For the participant: In this section, the SC lists the progress I have made. The SC also lists anything that is getting in the way of meeting my goal. This helps us to know if the help I am getting should go on. It may also help us to know if the help should end.

For the SC: Using dates, the SC will note ongoing progress and/or ongoing barriers to reaching goals. The SC will list solutions and adjustments to goals as justification to continue or discontinue this help.

Outcome/Results:

“We just got started.” (not prepared for discharge)

“We’re making progress.” (not prepared for discharge)

“We’re almost there!” (preparing for discharge)

“We met the goal!” (prepared for discharge) Date: / /



Brain Injury Services Fund Program (BISF)
Independent Living Plan (ILP)

“My Service Coordinator and I agree that this is my fourth priority.”

Crisis Issue/Need:

Goal 4:

Action steps (what we need to do and who does it):

1)

By when:

2)

By when:

3)

By when:

What we hope will happen as we work toward the goal (be specific):

Additional notes / Progress Notes for Interim Reassessments:

For the participant: In this section, the SC lists the progress I have made. The SC also lists anything that is getting in the way of meeting my goal. This helps us to know if the help I am getting should go on. It may also help us to know if the help should end.

For the SC: Using dates, the SC will note ongoing progress and/or ongoing barriers to reaching goals. The SC will list solutions and adjustments to goals as justification to continue or discontinue this help.

Outcome/Results:

“We just got started.” (not prepared for discharge)

“We’re making progress.” (not prepared for discharge)

“We’re almost there!” (preparing for discharge)

“We met the goal!” (prepared for discharge) Date: / /



Brain Injury Services Fund Program (BISF)
Independent Living Plan (ILP)

“My Service Coordinator and I agree that this is my fifth priority.”

Crisis Issue/Need:

Goal 5:

Action steps (what we need to do and who does it):

1)

By when:

2)

By when:

3)

By when:

What we hope will happen as we work toward the goal (be specific):

Additional notes / Progress Notes for Interim Reassessments:

For the participant: In this section, the SC lists the progress I have made. The SC also lists anything that is getting in the way of meeting my goal. This helps us to know if the help I am getting should go on. It may also help us to know if the help should end.

For the SC: Using dates, the SC will note ongoing progress and/or ongoing barriers to reaching goals. The SC will list solutions and adjustments to goals as justification to continue or discontinue this help.

Outcome/Results:

“We just got started.” (not prepared for discharge)

“We’re almost there!” (preparing for discharge)

“We’re making progress.” (not prepared for discharge)

“We met the goal!” (prepared for discharge) Date: / /



Brain Injury Services Fund Program (BISF)
Independent Living Plan (ILP)

C. Service Coordination Support Needs / Referrals:

Service Coordination is a problem-solving function and the level of help will vary with the participant's needs. The SC checks off the help that the SC will give in order to reach any of the goals listed in Section II.B. The SC also checks off any outside referrals to help resolve the participant's crisis. Some of these may involve assisting the participant in interfacing with commonly used technology or helping them resolve issues that arise in the course of the participant's crisis.

- Long-term services central registry waiting list: Date registered: / /
- Social Security / Disability Determinations or benefits (applying / accessing / understanding)
- NM Medicaid / Medical Assistance application
- Transition to Medicaid Centennial Care
- Medicare benefits (applying / accessing / understanding)
- Applying for other health insurance
- Veteran services (referrals and accessing)
- Locating affordable housing/shelters (Emergent)
- Housing applications
- Income support services
- Benefits counseling
- Legal assistance (referrals and accessing)
- Debt consolidation (basic guidance and referrals)
- Educational supports (referrals and accessing)
- Employment supports (referrals and accessing)
- Substance abuse supports - referrals
- Clothing assistance (referrals and accessing)
- Food bank assistance (referrals and accessing)
- Utilities issues (helping to set up or resolve issues)
- Support groups (referrals and accessing)
- Accessing an advocate (referrals and accessing)
- Peer support (referrals and accessing)
- Accessing community resources
- Setting Medication Reminder Cues
- Setting up appointments, as needed
- Other:
- Other:
- Other:

D. Life Skills Coaching Support Needs (SC checks all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Household management / Home Organization | <input type="checkbox"/> Activities of daily living (list): |
| <input type="checkbox"/> Nutritional counseling | <input type="checkbox"/> Maintaining health |
| <input type="checkbox"/> Locating affordable housing (non-emergent) | <input type="checkbox"/> Memory/cognition skills |
| <input type="checkbox"/> Time management / scheduling appointments | <input type="checkbox"/> Anger management |
| <input type="checkbox"/> Communication/social skills | <input type="checkbox"/> Childcare/parenting skills |
| <input type="checkbox"/> Safety skills | <input type="checkbox"/> Accessing public transportation |
| <input type="checkbox"/> Educational supports | <input type="checkbox"/> Employment supports |
| <input type="checkbox"/> Money management/financial literacy/ in-depth support for debt consolidation | |
| <input type="checkbox"/> Mindfulness Training | |
| <input type="checkbox"/> Other: | |
| <input type="checkbox"/> Other: | |



Brain Injury Services Fund Program (BISF)
Independent Living Plan (ILP)

E. BISF Home and Community Based Service (HCBS) Referrals

The SC checks off the BISF HCBS that will be needed to reach any of the goals listed in Section II.B. Note: Estimated cost is based on frequency of a service and the most current BISF Vendor Rate Lists. Rates, costs, or frequencies may change in the middle of an ILP without needing to write a new ILP and will be more accurately reflected on the MAD 751 Referral form. Service Providers may suggest the frequency, hours or duration of a service. However, the ultimate decision on frequency, hours or duration will be made by the Service Coordination Agency, based on the budget that is available to serve all participants enrolled in the BISF.

BISF HCBS Referrals	Frequency / hours / duration	Estimated Cost
<input type="checkbox"/> Professional Organizer / Life Skills Coaching services		\$
<input type="checkbox"/> Homemaker services (non-medical home care; respite)		\$
<input type="checkbox"/> Nursing/aide care (medical home care)		\$
<input type="checkbox"/> Therapy — outpatient mental/behavioral health care		\$
<input type="checkbox"/> Therapy — occupational		\$
<input type="checkbox"/> Therapy — physical		\$
<input type="checkbox"/> Therapy — speech/language		\$
<input type="checkbox"/> Alternative therapy — acupuncture		\$
<input type="checkbox"/> Alternative therapy — chiropractic		\$
<input type="checkbox"/> Alternative therapy — massage		\$
<input type="checkbox"/> Transportation (BI medical/therapy appointments)		\$
<input type="checkbox"/> Prescribed medications (related to brain injury)		\$
<input type="checkbox"/> Physician services (co-pay only)		\$
<input type="checkbox"/> Initial or emergency housing assistance		\$
<input type="checkbox"/> Special equipment (assistive technology)		\$
<input type="checkbox"/> Environmental modification		\$
<input type="checkbox"/> Retrofit automobile		\$
<input type="checkbox"/> Other (describe)		\$
<input type="checkbox"/> Other (describe)		\$
<input type="checkbox"/> Other (describe)		\$

Additional Notes about BISF HCBS:



Brain Injury Services Fund Program (BISF)
Independent Living Plan (ILP)

III. PARTICIPANT AGREEMENT

I, _____ (print name), helped build my Independent Living Plan (ILP). My plan lists the goals I need to help me end my crisis. This plan includes the needs that were noted in my BISF SC Assessment. The plan also helps me work toward more independence. This is so I can live in my home and community on my own. My signature means that I know the plan for me to get help. I know what action steps I have to do. I am committed to doing my part. I understand that certain services may end as I reach my goals. I also understand that there may be changes in how often I get certain services while my plan is active. In these cases, I will not need to sign a new ILP. Updates will be made by my SC to this ILP until this ILP ends.

Start date of ILP:	/ /	Due date of next ILP:	/ /
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Names and relationships of any persons who helped with the ILP:

SIGNATURES UPON OPENING THE ILP:

Participant signature: _____ Date: _____
 Family/guardian signature: _____ Date: _____
 Service Coordinator signature: _____ Date: _____

TO BE FILLED IN BY SERVICE COORDINATOR AS THE ILP EXPIRATION DATE NEARS

UPDATE AT CLOSE OF ILP:

Is the participant stable in the four life domains named below? If so, they should be considered for discharge. If not, then a new ILP should be made. If the participant has had one year of consecutive services, an Exception Request for Continued BISF Services must be submitted to the HSD Brain Injury Program Manager.

The participant has:

- Income to live independently in the community.
- Access to affordable health care and prescription services.
- Affordable and safe housing.
- Family/community members who can help with needs that arise from BI-related symptoms.

STATUS OF SERVICES AT CLOSE OF ILP:

- Services are active.
- Services are pending extension beyond one service year through HSD.
- Services have ended. Participant is being inactivated from the BISF Program.

SC notes about plan for discharge:

SIGNATURES UPON CLOSING THE ILP:

Participant signature: _____ Date: _____
 Family/guardian signature: _____ Date: _____
 Service Coordinator signature: _____ Date: _____



Brain Injury Services Fund Program (BISF)
Independent Living Plan (ILP)

Additional Goals Page (optional). This page may be submitted if there is an additional goal or a new service is added in the middle of an ILP cycle.

“My Service Coordinator and I agree that there is another important goal to meet.”

Crisis Issue/Need:

Goal # :

Action steps (what we need to do and who does it):

1)

By when:

2)

By when:

3)

By when:

What we hope will happen as we work toward the goal (be specific):

Additional notes / Progress Notes for Interim Reassessments:
For the participant: In this section, the SC lists the progress I have made. The SC also lists anything that is getting in the way of meeting my goal. This helps us to know if the help I am getting should go on. It may also help us to know if the help should end.
For the SC: Using dates, the SC will note ongoing progress and/or ongoing barriers to reaching goals. The SC will list solutions and adjustments to goals as justification to continue or discontinue this help.

Outcome/Results:

“We just got started.” (not prepared for discharge) “We’re making progress.” (not prepared for discharge)

“We’re almost there!” (preparing for discharge) “We met the goal!” (prepared for discharge) Date: / /



Brain Injury Services Fund Program (BISF) Independent Living Plan (ILP)

Form Instructions for Service Coordinators

PURPOSE:

This form is for use by the contracted Service Coordination Agency of the Brain Injury Services Fund (BISF). It is to help build a 6 month Independent Living Plan (ILP) that holistically considers the needs of the participant, so that they can live independently in their home and community, as they work to move out of their brain injury-related crisis. The basis of the ILP shall be the BISF Service Coordination Assessment. The ILP will serve as an agreement with the participant. It lays out goals to help end the participant's crisis. The main focus of the ILP shall be urgent crises and will list all help to be given by the Service Coordinator (SC) as well as help given using BISF Home and Community Based Services (HCBS) funding. The ILP lists what will be done to resolve issues as well as expected outcomes and progress. It will list any steps needed to reach the participant's goals and prepare the participant for discharge.

INSTRUCTIONS: The SC shall fill all fields at the top of the ILP and Section I. The SC and the participant work together to complete the crisis needs in Section II.A and the goals in Section II.B, which lists the goals the participant will work on with the Program's help. The SC completes all other sections of the ILP, meaning Section II (A - J). Section III is to be signed by both the participant/guardian and the SC, when the ILP is opened and when the ILP closes, in accordance with BISF Program requirements. In preparation for closing the ILP, the SC will complete the box in Section III. Certain fields can be expanded to allow entry of plan details.

Top of Page 1. Entry of Dates:

1. The first date entered is the date that the ILP was prepared or revised. This is regardless of the start date of the ILP and may occur mid-cycle. Also, check the box corresponding to the interim period. "Interim 1" denotes the first 6 month interim (months 1 through 6), and "Interim 2" denotes the second 6 month interim (months 7 through 12).
2. All ILPs shall name the participant's date of very first access to the BISF Program. This goes under "Date of 1st Access to Program."
3. If there is a reactivation of services, note the "Reactivation Date."
4. The SC will rely on BISF Program Standard Operating Procedures for more guidance on how to complete ILP start and end dates.

Section I: "Participant's Strengths and Barriers":

1. Section I.A: List participant's strengths in achieving goals and living independently.
2. Section I.B: List any barriers that currently prevent the participant from achieving goals and living independently.

Section II: "Building My Plan With My Service Coordinator" (completed by SC and participant together):

1. **Section II.A: "Describing My Crisis"**
 - a. Defining crisis need. A "Crisis Issue/Need" establishes why the participant needs BISF services. "Crisis" means an urgent situation that could pose clear danger. This could be homeless status, lack of health insurance, insufficient income to cover brain-injury-related health-care needs, loss of job due to brain injury, abandonment of and separation from support systems, an exacerbated medical condition related to or impacting the brain injury, and significant emotional/behavioral issues that remain untreated.
 - b. In the top grid, the participant expresses their crisis needs in their own words. (Example crisis: "I have no way to pay the many co-pays for my neurologist, so I can get treated for my brain injury.")
 - c. In the second grid, the SC adds their perspective on crisis needs to fill in gaps that they perceive need to be addressed (Example, "The participant will benefit from Outpatient Mental Health, because symptoms of depression and PTSD are not being treated and are adding to the participant's sense of overwhelm.")
 - d. The SC and participant discuss the most important goals to pursue, as they complete Section II.B.



Brain Injury Services Fund Program (BISF)

Independent Living Plan (ILP)

2. Section II.B: “My Goals” (completed by SC and participant together):
 - a. All goals in this section of the ILP should address the crisis needs identified in the SC Assessment. They should be written at the sixth grade reading level to help the participant understand.
 - b. A “goal” refers to what can be done to end a crisis need. Goals should be broken into “action steps.” All goals and action steps will list the steps needed to end each crisis. They should name the party who will complete each step. When possible, a time or calendar date for completion (“By when”) should be named. Example entries for the goal “Be able to pay for physician co-pays to treat the brain injury”:
 - “The SC will contact the office of the doctor treating the participant’s brain injury and arrange to have them complete and fax back the BISF Treatment Verification form. By when: Within 3 Business Days.”
 - “After the SC receives the Treatment Verification form back from the doctor, the SC will send in a referral to the fiscal agent to arrange for the BISF to pay the doctor’s co-pays. This will be done by (date or within 3 business days of receiving the form).”
 - “The SC will notify (Participant Name) as soon as the BISF fiscal agent says it’s ok to use the service.”
 - “After this notice, (Participant name) will schedule the first appointment to see the doctor. By when: Within 1 week of the ok.”
 - “The SC and participant will work to find other payer sources. By when: Ongoing.”
 - c. “*What we hope will happen as we work toward the goal:*” This will note the expected outcome of the action steps for each goal. It will list things that will qualify the person for discharge. (For example, “If (participant name) gets Medicaid, her physician copays will end when that service starts through the Centennial Care MCO.” Other reasons to discharge include: the end of the crisis, finding another payer source, finding an alternate community resource, or pending move out of an approved service region.)
 - d. “*Additional notes / Progress Notes for Interim Reassessments*” includes explanations for the participant and for the SC. In this section, the SC is to note the date of the update, participant progress, barriers to progress and justify any reasons to continue or discontinue a goal or service.
 - e. “*Outcome / Results*”: The check boxes show the readiness for discharge. This is based on completion of goals, which may include finding other community resources or payer sources. Completing this section with the participant will help them see how each crisis is resolved by setting goals and taking action steps. This is true for Section II.I. too. The date that any goal has been met shall be marked by the SC. This is entered next to the item “We met the goal! (prepared for discharge).”
 - f. An “Additional Goals Page” is included after “Section III: Participant Agreement”. This is in case more help is needed to end an additional crisis. This page may be used for any new services that are added while an ILP is in progress and may be submitted to the BISF Fiscal Agent, as a supplement to the ILP, without having to create and resubmit a whole new ILP.
3. Section II.C: Service Coordination Support Needs/Referrals:

The SC is to check off help they plan to give in ending the participant’s crisis.
4. Section II.D: Life-Skills Coaching Support Needs:

The SC is to check off any of Life-Skills Coaching needed to end the participant’s crisis. This will be a record of the LSC support that will be monitored until the crisis ends.
5. Section II.E: BISF HCBS Referrals:

All BISF HCBS referrals shall be named here. Note frequency, hours, and how long the service may be needed. Also note known costs, which can be estimates. Frequencies, hours and costs may change without needing to write a new ILP. These can be updated after the ILP expires on the new interim ILP.
6. Section II.F: Services being accessed or referrals made for alternate payer sources:

This section lists services that are or may be covered by alternate payer sources that are helping end the participant’s crises. Example, “Participant needs outpatient mental health to address PTSD and depression, which is covered under VA benefits. Participant is currently seeing a VA counselor for treatment.”
7. Section II.G: Services, Supports, and Referrals Recommended but Refused by the Participant:



Brain Injury Services Fund Program (BISF)

Independent Living Plan (ILP)

All services recommended by the SC to end a crisis should be listed on the ILP. If the participant refuses a recommended service or goal and refuses to make the recommendation as a goal, then the service/goal should be listed in this section. Refused services/goals that pose barriers to the resolution of the crisis shall carry over to any new ILP, as appropriate.

8. Section II.H: Services and Supports the Participant Wanted but Were Not Assessed as a Need:

List any services that the participant asked for but was denied. List any referrals made to other agencies that could fulfill the request. Examples, "Participant requested hyperbaric therapy, which is not a covered service," or "Participant requested an EMod for their wheelchair-bound partner, who does not live with a brain injury."

9. Section II.I.: Past Goals that Have Been Met (include goals from past ILPs):

List here all goals that have been met. This is to help the participant see their progress and how their crisis needs are resolving. This will include progress made over all ILPs.

10. Section II.J: Additional Notes:

The SC may enter more comments on the plan, including plans for discharge.

Section III: Participant Agreement:

At the opening of the ILP:

1. Fill in the start and end dates of the ILP. The end date is when the next ILP will be due, if services need to continue or goals have not been met.
2. Once the ILP has been built by the SC, the SC should review the plan out loud with the participant, guardian or other supports, who helped build the plan.
3. Read the acknowledgement statement aloud and have the participant or guardian print the participant's name, then sign and date on the appropriate line.
4. List the names and relationships of those who helped build the ILP.
5. Both the participant/guardian and the SC are to sign and date the ILP, under "Signatures Upon Opening the ILP". The SC should never have the participant/guardian sign a blank ILP. The two develop the ILP together.
6. The participant/guardian is given a signed copy for their records.

At the close of the ILP:

1. The SC fills in the boxed section "TO BE COMPLETED BY THE SERVICE COORDINATOR...." This section notes the degree to which the participant is stable living in their home and community on their own. The SC also notes the status of services at the close of the ILP and any plans for discharge. The discharge plan must name any other resources that the participant will be using once BISF Program services have ended.
2. The SC reviews progress made and any barriers and helps the participant understand which services should continue, which services must end, and any discharge plans.
3. Both the participant/guardian and the SC are to sign and date the ILP under "Signatures Upon Closing the ILP".
4. The participant/guardian is given a signed copy of the final closed ILP for their records. They may work together to open a new ILP for any ongoing or new services/goals.

ROUTING:

- A copy of each opened and closed ILP is given to the participant/guardian.
- Initial and interim ILPs will accompany referrals to the BISF HCBS Fiscal Intermediary Agent (FIA).
- The latest ILP is to accompany any request by the SC to the HSD Brain Injury Program Manager to continue services beyond an approved service year.

FORM RETENTION: Permanent. In accordance with the State of New Mexico Human Services Department Professional Services Contract provisions.