What is a Person-Centered Support Plan?
The Person-Centered Support Plan (PCSP) is a tool to individualize services and supports for an individual with a disability. For example, the Division of Services for People with Disabilities (DSPD) uses the Person-Centered Support Plan (PCSP) as a way to develop and document meaningful supports and goals, assign paid services, and support specific goals to work on during the year. Support coordinators use the PCSP to coordinate and monitor services and supports for the individuals they support. Service Providers, such as group home staff, use the PCSP to individualize supports, services, and strategies for individuals receiving DSPD Medicaid Waiver services.

Who Participates in a Person-Centered Support Plan (PCSP)?
The main participant in a PCSP is the individual receiving services from DSPD.

This individual is the one to determine who attends the PCSP meeting. They may be able to make this decision independently or need some support from the support coordinator, family or others to do so. The support coordinator should also be at the meeting as he or she has specific duties to fulfill. A support coordinator is a private contractor with the DSPD who works with an individual with disabilities and his or her support team to develop a PCSP based on the individual’s needs and goals. They monitor the progress an individual makes, coordinate services from providers, manage the budget, and ensure the health and safety of the individual.

Pre-planning
Prior to the meeting, the individual communicates with their support coordinator as to who they would like at their meeting, some possible dates for the meeting to be held, and where they would like to hold it.

The support coordinator or other PCSP team member can review a copy of the previous year’s PCSP, if applicable, with the individual. They may want to talk about what the individual would like to have happen in the next year, or longer. Some great tools to help with pre-planning can be found at www.lifecoursetools.com. Family members, the provider or support coordinator can help the individual fill out a Life Trajectory Worksheet, or the Tool for Developing a Vision which can provide a roadmap to what the individual wants and needs to live their best life.

The individual will be asked to make informed choices at the meeting regarding the services and supports they receive, and who provides them. This may require some pre-planning. Family members, providers or the support coordinator can provide information and experience with the options prior to the meeting so the individual will be able to make a truly informed choice. For example, if the individual is interested in getting a job, they could do an interest inventory to see what they might want to do, visit some businesses that interest them, or watch videos online of people doing a variety of jobs that fit their skills and abilities.

***If the individual does not want their support coordinator at the PCSP, they should discuss it with someone they trust. If they are not happy with their support coordinator, each support coordination company has a grievance process they can go through. They may also change support coordinators at any time. There is a list of support coordinators and a video on choosing or changing them at https://dspd.utah.gov/resources/find-a-support-coordinator/ ***

Others who may participate in the PCSP are guardians, parents, other family members, close friends, residential and day support providers, employment providers, therapists, teachers, a significant other, or anyone who provides support (paid or unpaid) to the individual.

The meeting should be held at a time and place that is chosen by the individual and is convenient for all attendees. The location should be comfortable, accessible, and quiet and provide privacy.

What to Expect at a PCSP Meeting?

The meeting will focus on what a PCSP is, who participates in PCSPs, and what the roles are of PCSP participants. Stay tuned! More newsletters will follow with additional information.
The support coordinator will invite attendees to join the meeting and prepare an agenda for the meeting. He or she will also send out any necessary paperwork for review by attendees, such as the previous goals, any pre-planning tools that have been filled out, a copy of the personal profile to be updated and a recent medical and social history.

The Personal Profile is a section of the PCSP which should give any person unfamiliar with the individual insight into how to provide quality service. It includes a general description of the individual’s interests, passions, and values as well as likes and dislikes. It should state the preferred communication style of the individual and their hopes, dreams, fears and personal goals. It should include the relationships and social roles that are important to the individual and any physical and emotional health and safety information. Legal issues such as who can speak for the person and any rights restrictions should also be included in the Personal Profile.

If an assessment needs to be done, it should be done prior to the meeting. The assessment currently in use by the DSPD, the Supports Intensity Scale (SIS), outlines what is important TO the individual and important FOR the individual, and must be updated every five years.

At the Meeting

The individual should lead the meeting to the extent they want to. The individual’s support coordinator and the PCSP team should help the individual to participate in the meeting in whatever capacity the individual would like. The support coordinator or other team member should facilitate the PCSP process and make sure the meeting focuses on what is important to the individual. Providers have an important role in the PCSP process because they are generally the ones who follow the support strategies to help the individual reach their goals and often spend a lot of time around the individual. Providers can offer suggestions and insights into the individual’s desires, as can family members and friends, and all can ensure that everyone is focused on the needs and wants of the individual.

The team will follow the agenda to make sure they discuss everything they need to. The PCSP will include identified goals and desired outcomes to guide supports and services throughout the year. The goals will reflect those specifically chosen by the individual as well as any clinical or support needs identified through an assessment which was completed prior to the meeting. Providers can give input into the support strategies for the goals so that they are written with the individual in mind, and are measurable, attainable and relevant. The individual must consent to the goals and strategies for reaching them.

The PCSP may not be finalized in the meeting as everything must be input into the DSPD system software by the support coordinator who will then activate it. But as a group, there should be consensus on the desired goals and support strategies that will be used to help the individual in reaching his or her goals. There should be a plan for which supports, paid and unpaid, will be used for each goal listed. It should document the home and community-based settings which were considered by the individual. (More information on Home and Community-Based Settings can be found in the August 2019 Parent Connections newsletter, at Utah State’s Center for Persons with Disabilities Technical Assistance Center.)

After the Meeting

After the meeting has concluded, the support coordinator should make sure that the discussion and decisions are captured in the DSPD software system. A draft PCSP should be generated and sent out to the team to verify that it correctly reflects the discussion and decisions from the meeting. Any changes should be reported to the support coordinator who can update the formal document in the software system. The PCSP should then be finalized and distributed to those involved in creating and carrying out the plan.

The individual should be a willing participant in working towards the goals set for the upcoming year. The providers and others who support the individual should use the plan to assist them as they work on goals. Progress should be documented and reported at least monthly to the support coordinator. The support coordinator will continue to monitor the person, the support plan contains, how the person is progressing in goals, how their health and safety needs are monitored and maintained, and if any changes are needed in the plan to accommodate any changes in the person’s life. A family member, significant other or a provider may be designated as a “champion,” and should also monitor progress, and provide encouragement and information to the individual when needed.

At any time, the individual can request a meeting, formal or informal, to discuss any concerns or questions about the PCSP. It can be changed or updated at any time, not just once a year. To initiate any changes or updates, the support coordinator should be contacted.

Do You Want Additional Information?

The Person-Centered Support Plan (PCSP) is the driving force for the services received by individuals, but many parents and families are not sure what it is or how to develop a well-written plan. Parents can reach out to their Support Coordinator to learn more about PCSPs and to get a written copy of the plan if they do not currently have one.

You can also contact Lisa Wade, the PCSP Consultant with the Utah Parent Center. She provides information, support and consultation to families in need of PSCP assistance. She can be reached by email at lisa@utahparentcenter.org, or by calling the Utah Parent Center at 801-272-1051 or Toll Free in Utah at 1-800-468-1160.