
PERSON-CENTERED PLANNING PROCESS

Directive 1.9

Forms: Person-Centered Service Plan

Authorizing Code: [26B-6-403](#)

Rule: n/a

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Purpose

The division supports person-centered planning (PCP), which is a way of assisting persons needing services and supports to construct and describe what they want and need to bring purpose and meaning to their life. PCP is individualized and incorporates the principles of self-determination, informed choice, integration, inclusion, person-centered thinking, and person-centered practice.

Definitions

1. “Self-determination” is the freedom of persons to make choices about their own life without the undesired influence of others; and to have the same rights and responsibilities as those without disabilities.
2. “Informed choice” means that the person has options to choose from, information about the options, and experience with the options.
3. “Integration” is the opportunity for a person to live in the community and be valued for their uniqueness and abilities to the same extent as others without disabilities.
4. “Inclusion” is the opportunity for a person to have full access to their community to the same extent as those individuals without disabilities.
5. “Person” means an individual found eligible for services with DSPD.
6. “Person-centered thinking” is the belief or mindset that persons are the experts of their own lives and that they should be at the center of all decisions that are made about them.
7. “Person-centered practice” is the alignment of service resources that give persons access to the full benefits of community living and ensure they receive services in a way that will help them achieve individual goals.
8. The “written PCSP” refers to the Person-Centered Support Plan (PCSP) created in the Utah System for Tracking Eligibility, Planning, and Services (USTEPS).
9. “Informed consent of the person in writing” includes approval obtained either on paper or through an

electronic format, including proxy approval where appropriate.

10. The “action plan” is part of the PCSP and includes the person’s goals, strengths, barriers, objectives, and desired services and supports.

Procedure

1. Prior to the PCP meeting, support coordinators will complete pre-planning activities including, but not limited to:
 - a. Assisting the person in identifying who they want to invite to their PCP meeting, otherwise known as the person’s “team.”
 - b. Identifying a time and location to hold the PCP meeting which would be most convenient for the person.
 - c. Creating an agenda for the PCP meeting with the input of the person.
 - d. Identifying the extent to which the person would like to lead their PCP meeting.
 - e. Completing person-centered tools with the person.
 - f. Sending out materials for the person and team’s review in advance of the PCP meeting.
2. The PCP process:
 - a. Must be led by the person where possible. The person’s representative should have a participatory role, as needed and as defined by the person, unless state law confers decision-making authority to the legal representative. All references to the person include the role of the person’s representative.
 - b. Include other people chosen by the person, otherwise known as the person’s team.
 - c. Provides necessary information and support to ensure that the person directs the process to the maximum extent possible, and is enabled to make informed choices and decisions.
 - d. Is timely and occurs at times and locations of convenience to the person.
 - e. Reflects cultural considerations of the person and is conducted by providing information in plain language and in a manner that is accessible to persons and those who are limited English proficient.
 - f. Includes strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants.
 - g. Offers informed choices to the person regarding the services and supports they receive and from whom.
 - h. Includes a method for the person to request updates to the plan as needed.

- i. Records the alternative home and community-based settings that were considered by the person.
3. Support coordinators shall use the PCP process, along with other formal and informal assessments, to develop the PCSP. (See division Directive 1.8).
4. The person's team will assist the person in creating their PCSP and identifying necessary services and supports based on the person's desired life and support needs.
 - a. The person receiving supports or the person's representative determines the membership of the team, which will include the support coordinator.
 - b. The team meets at least annually (within twelve months of the last PCP meeting), or more often as the person or other members of the team determine necessary.
 - c. Roles and responsibilities of team members:
 - i. The support coordinator assists the person in facilitating the planning meeting and developing the written PCSP.
 - ii. The provider offers action steps and services for the implementation of the person's PCSP.
 - iii. The family, guardian and the person's friends offer suggestions and insight into the individual's wants and needs.
 - d. Roles and responsibilities of team members for self-administered services (SAS): For those in SAS, the roles and responsibilities of individual team members are outlined in the Self-Administered Services Support Book.
5. The support coordinator ensures that the action plan is decided on by the person and the team at the planning meeting. The person, provider, and family will assess, plan, implement and evaluate goals and supports for which they are responsible, as agreed upon and listed on the action plan in the planning meeting. The action plan can be finalized after the planning meeting based on decisions that were made during the meeting. The PCSP should be finalized and agreed to, with the informed consent of the person in writing, and signed by all individuals and providers responsible for its implementation.
6. After the PCSP has been signed by the person, support coordinators shall complete monitoring activities to ensure that the PCSP is being implemented as prescribed, and that the plan continues to meet the person's needs and preferences. Post-planning activities include, but are not limited to:
 - a. On-site, face-to-face visits
 - b. Interviews with the person
 - c. Direct observation of supports provided to the person
7. Support coordinators should work with the person and their team if the PCSP needs to be amended due to changes to the person's needs or preferences, or in response to certain life events or circumstances. Examples of when a PCSP should be updated include, but are not limited to: adding, ending, or changing

a service; or major life changes that affect services.

8. If any interested party believes that person-centered planning is not being implemented as outlined, or receives a request from the person or their representative, they should immediately contact the support coordinator to resolve the issue by following the process outlined in Division Directive 1.11, Notice and Hearings for Agency Action, and 1.7, Entry to and Movement within the Service System.