

The [Consumer-Directed Services \(CDS\) Worksheet](#) (HCBS-3c) shall be used when the Division of Senior and Disability Services (DSDS) staff or its designee cannot access the participant's electronic case record or when necessary to support the development of a Person Centered Care Plan (PCCP) and authorization of the Independent Living Waiver (ILW). It contributes to a more consistent approach when determining the appropriate amount of services necessary to meet a participant's unmet needs. Suggested times and frequencies have been developed with the care needs of an average or typical participant in mind.

The HCBS-3c is an Excel document. When filling out the form electronically, there are auto-calculations built within the body of the document. In addition, there are certain restricted fields which do not allow data entry. Those fields can be identified by the shaded cells. In order to navigate the form efficiently, it is suggested to use the **tab key** to go from field to field.

INSTRUCTIONS

The HCBS-3c shall be completed on all CDS service authorizations when DSDS or its designee cannot access the electronic case record system.

PARTICIPANT INFORMATION

PARTICIPANT NAME: Enter the participant's name

DCN: Enter the participant's Departmental Client Number (DCN)

IHS: Check if the participant currently receives, or is being authorized for, other HCBS in addition to CDS

PROVIDER NAME: Enter the name of the participant's chosen provider

PROVIDER PHONE: Enter the chosen provider's phone number.

PERSONAL CARE ASSISTANCE: Check the type(s) of program in which the participant is enrolled (i.e., State Plan or ILW). Once units are calculated, enter the monthly units after the type of assistance.

START DATE: Enter the earliest date CDS can begin.

CALCULATIONS

SUGGESTED TIME: No Entry

SUGGESTED FREQUENCY: No Entry #MIN/DAY: Enter the estimated amount of time required to complete each task per day

#UNITS/DAY: No entry

#DAYS/WEEK: Enter the number of days per week

TOTAL UNITS/DAY: No Entry

MAX DAYS/MONTH: No Entry

UNITS/WEEK: No Entry

TOTAL UNITS/MO: No Entry

DESCRIPTION OF NEEDS

Enter any comments regarding care planning needs to be used as a reference upon return to the office. Completion of this column is only mandatory for Independent Living Waiver (ILW) requests and the information should provide clear explanation of why each task is being requested and why the amount of time requested is appropriate.

INDEPENDENT LIVING WAIVER (ILW) SERVICES: Indicate if ILW services (i.e., case management, financial management services, specialized medical equipment/supplies, and environmental accessibility adaptations) are being requested.

- Any participant who requires more units per month of State Plan Personal Care than allowed within the established cost maximums, must be considered for the ILW to meet that need. Approval for ILW services must be obtained from the Bureau of Federal Programs (BFP) prior to authorization.

COMMENTS

- Enter any comments or necessary information here.

ASSESSOR SIGNATURE AND DATE

- The individual completing the document shall sign and date the HCBS-3c on the date the worksheet is completed.

EMERGENCY CONTACT/PHONE

- Enter the participant's emergency contact name and phone number.