Person-Centered Planning, Goal Development, and Restrictive Interventions – Training FAQ (8/12/2026)

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IOWA Health and Human Services

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Background & Purpose

Why is this training being offered now if these are not new requirements?

Several developments in Iowa make this training timely:

- The HCBS Settings Rule transition period ended in *March 2023*, requiring full compliance.
- The CMS 2024 site visit identified missing person-centered goals and inadequate justification of restrictive interventions.

Ongoing quality oversight reviews show statewide challenges with person-centered planning, provider/case manager role clarity, and restrictive intervention documentation.

- Feedback from the HCBS network indicates confusion caused by inconsistent terminology, conflicting requirements, and differing templates across entities.

Can you explain more about the person-centered planning tool referenced in this training and FAQ document?

The person-centered planning tool referenced in this training and FAQ document is a simply, easily implemented tool for person-centered planning, especially goal development and planning for restrictive interventions, meant to assist members, case managers, and the whole Interdisciplinary Team (IDT) to develop a comprehensive, individualized person-centered service plan (PCSP).

It is meant to support conversations about goals, needs, and any restrictive interventions that may be part of someone's services. It's a structured guide to help organize those discussions, but it is not intended to capture every detail of the broader planning process.

Key Rules & Requirements

What federal regulations apply to person-centered planning (PCP) and HCBS?

The following federal rules were cited in the training, but this is not an exhaustive list of Code of Federal Regulations (CFR) that addresses HCBS settings and person-centered planning requirements:

- CFR 441.301(c) – HCBS waiver requirements, person-centered planning, provider vs. case manager roles, settings standards.
- CFR 441.710 – State plan HCBS requirements.

What state rules are relevant?

The following Iowa Administrative Code (IAC) chapters were cited in the training, but this is not an exhaustive list of IAC addressing HCBS settings and person-centered planning requirements:

- Chapter 90 – Case management, PCSP, rights restrictions.
- Chapter 83 – Eligibility; service plans and IDT requirements.
- Chapter 78 – Definitions, PCSP content, settings requirements.
- Chapter 77 – Provider qualifications, restrictive intervention rules, basic rights and dignity standards.

Person-Centered Planning Requirements

What is person-centered planning?

Person-centered planning is the overall process used to understand what matters most to the member—their goals, preferences, strengths, needs, and the supports they want in their life. It is led by the member (or their authorized representative) and involves people important to the member.

Person-centered planning focuses on listening to the member, exploring options, and helping them make informed decisions about their services, supports, living situation, and goals.

What is a person-centered service plan (PCSP)?

The Person-Centered Service Plan (PCSP) is the written document that comes out of the person-centered planning process. It records the member's goals, assessed needs, chosen services, supports, providers, backup plans, and any agreed-upon action steps. The PCSP is the formal plan that guides service delivery and documents informed consent, responsibilities, and how progress will be monitored. It is updated at least annually, whenever the member's needs or circumstances change, or at the request of the member.

What are the required elements of the person-centered planning process?

Federal rules require that the person-centered planning process:

Is led by the member. (Note: When the individual member is referenced, it encompasses the individual's authorized representative if applicable.

- Includes people the member chooses.

- Is timely and occurs at times and locations convenient for the member.
- Provides necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions.
- Reflects cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who have limited English proficiency.

Offers informed choices to the individual regarding the services and supports they receive and from whom.

- Includes strategies for solving conflict or disagreement within the process, including clear conflict of interest guidelines for all planning participant

Prevents the provision of unnecessary or inappropriate services and supports.

Provides a way for the member to request updates to their PCSP.

Who writes the PCSP? Can HCBS providers write it?

Federal rules require that the member's HCBS providers, or anyone who has an interest in or is employed by an HCBS provider for the member must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS. In these cases, the State must devise conflict of interest protections including separation of entity and provider functions within provider entities, which must be approved by CMS. Iowa does not have this special approval.

Because HCBS providers cannot act as case managers, they do not write the PCSP.

However, HCBS providers still play an essential role as part of the Interdisciplinary Team (IDT). They participate in the planning meeting, provide input, and help identify needs, supports, and action steps — but the case manager is responsible for writing the actual PCSP document.

Providers may also create their own supplemental provider plans to give staff detailed instructions. These must:

- be reviewed in the IDT,
- align with the PCSP, and
- be attached to the PCSP so everything is consistent.
- Providers cannot add goals, restrictions, or interventions that are not already written in the PCSP, though they may add detail about how staff will carry out what the PCSP already includes.

Should provider supplemental plans/documents match the PCSP exactly?

Any supplemental plans/documents created by the HCBS provider must align with the PCSP, not conflict with it, and be incorporated into the main PCSP. Providers must not develop goals or implement limitations, modifications, or restrictive interventions that are not vetted through the IDT and included in the PCSP.

Providers may create their own supplemental plans/documents but the PCSP must be used to guide service provision. Any supplemental plans/documents need to align with the main PCSP.

What must be documented in a PCSP?

A compliant PCSP is written by the member's case manager and must, at a minimum:

Reflect the member's strengths, preferences, and assessed needs.

- Document that the setting in which the member resides was selected by the individual and that the setting is integrated in, and supports full access of to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and access resources in the community to the same degree of access as individuals not receiving HCBS.
- Include individually identified goals and desired outcomes.
- Include paid and unpaid supports.
- Detail what paid and unpaid supports will do to assist the member in meeting their needs and achieving their goals.
- Include service details (amount, duration, scope).
- Identify risk factors, measures to minimize risks, and backup plans.
- Document who is responsible for ongoing monitoring of the PCSP.
- Document due process of restrictions or limitations and their justification.
- Be written in a way that is understandable to the member and the individuals supporting the member.

Be finalized and agreed to, with evidence of informed consent of the individual in writing and signed by all individuals and providers responsible for its implementation.

- Be distributed to the individual and other people involved in the plan.
- Include any services, the individual elects to self-direct.

How often must the PCSP be reviewed?

The PCSP must be reviewed at least once every 12 months, but it can be reviewed sooner whenever the member's needs or circumstances change or whenever the member asks for an update. Regular and timely review ensures the plan continues to reflect the member's current needs, wants, and desired outcomes.

Are case managers required to send the PCSP to providers for signature afterward?

Federal rule requires the PCSP to be finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation. Rule goes on to say it must be distributed to the individual and other people involved in the plan.

What if guardians or other participants won't return signatures?

Again, federal rule requires the PCSP to be finalized and agreed to, with the informed consent of the member in writing, and signed by all individuals and providers responsible for its implementation. Rule goes on to say it must be distributed to the individual and other people involved in the plan. Case management groups should follow their internal processes when signatures cannot be obtained per requirements.

Is the provider responsible for ensuring the case manager "does their job"?

This belief reflects a misunderstanding of how the IDT and the person-centered planning process are intended to function. Person-centered planning is a collaborative, member-focused process in which everyone on the team has an important and clearly defined role.

The case manager is responsible for facilitating the person-centered planning process, ensuring all required elements are completed, coordinating the meeting, writing the PCSP, and keeping the team focused on the member's needs, wants, and desired outcomes. Case managers are also responsible for building conflict resolution into the process, so the team can work through disagreements in a way that maintains focus on the member.

Providers are responsible for collaborating within the IDT, sharing observations and expertise based on their work with the member, and helping identify supports, strategies, and pathways that align with what the member wants to achieve.

The person-centered process relies on shared responsibility**,** not oversight of one discipline by another. Providers do not monitor whether the case manager "does their

job.” Instead, they participate fully in the planning process, contribute their expertise, and work with the case manager and other team members to develop a plan that truly reflects the member’s needs, wants, and desired outcomes.

Interdisciplinary Team (IDT)

What is the Interdisciplinary Team (IDT)?

The Interdisciplinary Team (IDT) is a collection of people involved in a member’s life who collaborate with the member and each other to develop and implement a holistic, person-centered service plan that addresses the member’s physical and mental health social /relational, daily living and service needs. The IDT is directed by the member to the maximum extent possible and facilitated by the member’s Case Manager. The IDT empowers the member and comes alongside them to help them make decisions, understand their options, and carry out the agreed upon PCSP.

Who must be included in the IDT?

- The member (leads the team to the extent possible)
- Case manager (facilitator, PCSP writer)
- Legal representatives or guardians
- Parents (for minors and unless restricted or otherwise unable to participate)
- Current service providers
- Anyone else the member chooses

What are providers’ responsibilities on the IDT?

Providers must:

- Participate collaboratively.
- Give input.
- Use the PCSP as the primary guide for service delivery.
- Provide supplemental plans (“provider plans”, staff instructions, therapy plans) for inclusion in the PCSP.
- Deliver services using a person-centered approach.

What if a case manager and HCBS provider do not agree on the goals or restrictive interventions or some other aspect of what and how these elements should be documented in a member's PCSP?

When a case manager and HCBS provider disagree on goals, restrictive interventions, or how something should be documented in a member's PCSP, the case manager is responsible for ensuring the person-centered planning process includes conflict resolution, as required in HCBS rules. In any disagreement, the team should return to the member's needs, wants, and desired outcomes and focus on how the member prefers the goal or intervention to be written. The final plan must reflect the member's direction, include the full process for any restrictive interventions, and document why the chosen approach best supports the member's assessed needs while honoring their preferences.

What if case managers hold meetings without the HCBS provider and make changes?

The IDT must include current service providers. If an HCBS provider cannot attend a meeting, the case manager should make every effort to involve the HCBS provider outside of the meeting.

Guardians don't understand their reach. What IS their role?

In Iowa, guardians have authority to act in the best interests of the protected person, but their powers are always subject to court oversight, statutory limits, and the protected person's rights. Guardians must balance decision-making with the goal of promoting independence and minimizing restrictions. Guardian preferences for everyday choices should be discussed and considered in the person-centered planning process, but their preferences alone do not constitute "justification" for rights restrictions. The requirements for implementing a limitation, modification, or restriction must still be followed.

According to the Handbook for Adult Guardians and Conservators, the role of the guardian or conservator is as follows.

A guardian or conservator has a responsibility to help the protected person develop self reliance. You should involve the protected person in making decisions as much as they are able. Many times, a guardian or conservator's role is really to help the protected person make a decision by helping the protected person gather information, talking through the options, and helping guide the protected person through the process of deciding. When the protected person is unable to participate in making the decision, or when the protected person wants to choose something that would be impossible or that

would cause substantial harm, the guardian or conservator may have to make the decision for the protected person.

The guardian or conservator should try to make the decision the protected person would make if they were able to. The guardian or conservator should think about the protected person's goals, needs, values, and preferences. If you don't know the protected person's wishes or preferences and you can't find out about them from the protected person or others who know the protected person well, you might have to make a decision based on the protected person's "best interests." This means choosing the course of action that is the least intrusive, most normalizing, and least restrictive way possible to meet the protected person's needs.

You do not have to make decisions alone. You can consult with the team involved in the protected person's care to information about your options. You can reach out to the Office of Public Guardian or an organization for guardians, like the Guardianship Association of Iowa Network (GAIN) or the National Guardianship Association (NGA) for guidance. You may also consult with an attorney.

Developing the Person-Centered Service Plan

How are goals developed in a person-centered way?

In the approach provided in this training, the IDT works with the member to:

- **Discover** needs, wants, desired outcomes.
- **Choose pathways** to address them:
  - Pathway 1: Goals/Skill-building
  - Pathway 2: Practical Adjustments
  - Pathway 3: Acceptable Risk
  - Pathway 4: Limitations/Modifications/Restrictions
- Obtain **consent/agreement**
- **Write** the PCSP
- **Implement** the PCSP
- **Monitor and adjust** the PCSP as needed and required

Do all services require their own goal? For example, does the PCSP need to have a goal for day habilitation, a goal for supported community living, a goal for respite, etc.?

All services must be addressed in person-centered planning and on the PCSP, but goals should not be put in place for the sole reason of justifying the authorization of the service. Services should be installed to help address needs and reach individually identified goals. Requiring a goal *for each service* is backwards and can lead to unnecessary or inappropriate services.

What are non-disability-specific options?

Non-disability-specific options are services or resources available to anyone in the community. Examples cited in the training included retail stores, gyms, libraries, restaurants, recreational classes or sports, golf courses, basketball, tennis, pickleball courts, salons, barbers, spas, clubs, housing, jobs, etc. These non-disability specific resources must be presented as choices when determining how to address the member's needs, wants, and desired outcomes and in reaching their individually identified goals.

What are natural supports?

Natural supports are unpaid supports (family, friends, coworkers, neighbors) that help meet needs and should be included in the PCSP when they are used to help address the member's needs, wants, and desired outcomes and in reaching their individually identified goals.

What are practical adjustments?

The term "practical adjustments" as used in this training, are simple, non-restrictive environmental or routine changes that help meet a need (e.g., removing tripping hazards). They preserve independence and autonomy.

What does "dignity of risk" mean?

Members have the right to make informed decisions, even risky ones, when risks are reasonable, typical in daily life, and promote autonomy. Avoid automatically imposing restrictions when risks can be safely managed.

Are goals written by the case manager or the HCBS provider?

Goals are identified by the member with help from the IDT and written into the PCSP by the Case Manager.

What if the HCBS provider is asked to write goals?

Providers give input on the goals through the person-centered planning process, but writing the goals into the PCSP is done by the case manager. HCBS providers have valuable insight into the daily life, needs, wants, and desires of the individual member and therefore have a crucial and unique role in helping the member identify goals.

Case managers say goals should be member "wants," and needs should be in service authorization. Is that correct?

Person-centered planning is not about separating "wants" into goals and "needs" into the service authorization. Instead, the person-centered planning tool is used to help the IDT discover the member's needs, wants, and desired outcomes**,** and then determine the appropriate pathways to address each of them.

Whether something is identified as a want or a need does not determine how it should be addressed. All needs, wants, and desired outcomes must be explored through the person-centered process, and the IDT decides together how each one is best supported, whether through Goals/Skill Building, Practical Adjustments, or Acceptable Risk, or Limitations/Modifications/Restrictions Pathways.

Services are installed to help the member achieve their goals and to help meet their needs, wants, and desired outcomes. Simply dividing wants and needs into different documents or categories minimizes the holistic, person-centered nature of the planning process.

How do we measure progress towards goals? Can percentages and prompts be used?

How progress is measured depends on the nature of the member's own identified goal. It's important for the IDT to ensure they are measuring progress toward what the member wants to achieve, not toward goals created simply because they are easy to track.

Often, goals like "I want to brush my teeth with three or fewer prompts" are not truly meaningful to the member. In these situations, the team should elevate the conversation to understand why the member might want to complete that task more independently. This will usually reveal a more authentic goal, such as increasing

independence, improving health, avoiding future dental work, or preparing to live more autonomously. Once the member's real goal is identified, the team can ask the member what "progress" looks like to them. For example, progress might be:

- Doing more daily tasks without assistance
- Receiving a positive report at the dentist
- Feeling healthier or more confident

Successfully completing several different independent living skills—not just brushing their teeth

In this context, brushing teeth independently becomes **one objective** under a larger, meaningful goal rather than the goal itself. Other objectives may also demonstrate progress toward that broader goal.

The number of prompts needed before a member completes a task generally does *not* show meaningful progress toward a member identified goal. It is often influenced more by the member's mood or how the prompt is delivered than by learning or skill development. Goals must reflect what matters to the member, and the action steps should demonstrate how services support their progress toward those meaningful outcomes.

Using prompts as a measurement tool is typically only effective when the member's desired outcome is related to becoming more independent in that specific skill. Otherwise, progress is often better measured through indicators that align directly with the member's own definition of success.

What if the case manager does not write the PCSP so that the goals are measurable or the action steps are not specific enough to be actionable?

The PCSP is created through the IDT, and every member of the IDT, including providers, has a responsibility to contribute to the development of clear, meaningful, and actionable goals. If a PCSP is written in a way that does not include measurable goals or does not provide enough direction for providers to carry out services effectively, the IDT should work together to address this during the person-centered planning process.

Providers should offer input about what they need to successfully deliver services and support the member. Action steps must be specific, clear, and detailed enough to guide staff implementing the plan. The people carrying out the PCSP need to understand exactly what they are expected to do, and the member needs to understand what progress looks like.

The case manager facilitates the meeting and ensures all required elements of the PCSP are met, but the plan is a team product, shaped by input from everyone who

supports the member. Case managers also have a responsibility to build conflict resolution into the process when needed and to keep the team focused on the member's needs, wants, and desired outcomes.

When the IDT collaborates effectively, goals become meaningful, measurable, and actionable resulting in a PCSP that supports the member's success and reflects what genuinely matters to them.

Restrictive Interventions

What is a restrictive intervention?

Restrictive interventions are any actions, limitations, modifications, or restrictions that limit a member's rights or freedoms. This includes restraints, restrictions, and behavioral interventions that reduce what a member can do or how they can access their environment.

Federal rules, state rules, and other documents and systems use different words—such as "limitations," "modifications," "restrictions", "restraints," or "behavioral intervention plans" — but in practice, they all refer to the same concept. These terms all describe actions that reduce or change what a member is allowed to do or how they access their environment, and all must follow the same federal and state requirements for justification and due process.

What criteria must be met and documented when authorizing a restrictive intervention?

Per federal and state rule, restrictive interventions can only be used when:

- There is a specific assessed need for the limitation, modification, or restriction
- Less restrictive and positive interventions and supports were tried but were unsuccessful.
- The restriction is the next least restrictive options and is proportionate to the need.
- The restriction is time-limited and reviewed at least quarterly to determine if sufficient progress has been made to reduce or eliminate the restriction.
- The member gives informed consent.
- It causes no harm.
- It is for reducing or eliminating maladaptive target behaviors that are identified in the member's behavioral intervention program.
- It is for the benefit of the member and not as punishment, for the convenience of the staff, or as a substitute for a non-aversive program.

What is informed consent?

Informed consent means that a member has been given clear, accessible information about their options, the risks and benefits of those options, and any proposed services, supports or restrictions — and has had the opportunity to ask questions, consider alternatives, and make a voluntary, uncoerced decision.

Informed consent requires a meaningful conversation, not just a signature. Members may need different communication tools, additional time, or specific accommodations to ensure they fully understand their choices.

Consent is not merely a signature. Consent is the result of a thorough, person-centered process in which all pathways are explored, all options are explained, and the member understands what they are agreeing to.

Are there any things that are ALWAYS considered a support or ALWAYS considered a restriction?

The terms “supports” and “restrictions” are frequently used to mean a specific section of a PCSP template. Some templates have separate sections titled “goals,” “supports,” and “restrictions,” but this training does not prescribe where content must go in a template. Instead, it teaches the IDT to use the person-centered planning tool to discover needs, wants, and desired outcomes and address them through various pathways:

- Goals/Skill-building (including supports to achieve the goal or build the skill),
- Practical Adjustments
- Acceptable Risk
- Limitations/Modifications/Restrictions

If going down the “Limitations/Modifications/Restrictions Pathway”, the IDT must take every step in the pathway.

Are providers allowed to turn restrictions into “supports”?

If something truly limits or modifies a member’s rights, it *must* follow the *full* restriction pathway.

This includes:

- Identifying the assessed need
- Documenting positive interventions already tried
- Documenting less-intrusive options attempted
- Ensuring the restriction is proportional to the need
- Establishing a plan to reduce or eliminate the restriction
- Collecting and reviewing data
- Obtaining informed consent

*Calling a restriction a "support" does **not** change what it is.*
If it limits a right, it must be justified as a restriction — not placed in a "supports" section to avoid due process.

What is a behavioral intervention plan (BIP)?

A *Behavioral Intervention Plan (BIP)* as used in this training, is a formal, structured plan that targets one or more specific maladaptive behaviors that pose a risk to the member or others, such as but not limited to, self-harm, aggression, elopement, stealing, inappropriate sexual behavior, or severe verbal outbursts.

A BIP outlines the exact interventions, strategies, and steps staff must follow to reduce or eliminate the identified behavior. Because BIPs involve restrictive measures or behavior specific interventions, they must meet all federal and state requirements for documenting limitations, modifications, and restrictions.

A BIP may be written directly into the PCSP or included as a supplemental document to the PCSP, but it must be reviewed and approved by the IDT and attached to the PCSP to ensure informed consent, oversight, and due process.

What are behavioral supports?

Behavioral supports as used in this training, are general strategies, tools, or everyday practices used to help a member understand, manage, and respond to their emotions and behaviors in positive ways. These supports help the member cope with frustration, build communication skills, regulate emotions, and navigate daily challenges.

Behavioral supports are part of the broader PCSP and may be used on their own or alongside a formal BIP. Unlike a BIP, behavioral supports do not target a specific maladaptive behavior; instead, they help promote emotional well-being and prevent behaviors from escalating.

What is the difference between behavioral supports and BIPs?

Behavioral supports are regular, non-restrictive strategies for typical emotional/behavioral needs while BIPs are formal plans to target specific maladaptive behaviors. BIP must be individualized, detailed, and meet all restrictive intervention requirements.

Who writes a Behavioral Intervention Plan (BIP)?

A Behavioral Intervention Plan (BIP) may be developed with input from many sources, including professionals with behavioral-health expertise. A behavioral specialist, psychologist, or other qualified professional may assess the member, offer recommendations, or even draft a version of the plan. However, the responsibility for incorporating the Behavioral Intervention Plan into the Person-Centered Service Plan (PCSP) rests with the case manager.

The case manager must ensure that:

- The BIP is included in the PCSP, either as an attachment or written directly into the PCSP document (if the format allows).
- The IDT, including HCBS providers participate in developing, reviewing, and refining the plan based on their expertise and their day-to-day experience working with the member.
- The BIP meets all required HCBS standards for a BIP.
- The IDT fully vets any plan provided by an outside professional to make sure it meets these requirements before it is incorporated into the PCSP.

Requirements for a compliant BIP include:

- Targets one or more specific maladaptive behaviors that pose a risk to the member or others
- Outlines the exact interventions, strategies, and steps staff must follow to reduce or eliminate the identified behavior.
- Demonstrates that the BIP is only for the benefit of the member and not used as punishment, for the convenience of the staff, or as a substitute for a non-aversive program.
- Does not constitute the use of corporal punishment or abuse.
- Follows all federal and state requirements for documenting limitations, modifications, and restrictive interventions including:
    - There is a specific assessed need for the limitation, modification, or restriction
    - Less restrictive and positive interventions and supports were tried but were unsuccessful.
    - The restriction the next least restrictive options and is proportionate to the need.

- The restriction is time limited and reviewed at least quarterly to determine if sufficient progress has been made to reduce or eliminate the restriction.
- The member gives informed consent.
- It causes no harm.

Because external professionals may not be familiar with HCBS requirements or state-specific expectations, their plans may need adjustments to meet these standards. For that reason, the IDT must work together—using the professional's expertise, the team's knowledge of the member, and the case manager's planning responsibilities—to finalize a BIP that is both clinically sound and fully compliant.

Can you summarize suggestions for right-restriction planning?

The team must always begin with the person-centered planning tool to identify the member's needs, wants, and desired outcomes. Never start with a restriction already in mind.

1. Identify the Need, Want, or Desired Outcome

Work with the member and the IDT to determine whether any limitation, modification, or restriction may be needed to address what the member wants or needs.
Identify what has already been tried but did not adequately address the concern.

2. Plan the Least Restrictive Option

Ensure the next step is truly the *next least restrictive* option.
Confirm that any limitation, modification, or restriction is proportional to the assessed need.
Determine what needs to be done to reduce or eliminate the restriction over time.

3. Obtain Agreement and Consent

Make sure the member and IDT understand the plan and their roles in carrying it out.
Ensure the member fully understands the options and feels they made an informed choice.

4. Create or Update the PCSP

Document the entire planning process, including assessed needs, chosen pathways, and agreed-upon actions.
Adjust the PCSP and any corresponding plans to reflect the decisions made.
Obtain required signatures and ensure the case manager distributes the PCSP to all involved parties.

5. Implement the Plan

All responsible parties follow the PCSP and perform their identified roles.

What are common mistakes to avoid in planning for restrictive interventions?

Person-centered planning meeting with pre-determined limitations, modifications, or restrictions that are not based on the member's assessed needs. This often shows up as "blanket" or standardized restrictions applied to everyone in a setting—such as locking all medications, installing cameras, limiting visitors, or restricting access to common areas—which violates person-centered requirements.

Another common error is failing to follow every step in the Limitations/Modifications/Restrictions Pathway or not documenting those steps adequately. Restrictions must be tied to an assessed need, attempted supports and less intrusive interventions must be documented, proportionality must be demonstrated, plans for reduction must be included, and informed consent must be obtained. Simply stating in the PCSP that "this is a restriction" does not justify it.

Finally, restrictions cannot be added solely because a guardian, provider, or anyone else prefers them; they must meet federal and state requirements and be grounded in the member's assessed needs, wants, and desired outcomes.

The IDT must always begin with person-centered discovery—not assumptions—and proceed through every pathway step to ensure rights are limited only when absolutely necessary and fully justified.

What if the guardian wants a restriction but the member doesn't?

When a guardian wants a restriction that the member does not, the IDT can help the guardian understand that their role is not to impose their own preferences but to support the protected person in developing self-reliance, participating in decisions, and exercising as much independence as possible.

According to the state's Handbook for Adult Guardians and Conservators, guardians are expected to involve the protected person in decision-making to the extent they can, help them gather information, talk through options, and guide them, not replace them, unless the member is unable to participate or the member's choice would lead to substantial harm. Even then, any decision the guardian makes should reflect what the protected person would choose if they were able, based on the person's goals, needs, values, and preferences.

When those preferences cannot be determined, decisions must be made in the member's "best interests," using the least intrusive, most normalizing, and least restrictive option. A guardian's preference alone does not justify a right restriction.

Any limitation, modification, or restriction must still meet all HCBS requirements. If a guardian proposes a restriction, the IDT must evaluate whether the member has an assessed need indicating actual risk, and whether the restriction can be avoided by using skill-building, practical adjustments, or other supports.

Common Scenarios

Blanket Restrictions (Provider Policy)

Sometimes HCBS providers have formal or informal policies that limit, modify, or restrict members' rights without any assessed need for the individuals affected. We sometimes refer to these as "blanket restrictions" or "standardized restrictions".

For example, a provider may lock all members' medications or money, or use cameras to monitor the home, and justify it by saying it is "provider policy." Provider policy alone is not acceptable justification for any limitation, modification, or restriction.

When this happens, the IDT should return to the beginning of the person-centered planning tool and identify the specific assessed need, want, or desired outcome that requires attention. The team must then work through the appropriate pathways, including the Limitation/Modification/Restriction Pathway and follow every required step.

If the member does not have an assessed need for the proposed restriction, or if any required step in the pathway cannot be met, the IDT cannot justify the restriction for that individual.

Cameras (Including Ring doorbells, Alexa Units with Cameras)

Federal rules protect individuals' right to privacy in all HCBS settings. Any limitation, modification, or restriction of a member's rights must be directly tied to an assessed need and justified in the person-centered service plan. Cameras limit the member's privacy and must always follow the full process for limitations, modifications, and restrictions.

Cameras may not be used to monitor staff performance, prevent potential theft, prevent possible abuse, or for any other purpose based on staff or provider preference. Cameras may only be considered if a member need is clearly identified through the person-centered planning process.

If the IDT identifies a legitimate member need that might be addressed through the use of cameras, the team must explore all appropriate pathways in the person-centered planning tool.

If cameras are included in the plan, they may appear under pathways such as Goals/Skill building or Practical Adjustments. However, because they always limit a

member's privacy rights, the team must also complete every step required for limitations, modifications, and restrictions.

Cameras cannot be placed in bathrooms or bedrooms unless very specific conditions are met and documented, justified, and approved as part of the limitation/modification/restriction process. If necessary, there must be an identified, specific need directly related to the member's health or safety risk that warrants the use of the cameras in bedrooms or bathrooms. If the bathroom or bedroom is shared with others, each member must have an identified health or safety risk justifying the use of the camera and each must provide informed consent for the use of the camera.

For members for whom there is not an identified health or safety need for cameras in the bathroom and for whom there is no informed consent for the use of a camera in the bathroom, the camera must have the functionality that allows it to be shut off by the member or staff while that member is using the bathroom.

When a member lives with other people, placing cameras in common areas generally does not meet the requirement of being the least restrictive option. This is especially true when other household members do not have a need for the cameras. The team must carefully evaluate the living environment and whether cameras respect the rights of all individuals in the home.

Regular cameras, including Ring doorbells and Alexa devices with cameras, should not be labeled as remote supports and cannot be used as a substitute for in-person supported community living (SCL) or home-based habilitation (HBH) services. Remote supports is a modality of delivering SCL or HBH with a specific definition and requirements. Only true remote supports that meet the formal definition may be used as a service delivery modality.

There have been legitimate situations where cameras have been appropriately used. For example, a member living alone had a history of intermittently aggressing toward staff when waking at night. The member did not require two overnight staff on a regular basis, but staff needed a way to safely respond during unexpected incidents. To maintain the member's independence and ensure the provider could continue serving them safely, the team explored the use of cameras paired with an activation button to summon staff from a nearby home when needed.

In this situation, the need was clearly documented. The solution supported the member's independence, helped ensure the provider was able to meet their needs, and addressed safety concerns. The cameras were included under Goals/Skill-building and Practical Adjustments, and because they restricted privacy, all requirements for Limitations/Modifications/Restrictions were completed.

Housemate Restriction Applied to Everyone

When a member lives in an HCBS residential setting with housemates and has a need that requires a limitation, modification, or restriction, the IDT must determine whether the proposed restriction is truly the least restrictive option within a shared living environment. Restrictions that affect housemates without an assessed need are rarely the least restrictive option.

The IDT of the unrestricted member should look for individualized solutions—such as keys, bio-locks, separate accessible storage, or other practical adjustments—that allow unrestricted housemates to maintain access to food, medications, personal items or spaces within the home. The IDT of the restricted member should consider the member's living arrangement when determining how to best address the member's need.

"Alone Time"

Many IDT will come up with fixed amounts of "alone time" members may have at home and/or in the community and list it as "rights restriction" in the member's PCSP. These arbitrary time limits do not reflect a member's real supervision needs. The IDT should use the person-centered planning tool to identify the member's supervision needs and then decide which pathway or pathways they will take to address the need.

Different people need different levels of supervision. Some may only need support during certain activities like meals, medications, or getting ready for the day and can otherwise be at home independently. Others may require continuous supervision and support due to safety concerns or behavior around others. These situations cannot be addressed by assigning a set number of minutes or hours.

Fixed time limits are problematic because they focus on an arbitrary number instead of the member's actual supervision needs. A set amount of "alone time" doesn't mean the member's supervision needs are even being met and it can result in plans that don't fully address the person's abilities, needs, risks, or goals. It also creates confusion: in some cases, staff who left a member alone for more than the allotted time, even by just a few minutes, have been reported for dependent adult abuse. Time limits encourage teams to manage minutes, not needs, and often lead to overly restrictive practices driven by liability concerns rather than the person's right to safe independence.

"Is this a rights restriction?"

Asking this question usually shows that the team is not using the person-centered planning tool correctly. Instead of starting with the member's needs, wants, and desired outcomes, the team is starting with something they think should be restricted and then trying to justify it afterward.

The correct approach is to begin at the top of the person-centered planning tool: identify the need, want, or desired outcome, then choose the appropriate pathway to address it. If meeting that need truly requires a limitation, modification, or restriction of rights, the team will discover that naturally by working through the tool and following all required steps.

If you want to know whether something is a rights restriction, you determine that by starting at the top and working your way through—not by starting with the restriction and working backwards.

Legal Decision Makers: Guardianships, Payees, Conservatorship, POAs, etc.

CMS requires that individuals receiving HCBS retain the right to control their personal resources—such as cash, savings, checking accounts, and SNAP benefits—unless there is an assessed need that limits or modifies that right. CMS also requires that each member's individual initiative, autonomy, and independence in making life choices be protected. This includes choices related to daily activities, physical environment, and social interactions, as well as decisions about services, supports, and providers.

If a member has an assessed need for assistance with decision making and/or money management, the team must determine how that need will be addressed.

In most situations, though not all, having a legal decision maker or someone managing the member's money means the team will need to follow the Limitations/Modifications/Restrictions Pathway. This is because legal decision makers typically indicate that the member's right to manage personal resources or make certain decisions is already being limited. However, there are situations where having a legal decision maker or money manager does not automatically mean a limitation is in place.

For example, some Power of Attorney (POA) arrangements do not take effect until a specific triggering event occurs. Until that event happens, the POA is not making decisions and the member's rights are not limited. Similarly, a member might receive help budgeting, paying bills, or tracking their money, while still retaining full decision-making authority over how funds are spent.

Additionally, some legal decision makers or money managers may only assist with specific decisions or particular income sources. For example, a representative payee may manage Social Security income but not earnings from employment or other funds, and some legal decision makers may help with certain decisions but not all aspects of a member's life. In these situations, the member's need for support may be addressed through the Goals/Skill Building, Practical Adjustments, or Acceptable Risk Pathways, while any limits on the member's decision-making capacity or money management are addressed through the Limitations/Modifications/Restrictions Pathway.

It is important to remember that guardians have a responsibility to help the protected person develop self-reliance and should involve the protected person in decision making as much as possible. Often, a guardian's role is to support the protected person in making their own decisions by helping gather information, discussing options, and guiding them through the decision-making process.

When the protected person is unable to participate, or when they choose something that is impossible or would cause substantial harm, the guardian may need to make the decision. They should make the decision the protected person would make if they were able.

If the team determines that a limitation, modification, or restriction is needed, all required steps in that pathway must be completed:

- The restriction must be clearly tied to an assessed need.
- The team must identify the least restrictive option that is proportional to the need.
- The plan must include steps to reduce or eliminate the restriction over time.
- A timeline or specific review point must be established to determine ongoing necessity.

In Iowa, all restrictions require quarterly review by involved providers and the member's case manager. During each review, look for opportunities to reduce or remove the restriction. Continuing a restriction simply because "they have always had a guardian" is not sufficient—each restriction must be justified, monitored, and re-evaluated.

HCBS in Licensed Settings

Licensed facilities such as Residential Care Facilities (RCFs) often have their own regulatory requirements related to secure storage of chemicals, medication handling standards, or restrictions around commercial kitchens. These requirements can sometimes appear to conflict with HCBS setting requirements, which focus heavily on autonomy, access, rights, and independence.

If the member has an assessed need for the level of care provided in a licensed environment**,** such as an RCF, then some restrictions may be necessary due to the nature of the setting. In those situations, the team must follow the Limitations/Modifications/Restrictions Pathway and take every step on that pathway.

At the same time, the provider should look for practical adjustments that allow the member to exercise as much independence and autonomy as possible within regulatory limits. Examples include but are not limited to:

- Providing access to laundry soap through individualized storage so the member can do their own laundry even if bulk chemicals must be locked.

- Allowing food access at any time by using mini-fridges, personal food storage areas, or a secondary non-commercial kitchen that residents can use freely.
- Supporting medication independence, such as providing an individualized locked storage area in the member's unit.
- Ensuring personal resources remain under the member's control unless there is an assessed need requiring a restriction.

These practical adjustments and limitations, modifications, or restrictions can be paired with the Goals/Skill-Building pathway when the member is actively working toward greater autonomy in these areas. The provider can be working with the member on skill building goals to increase the member's independence with daily activities like laundry, meal preparation, or medication management.

Staff Having Keys

In provider-owned or controlled HCBS residential settings, federal rules require that each person has privacy in their sleeping and living unit, including doors the individual can lock, with only appropriate staff having keys, and the setting must be physically accessible to the individual. Staff should not automatically have unrestricted key access to a member's home or bedroom. Any limitation of this right must follow the Limitations/Modifications/Restrictions Pathway and be tied to an assessed need.

Providers should first explore accommodations that strengthen the member's autonomy and accessibility—such as keyless entry systems, bio-locks, or other individualized solutions—so the member can reliably access and secure their home. These accommodations not only support independence but also make the home more physically accessible to the member by allowing them to enter and secure their living space in a way that works for them.

Because the home is the member's home, staff should ideally knock and be let in rather than entering at will, and the same expectations apply to bedrooms. Many standard leases specify that landlords maintain a master key and outline the limited circumstances under which they may enter, along with required notification timelines. This is an appropriate way to ensure that master keys or door codes are maintained.

It is equally important that members have a way to regain control of keys or access codes when staff no longer work with them or no longer require entry. This is another reason why limiting staff access to keys or codes is essential for protecting member privacy and safety.

In situations where a member rents from a community landlord but the provider operates the HCBS setting, the provider—not the landlord—is responsible for ensuring HCBS requirements are met. This may include helping the member work with the

landlord, consistent with the lease, to make the home accessible and to ensure the member's privacy rights are fully protected.

Restriction Minors (Bedtime, Screen Limits, etc.)

CMS does not provide special guidance for minors or identify what might be called "ordinary parental controls." The person-centered planning approach outlined in this training can be used for adults and minors to identify the need, want, or desired outcome, and determine which pathway addresses it — Goals/Skill Building, Practical Adjustments, Acceptable Risk, or Limitation/Modification/Restriction.

To decide whether a need, want, or desire warrants a rights restriction for a minor, the IDT should consider if this is something a child of this age normally has the right or ability to choose for themselves. Children typically do not have unlimited rights to:

- Stay up as late as they want
- Skip school
- Be home alone without supervision
- Roam the community independently
- Use media without limits
- Choose who they interact without limits

If a youth ordinarily would not have that right at their developmental stage, then setting a limit might not be considered a rights restriction but more like a normal part of caregiving. In those cases, the team can still use the person-centered planning tool to address the needs through other pathways like Goals/Skill-building (including supervision and supports), Practical Adjustments, etc.

However, when a limit does restrict a right that minors do have, such as privacy, access to food, communication, visitors, or autonomy appropriate for their age, then it is a restriction and must meet all required steps.

Locked Areas of the Member's Home (Including Housemates' Rooms)

Sometimes an IDT may consider whether certain areas of a member's home should be locked to securely store personal information or provider materials and may mistakenly treat this as a restriction of the member's rights. Federal HCBS rules do require that provider-owned or controlled HCBS residential settings be physically accessible to the individual, but questions about locked or inaccessible areas within a home are more appropriately addressed through the lease agreement, because they relate to what part of the dwelling the member is actually renting.

If the provider needs space within the home for things such as securely storing staff belongings while they work, member files, or providing a private space for staff to

complete documentation, those areas must be clearly outlined in the lease and excluded from the member's rent. This approach mirrors standard clauses in typical community leases, and federal rules require HCBS residential units to be rented under legally enforceable agreements that provide the same protections as standard landlord-tenant law. In short, leases that specify certain non-accessible areas are common in the general community and are the correct mechanism for identifying space the member is not renting, rather than treating such areas as rights restrictions.

Importantly, it is not a "right" for a member to enter housemates' bedrooms, and preventing entry into another person's private space is not a rights restriction requiring the Limitations/Modifications/Restrictions pathway. This is simply part of teaching and supporting good housemate behavior and respect for others' privacy, just as it would be in any typical shared living arrangement.

Cell Phone or Technology Restrictions

Restrictions on cell phone or other technology use are considered limitations of a member's rights and must follow the full Limitations/Modifications/Restrictions Pathway, beginning with a clearly documented assessed need. The IDT should use the person-centered planning tool to understand what need, want, or desired outcome is driving conversations about limiting phone or technology access—whether concerns relate to safety, spending, privacy, exploitation, or skill development.

Before any restriction is considered, the team must explore supports, practical adjustments, teaching opportunities, and risk-management strategies that could address the concern without limiting the member's rights. Only if those supports are attempted and found insufficient may the team consider the least restrictive option, which must be proportional to the assessed need, time-limited, consented to, and paired with data collection and a plan to reduce or eliminate the restriction.

By grounding the discussion in person-centered discovery, the IDT can ensure technology-related concerns are addressed in ways that honor the member's autonomy, build skills when appropriate, and restrict rights only when absolutely necessary and fully justified.

Punishment/Reward Scenarios

Sometimes teams unintentionally create punishment-and-reward systems within behavioral intervention plans or informal support strategies. For example, members may be required to "earn" money, food, preferred activities, or time in the community by controlling certain behaviors or completing tasks first.

State rules prohibit using restrictive interventions as punishment, for staff convenience, or as a substitute for non-aversive supports, and withholding something the member

has a right to—money, possessions, community access, or preferred activities—because they did not do something is a form of punishment. The inverse is also true: giving access only if the member complies turns the system into a reward that becomes punitive when withheld.

That does not mean it is inappropriate to support a member in pausing to cool down before engaging with others or going into the community when they are emotionally or physically escalated, nor is it inappropriate for a member to work toward healthier routines or habits by choosing to do certain things before others. In those cases, supports should be framed within the Goals/Skill-Building pathway, where staff can encourage the member by reminding them of their own goals—not by withholding access if the member does not complete the desired task on a given day.

Dietary Orders

Members, like anyone else, may be instructed by a medical professional to limit certain foods or follow a specific diet. Even in these situations, the IDT should use the person-centered planning tool to understand the need, want, or desired outcome behind the dietary order and determine the most appropriate pathway for addressing it. The team may use any of the pathways—Goals/Skill-Building, Practical Adjustments, Acceptable Risk, or Limitations/Modifications/Restrictions—depending on how much choice the member will retain.

If the member will be required to follow the dietary order, the team must use the Limitations/Modifications/Restrictions Pathway, including all required steps. If the member will maintain some choice, the IDT may choose other pathways. For example, the member might participate in health-coaching or cooking classes, learn to identify foods that meet their dietary needs, or have snacks and meals available that align with the order.

The member may also choose to accept some risk and eat foods outside the recommendation, in which case the Acceptable Risk Pathway should be used to ensure consent and shared understanding. Dietary needs can also be addressed in a blended approach—such as following the dietary order while at home but choosing freely when out in the community or at day habilitation.

A member can simultaneously participate in skill-building, benefit from practical adjustments, accept certain risks, and have limited restrictions where necessary; the important thing is that every selected pathway is fully completed and aligns with the member's assessed needs, choices, and desired outcomes.

Court Committals

Members may be committed by a court to specific services, providers, or residential settings when the court determines that the individual's health, safety, or welfare cannot be met independently and a structured environment is necessary. Even in these situations, the IDT should continue to use the person-centered planning tool to understand the underlying needs, wants, or desired outcomes that led to the committal—such as decision-making needs, behavioral health concerns, or care needs—and to determine how best to support the member.

A court committal does limit certain rights, including the member's ability to select their setting from among typical community options and their ability to choose services, supports, and providers. While courts may consider the person's preferences and resources, choosing a different setting generally requires additional legal action, which is itself a limitation.

Because the member is legally required to receive services in a specific setting or structure, the IDT must use the Limitations/Modifications/Restrictions Pathway and complete every step, even if the member is simultaneously working on stabilizing the condition that led to the committal or building skills to eventually remove the restriction.

This ensures that the member's rights are honored to the greatest extent possible while supporting safety, compliance with the court order, and progress toward the member's long-term goals.

Not A Right

Some limitations arise from laws, contracts, lease agreements, or other governing rules, and in those situations the issue is not a restriction of the member's rights because the member does not have the right in question to begin with.

For example, using illegal substances, violating lease conditions such as visitor limits, keeping pets where prohibited, smoking in a non-smoking unit, or engaging in any activity that breaks the law are all actions that a member is not legally entitled to do.

Because there is no right to engage in these activities, preventing or limiting them is **not** a rights restriction and does not require rights restriction due process.

For a limitation to qualify as a restriction, an actual right or freedom must be restricted; when no such right exists, the Limitations/Modifications/Restrictions Pathway does not apply.