



# **Community HealthChoices Service Coordinators Role in Home and Community-Based Services**

**Long-Term Services and Supports Subcommittee Meeting**

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Presented by:

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## Community HealthChoices Service Coordinator's Role in Home and Community-Based Services

- Service Coordination includes the primary functions of providing information to Participants and facilitating access to, locating, coordinating, and monitoring needed services and supports for Participants.
- Through a comprehensive needs assessment, Service Coordinators lead the person-centered service planning process to identify, coordinate, and assist Participants in gaining access to needed Long-Term Services and Supports (LTSS) and other Covered Services, as well as noncovered medical, social, housing, educational, employment, and other services and supports.
- Service coordinators must meet with LTSS Participant's at least once every three (3) months by phone or in person to ensure that a Participant's LTSS are meeting their needs. At least two (2) of these visits must be in person every year.

Please walk us through a typical initial assessment with a participant and their support team.

## Service Coordinator's Assessment of Participant's Goals and Supports

How do you assess participant's goals, community engagement, and the supports needed to achieve them?



When someone is identified to need Personal Assistance Services (PAS), how do you determine the recommended PAS hours, what tools do you use and how do you explain and consider all the other services available?

When intermittent needs are identified, like incontinence and supervision for safety, how do you work with the participant to address them?

## Service Coordinator's Assessment Finalization and Approval

What happens after the initial assessment and before plans are finalized? How do you engage with utilization management or handle situations where the total hours recommended are questioned?

## Anticipating Participant's Special Needs

If a participant identified an anticipated temporary change in condition – such as an upcoming surgery with significant supports while they recover, or a primary caregiver/informal support not being available due to a business trip/vacation requiring significant changes to supervision - how do you plan for these events and address them in a person-centered service plan?

## Service Coordinators Caseload Management Process

How do you manage your caseload and time?  
How much time does it usually take to finish up tasks needed from the initial assessment, such as documentation, referrals, gathering additional information etc.?

# ▶ Additional Questions

