INDIVIDUAL SUPPORT PLANNING

Information gathered in this document includes an assessment of health and safety issues, individual preferences, priorities and needs that promotes a person-centered planning process in developing outcomes and positive approaches in supporting the individual.

Individual's Name:	Click here to enter text.
Supports Coordinator's Name:	Click here to enter text.
Date:	Click here to enter a date.

Office of Developmental Programs

Use the links below to quickly access an area of the ISP

Instructions

To enter text into the form, click within the **Enter Text** fields and begin typing. Or, use [Tab] on the keyboard to advance between fields. Click within the check boxes to make selections, and enter dates when required, using the pick a date selector.

To **Create Additional Rows** to an existing table or embedded table:

1. Click immediately to the right of a row that you wish to add an additional row.
2. Press Enter or Return. Additional rows will appear below the row.
3. Continue adding rows until there are enough rows for the information.

***Annual Review Update Date** Select Date

***Annual Review Meeting Date** Select Date

***Category of Plan Changes** - The ISP shall be revised if there has been no progress on an outcome, if an outcome is no longer appropriate, or if an outcome needs to be added. If the plan changes are a result of changes in the individual's circumstances, determine if a revised Prioritization of Urgency for Needs (PUNS) is necessary.

Select the appropriate checkbox:

ISP Status	
Fiscal Year Renewal – *Used to renew the ISP for the following FY. The ISP will reflect a FY begin date of July 1 and a FY end date of June 30.*	☐
Critical Revision - *Used when individual supports, services, or funding changes in the existing or future plan.*	☐
Bi-annual Review - *Used for ISP's requiring reviews 2 x a year such as for Pennhurst Class members. Can be used to edit or update an existing plan. This option will not allow the Supports Coordinator role to modify the plan start and end dates.*	☐
Plan Creation - *Used when plan is being created for the first time.*	☐
Quarterly Review - *Used for ISP's that must be reviewed at least every 3 months originating from the date of the Annual Review.*	☐
General Update – *Used to update information such as medical information. This should not be used when modifying services and supports*	☐
Annual Review Update- *Used to update information from the annual review ISP meeting.*	☐
The individual/family requested a limited service and an abbreviated plan ☐ YES ☐ NO *An abbreviated plan can be used for an individual who is not enrolled in a waiver and receives limited services and supports under $2000.*	
Reason for the abbreviated plan: Enter text	

Plan: Individual Preferences: *The Individual Preferences section provides an opportunity for the ISP team to learn and know more about the specific wants, desires, and ways to best support the person. It should identify what has been learned about the person's personality, desires, and priorities. The Individual Preferences section is based on Person Centered Planning and is an excellent resource in guiding and supporting the rest of the planning process, including development of outcomes and the identification of meaningful services and supports that are necessary to meet the person's needs.*

Plan: Individual Preferences: Like And Admire

What do others like and admire about the individual?

List attributes regarding what others like and find admirable about the individual (positive traits, characteristics, ways of interacting, accomplishments, and strengths). This information sets the tone for the plan and should be gathered from multiple viewpoints. It is intended to highlight an individual's admirable qualities and should only present his or her "positive" reputation.

Enter text

Plan: Individual Preferences: Know and Do

What does consumer/family think someone needs to know to provide support?

Provides information that people need to know and do so the individual gets what is important to him/her or for him/her to stay safe and healthy. Consider everything that is important to the individual to determine if there is something caregivers need to know and do. Ask the individual and close friends. Discover what traits, habits, coping strategies, preferences for interaction and communication, relationships, types of activities, approaches, or reminders have been helpful to the individual. Include supports needed for daily living skills. Also include items that the individual might enjoy (employment opportunities, establishing community connections, full participation in community life, voting, learning new skills or hobbies, connecting with other people, helping others (such as community volunteers), relationships, dating, etc.) If more detailed information is elsewhere in the plan such as in Health Promotion or Communication, include a statement that refers to that area of the plan.

Enter text

Plan: Individual Preferences: Desired Activities

What are the activities that the individual would like to participate in or explore?

Record activities that the individual would like to continue, begin, or explore further. This information can help the Support Team (Circle) create outcomes with the individual that can assist in exploring activities important to him or her, (employment opportunities, establishing community connections, full participation in community life, voting, learning new skills or hobbies, enjoyable activities, connecting with others, helping others (such as community volunteers), relationships, dating, etc.

enter text.

Plan: Individual Preferences: Important To Individual

*List and prioritizes things that are important to the individual. It describes things that need to stay the same in the individual's life, and/or items that would be important for the team to address. Include only things that are important **TO** the individual. Capture what is important **FOR** the individual in other areas of the plan, such as in Health and Safety.*

This information should reflect who and what is important to the individual in relationship with others and their interactions, in things to do or have, in rhythm or pace of life, or in positive rituals or routines. Give consideration to: caring relationships, current job situations, employment opportunities, living arrangements, recreational community connections, spiritual needs and faith preferences. These could include volunteering in the community and getting to know neighbors, etc. Things that are important to an individual should be linked to outcomes.

Two levels of priorities are tracked:

- **Essential:** Those things which must/must not be present in the individual's life in order for a good day to occur.
- **Strongly desired:** Those things listed which would strongly contribute to the individual's happiness, but, would not be detrimental to their well-being if not present.

Priority/Description of Essential or Strongly Desired items	Essential	Desired
1enter text.	☐	☐
2 enter text.	☐	☐

3 enter text.	☐	☐

Priority/Description of Essential or Strongly Desired items	Essential	Desired
4 enter text.	☐	☐
5 enter text.	☐	☐
6 enter text.	☐	☐

Plan: Individual Preference: What Makes Sense?

What experiences do and do not make sense in the life of the individual RIGHT NOW? For example, ask "What currently makes the individual's life experiences more meaningful or easier?" When referring to "what makes sense", an alternative expression may be, what is the "upside" right now in the individual's current life experience that needs to be maintained? "What doesn't make sense" may express things that currently occur but do not work and need to be changed.

"What makes sense" and "What does not make sense" are not necessarily opposites of each other. *For example, an individual may indicate what works in a day is having a nap and it doesn't work when the individual does not get a nap. However, it may make sense that the individual has a glass of milk every morning, but it is not necessarily true that it doesn't make sense when the individual does not have a glass of milk in the morning.*

This section is the aspect of the planning that bridges the gap between the assessments of what is important to and for the individual and the specific actions that will be taken to assure those things occur in balance. This information helps to set the agenda for what should be changed and what needs to continue. It is based on the perspectives of multiple people who care about the individual. This section is the groundwork for negotiating around areas of disagreement. It is NOT a wish list, nor is it a collection of things that are currently not happening, but what team members think might be helpful or enjoyable to the individual. It is designed to be a "picture of current reality from multiple perspectives."

Set 1

***Whose Perspective/View?** *Individual, family, or team members).*	enter text.
What Makes Sense? *What works? What needs to be maintained/enhanced? What makes sense right now in the individual's current life experiences?*	enter text.
What Does Not Make Sense *What doesn't work? What needs to change? What must be different? (what does not make sense in the individual's current life experiences).*	enter text.

Set 2

***Whose Perspective/View?** *individual, family, or team members)*	enter text.
What Makes Sense? *What works? What needs to be maintained/enhanced? What makes sense right now in the individual's current life experiences?*	enter text.
What Does Not Make Sense *What doesn't work? What needs to change? What must be different? (What does not make sense in the individual's current life experiences?)*	enter text.

Plan: Medical: Medications/Supplements (and treatments) *The reason for the use of medication should be reflected in diagnosis or special instructions.*
***Specific Diagnosis or purpose of medication (not the symptom) i.e. arthritis, not "pain", GE reflux, not stomach acid**
enter text.
***Medication/Supplement Name/Dosages –scripts, dosage, OTC and herbal, food supplements**
enter text.
***Medication/Supplement Name/Dosages –scripts, dosage, OTC and herbal, food supplements**
enter text.

Frequency (Choose correct item)*

☐ QD-1x a day	☐ QID-4x a day	☐ PRN-as needed
☐ BID-2x a day	☐ HS-bedtime	☐ Other (use special instructions)
☐ TID-3x a day		

***Route of Medication**

☐ By Mouth – swallowed through the mouth	☐ Intramuscular – given into a muscle
☐ Intravenous – IV, into a vein via a port or catheter	☐ Skin Patch – applied to skin with an adhesive patch
☐ G Tube – given via a tube that goes into the stomach	☐ Drops – medication given through the ear or eye
☐ Topical – applied to the skin	☐ Vaginally – put into the vagina
☐ Rectally – put into the rectum	☐ Nasal – sprays or drops given through the nose
☐ Sublingual – given under the tongue	☐ Other Means
☐ NG Tube – An NG Tube is a nasogastric tube that goes through the nose to the stomach.	
☐ J Tube – given into a tube that goes through the stomach into the small intestine (jejunum)	
☐ Subcutaneously – given with a needle under the skin, example insulin for diabetes	
☐ Inhalant - Inhalant includes all types of inhaled medications including inhalers, spin inhalers, nebulizers, etc.	

***Blood Work Required?** ☐ YES ☐ NO

Blood or other lab work as ordered by a prescribing physician. If you answer yes, record blood/lab work results in Special Instructions/Precautions below. Include the month, year and level of the drug.

If Yes, how frequently? Choose an item.

How often physician wants blood level checked.

***Does the individual self-medicate?** ☐ YES ☐ NO

For self-administration of meds an individual must recognize and distinguish their meds from other meds, and know how much to take (by communicating or picking up the correct amount). He or she must know when to take med (after meal, before bed, etc.). Staff assistance to open the container and remove the medication is permitted.

Name of Prescribing Doctor

Last Name of Doctor enter text. First Name of Doctor enter text.

***Special Instructions/Precautions**

Situations in which not to use the medication, precautions when taking the medication, when to call the physician, parameters for use (example: heart rate over 70) and drug levels, including month and year. enter text.

Plan: Medical: Medications/Supplements (and treatments)

The reason for the use of medication should be reflected in diagnosis or special instructions.

***Specific Diagnosis or purpose of medication (not the symptom) ie, arthritis, not "pain", GE reflux, not stomach acid**

enter text.

***Medication/Supplement Name/Dosages –scripts, dosage, OTC and herbal, food supplements**

enter text.

***Medication/Supplement Name/Dosages –scripts, dosage, OTC and herbal, food supplements**

enter text.

***Frequency** Choose an item.

☐ QD-1x a day	☐ QID-4x a day	☐ PRN-as needed
☐ BID-2x a day	☐ HS-bedtime	☐ Other (use special instructions)
☐ TID-3x a day		

***Route of Medication** Choose an item.

☐ By Mouth – swallowed through the mouth	☐ Intramuscular – given into a muscle
☐ Intravenous – IV, into a vein via a port or catheter	☐ Skin Patch – applied to skin with an adhesive patch
☐ G Tube – given via a tube that goes into the stomach	☐ Drops – medication given through the ear or eye
☐ Topical – applied to the skin	☐ Vaginally – put into the vagina
☐ Rectally – put into the rectum	☐ Nasal – sprays or drops given through the nose
☐ Sublingual – given under the tongue	☐ Other Means
☐ NG Tube – An NG Tube is a nasogastric tube that goes through the nose to the stomach.	
☐ J Tube – given into a tube that goes through the stomach into the small intestine (jejunum)	
☐ Subcutaneously – given with a needle under the skin, example insulin for diabetes	
☐ Inhalant - Inhalant includes all types of inhaled medications including inhalers, spin inhalers, nebulizers, etc.	

***Blood Work Required?** ☐ YES ☐ NO

Blood or other lab work as ordered by a prescribing physician. If you answer yes, record blood/lab work results in Special Instructions/Precautions below. Include the month, year and level of the drug.

If Yes, how frequently? Choose an item.

Document how often the physician wants the blood level checked.

***Does the individual self-medicate?** ☐ YES ☐ NO

For self-administration of meds an individual must recognize and distinguish their meds from other meds, know how much to take (by communicating or picking up the correct amount). Must know when med is to be taken (after meal, before bed, etc.). Staff assistance to open the container and remove the medication is permitted.

Name of Prescribing Doctor

Last Name of Doctor enter text. First Name of Doctor enter text.

Plan: Medical: Allergies - Record all known:

- ***Allergies****- an allergy is a physical reaction to a substance that results in an itchy rash, hives or wheezing. Include allergies to food, insect bites or stings, seasonal, animal, latex, medications, etc.*
- ***Sensitivities and adverse reactions*** *– these are unusual reactions to a substance such as stomach bleeding with aspirin or nausea associated with particular medications such as Amoxicillin and other antibiotics*
- ***Medication contraindications*** *– these are medications that the individual cannot take due to a known diagnosis such as if the individual has peptic (stomach) ulcers, ibuprofen should not be taken. "For the Required Response," enter not applicable.*

Do not leave the spaces blank. Enter N/A when there are no known allergies, etc.

***Known Allergy**	enter text.
***Reaction**	enter text.
***Required Response**	enter text.
***Known Allergy**	enter text.
***Reaction**	enter text.
***Required Response**	enter text.
Sensitivities/ reactions	enter text.
Medication contraindications	enter text.

Plan: Medical: Health Evaluations *Include all known visits to any health care practitioner in the past 12 months. Examples include routine/scheduled or acute visits to practitioners such as primary care practitioners, cardiologists, dentists, etc. Medical contact information related to visits should be included in Medical Contacts.*

***Type Of Appraisal** (If Other, Specify)*"Physical" Use Only For The Annual Physical.*

☐ Physical	☐ Dental	☐ Vision	☐ Audiological
☐ Gyn	☐ Mammogram	☐ Prostate	☐ TB – Mantoux
☐ Hearing	☐ Psychiatric	☐ Other	

If Other –enter text.

***Specialist Type:**enter text.

***Medical Contact:** enter text.

***Was Diabetes Management Considered?** ☐YES ☐NO ☐N/A

Select "N/A" if the individual does not have diabetes or it is not an appropriate question for this appraisal.

If the person has been diagnosed with diabetes:

- *Select "Yes" if the person attended a diabetes education class; was taught how to manage their diabetes (glucose monitoring and control, diet, exercise, what to do during an illness, complications such as eye and foot problems; or if the person works with a clinician around managing their diabetes.*
- *Select "No" if the individual was diagnosed with diabetes, but diabetes management was not considered.*

If Yes, provide details: enter text.

Date of Appraisal: enter a date.

Appraisal Freq: ☐ Wkly, ☐ Mthly, ☐ Qrtrly, ☐ 6 Months, ☐ Yearly , ☐ Every 2 Years, ☐ As Needed

Person Responsible for Arranging/Completing Appraisal

☐Individual, ☐Family, ☐Provider, ☐Other – if other, specify: enter text.

***Type Of Appraisal** (If Other, Specify) *"Physical" Use Only For The Annual Physical.*

☐ Physical	☐ Dental	☐ Vision	☐ Audiological
☐ Gyn	☐ Mammogram	☐ Prostate	☐ TB – Mantoux
☐ Hearing	☐ Psychiatric	☐ Other	

If Other –enter text.

***Specialist Type:** enter text.

***Medical Contact:** enter text.

***Was Diabetes Management Considered?** ☐YES ☐NO ☐N/A

See notes in previous Diabetes Management question.

If Yes, provide details: enter text. **Date of Appraisal** enter a date

Appraisal Frequency: ☐ Weekly, ☐ Monthly, ☐ Quarterly, ☐ Every 6 Months, ☐ Yearly , ☐ Every 2 Years,☐ As Needed

Person Responsible for Arranging/Completing Appraisal

☐Individual, ☐Family, ☐Provider, ☐Other – if other, specify: enter text.

Plan: Medical: Medical Contacts

Include below contact information for any current medical contacts such as doctors, dentists, psychiatrists, allied health professionals, specialists, etc. seen in the past 12 months.

***First Name**	enter text.
***Last Name**	enter text.

Middle Initial	enter text.
Clinic/Practice name	enter text.
Specialist Type	enter text.
Address	enter text.
City, State Zip	enter text.
***Phone Number** (123)456-7890	enter text.
Fax Number (123)456-7890	enter text.
***First Name**	enter text.
***Last Name**	enter text.
Middle Initial	enter text.
Clinic	enter text.
Specialist Type	enter text.
Address	enter text.
City, State Zip	enter text.
***Phone Number (123)456-7890**	enter text.
Fax Number (123)456-7890	enter text.

Plan: Medical: Medical Contacts

Include below contact information for any current medical contacts such as doctors, dentists, psychiatrists, allied health professionals, specialists, etc. seen in the past 12 months.

***First Name**	enter text.
***Last Name**	enter text.
Middle Initial	enter text.
Clinic / Practice name	enter text.
Specialist Type	enter text.
Address	enter text.

City, State ZIP	enter text.
***Phone Number** (123)456-7890	enter text.
Fax Number (123)456-7890	enter text.
***First Name**	enter text.
***Last Name**	enter text.
Middle Initial	enter text.
Clinic	enter text.
Specialist Type	enter text.
Address	enter text.
City, State ZIP	enter text.
***Phone Number** (123)456-7890	enter text.
Fax Number (123)456-7890	enter text.

Plan: Medical: Medical History
Current Health Status: *List below the date and reason for hospitalizations, surgeries, emergency room visits, and new adaptive equipment. Include any new diagnoses and related recommendations. List results of health evaluations, screenings, testing and blood work other than drug levels. Examples include: TB-Mantoux – normal or abnormal, hearing – normal or abnormal. If abnormal, include related recommendations. Briefly describe how the individual's health compares to previous years.*

Type of event: ☐Hospitalization ☐Surgery ☐Emer Room ☐New Adaptive Equip enter a date.

New Diagnosis: enter text.

New Recommendation: enter text.

Type of event: ☐Hospitalization ☐Surgery ☐Emer Room ☐New Adaptive Equip enter a date.

New Diagnosis: enter text.

New Recommendation: enter text.

Type of event: ☐Hospitalization ☐Surgery ☐Emer Room ☐New Adaptive Equip enter a date.

New Diagnosis: enter text.

New Recommendation: enter text.

Health evaluation 1 / Result:enter text.

Health evaluation 2 / Result:enter text.

Health evaluation 3 / Result: enter text.

Developmental Information *Record the following below:*

- *Mother's pregnancy and the individual's birth history.*
- *Developmental milestones such as when the individual walked, talked, sat up, fed him or herself, and learned daily living skills such as dressing and feeding skills.*
- *Cause or etiology of intellectual disability (ID) such as congenital or genetic syndrome, meningitis, traumatic brain injury, etc.*
- *Brief description of how the disability and/or the diagnosis of the disability occurred.*
- *Brief family social history that may have impacted the individual's development.*

Complete a lifetime medical history (in accordance with MR Bulletin 00-94-32) and update annually.

Indicate where the lifetime medical history is kept and how it can be accessed.

Mother's Pregnancy / Person's Birth History: enter text.

Developmental Milestones: enter text.

Cause of ID: enter text.

How Disability/Diagnosis Occurred: enter text.

Location of Medical History: enter text.

How to Access Medical History: enter text.

Psychosocial Information:

Include all behavioral, mental health or psychiatric diagnoses, current symptoms such as mood and sleep patterns and related interventions and recommendations including medication changes (indicate if increased, decreased or different medication) and responses.

List the date and reason for hospitalizations or emergency room visits related to behavioral health. Briefly describe how the individual's behavioral health compares to previous years.

Note: For people that have either a diagnosis of a mental illness or receive psychotropic medication for treating a mental illness or problematic behavior and continue to have active symptoms or challenging behavior, complete a psychiatric questionnaire as requested in the *OMHSAS & OMR Bulletin 00-02-16 Coordination of Treatment and Support for People with a Diagnosis of Serious Mental Illness Who also Have a Diagnosis of Mental Retardation*. Information from the questionnaire should be summarized here. If a psychotropic medication is prescribed, provide a summary of the behavioral support plan in the Behavioral Support Plan area of the ISP.

Behavioral /Mental Health or Psychiatric Diagnoses: enter text.

Current Symptoms/Mood/Sleep Patterns: enter text.

Related Interventions and Recommendations: enter text.

Medication Changes (increased, decreased or different medication) and responses: enter text.

Describe how the individual's behavioral health compares to previous year(s): enter text.

Psychiatric Questionnaire Summary: enter text.

Physical Assessment

Chronic diagnoses or conditions not requiring medication (and not listed under Medications / Supplements). Provide a description on all relevant body system areas and describe how to support the individual. Example: wears glasses, needs assistance putting on glasses.

System Area	***Description***
Vision: eyes	enter text.
Integumentary: skin	enter text.
Respiratory: lungs	enter text.
Endocrine: glands, hormones	enter text.
Lymphatic	enter text.
Cardiovascular: heart, blood vessels	enter text.
Dental	enter text.
Nervous System: nerves, brain function	enter text.
Hearing: ears	enter text.
Musculoskeletal: muscles, bones	enter text.
Digestive: stomach	enter text.
Genitourinary: genitals, urinary function	enter text.
Blood System	enter text.

Immunization/Booster *Record all immunizations or boosters currently known that the individual has received, and update with new dates as the individual receives immunizations.*		
	***Immunization/Booster** (Mark all that apply)	***Date Administered** (mm/dd/yyyy)
☐	Hepatitis B – Shot #1	enter a date.
☐	Hepatitis B – Shot #2	enter a date.
☐	Hepatitis B – Shot #3	enter a date.
☐	Diphtheria	enter a date.
☐	Tetanus	enter a date.
☐	Pertussis *(whooping cough)*	enter a date.
☐	Hemophilus Influenzae type B *(H flu vaccine)*	enter a date.
☐	Inactivated Polio *(use for any polio)*	enter a date.
☐	Measles	enter a date.
☐	Mumps	enter a date.
☐	Rubella *(German measles)*	enter a date.
☐	Varicella (*Select if the individual has received the chicken pox or shingles vaccine.)*	enter a date.
☐	Tuberculosis *(refers to the BCG vaccine)*	enter a date.
☐	Pneumovax *(also known as strep or pneumonia vaccine)*	enter a date.
☐	Other, explain *(One reason to select is to indicate if the individual has had a seasonal flu vaccine.)*	enter a date.

Plan: Health And Safety: Focus area

When completing the Health and Safety area of the plan, include the source of the information such as the role of the person or if it was provided through an assessment. Indicate if no assessment exists for a particular area.

Record a summary of the assessment information and the skills and needs in each area. Identify the level of support or technology the person needs to manage any significant health and safety risks. Identify the level of support or technology the person needs to:

- *Maintain or enhance their current status*
- *Live a healthier lifestyle,*
- *Be more independent and/or*
- *Achieve the outcomes important to them and noted in this plan.*

Include any environmental changes that have occurred or are planned.

If there are any significant health and safety risk(s) in any of the focus areas, describe what type of assistance the person may need such as verbal assistance, partial physical assistance or total physical assistance.

Verbal assistance is defined as step by step instruction; walking a person through required steps; providing visual prompts/showing; modeling, teaching, role play, social stories.

Partial physical assistance is defined as the individual participates in some parts of the activity; some essential steps are required to be completed for the person. *Total physical assistance is defined as all essential steps need to be completed for the person.*	
General Health and Safety Risks *Include the team review of any incidents (include injuries and accidents) that may have occurred over the past year to look for trends or potential areas of concern. Include any other information pertaining to health and safety other than what is recorded in the other Health and Safety focus areas.* *Note the need for protection from heat sources, electrical outlets, knives, etc., if applicable.* *If there is any significant health and safety risk(s) in this area, describe what type of assistance the person may need (verbal assistance, partial physical assistance or total physical assistance).* *Record any significant health and safety risks that the person may have. Identify the level support the person needs or technology that should be used to:* • *Maintain or enhance their current status,* • *Live a healthier lifestyle,* • *Be more independent,* • *Achieve outcomes that are important to the person and noted in this plan.* *Include any environmental changes that have occurred or are planned.*	enter text.
Fire Safety *Record individual's ability to react during a fire or fire drill. Identify the level of support needed and any technology or equipment required for the person to safely evacuate his/her home or another location.* *If there is any significant health and safety risk(s) in this area, describe what type of assistance the person may need (verbal assistance, partial physical assistance or total physical assistance).* *If relevant, include information about fire safety training, including understanding of smoke detectors, evacuation plan at the home, where to meet, whether or not the individual has the skills to call 911 if necessary, etc. If the individual smokes, include his or her level of awareness of*	enter text.

smoking safety. If the individual needs assistance to evacuate, document notification of the local fire company.	
Traffic *Identify the level of support needed and any technology or equipment required for the person to travel in the community.* *Include any equipment needed/used. Specify need for picture ID, cell phone, GPS, ability to provide self-identifying in formation.* *Address any significant health and safety risk areas such as:* • *How and under what circumstances the individual can safely cross streets* • *Awareness of rural vs. urban streets, highways or side streets, parking lots* • *Interacting with community members* • *Shopping* • *Visiting friends or family* • *Enjoying preferred community activities* *If there is any significant health and safety risk(s) in this area, describe what type of assistance the person may need (verbal assistance, partial physical assistance or total physical assistance).*	enter text.
Cooking/Appliance Use *Record individual's ability to use cooking and kitchen appliances, such as a stove, toaster, regular or microwave oven. Indicate the individual's ability to prepare a basic meal, get hot and cold drinks, get a snack, peel fruit, chop, stir, pour beverages, scoop ice cream, etc. Indicate the individual's understanding of safe food storage.* *Identify the level of support needed and any technology or equipment required for the person when cooking or using appliances.* *If there is any significant health and safety risk(s) in this area, describe what type of assistance the person may need (verbal assistance, partial physical assistance or total physical assistance).*	enter text.

Outdoor Appliances *Record individual's ability to use outdoor appliances, such as a lawn mower, weed whacker, gas grill, etc.* *Record any significant health and safety risks that the person may have related to the use of outdoor appliances. Identify the level of support needed and any technology or equipment required for the person to use outdoor appliances.* *If there is any significant health and safety risk(s) in this area, describe what type of assistance the person may need (verbal assistance, partial physical assistance or total physical assistance)?*	enter text.
Water Safety (Including Temperature Regulation) *Record individual's ability to understand water safety and temperature safety.* *Can the individual:* • *temper bath water or water to wash his/her hands,* • *be alone in a shower/bath* *Record any significant health and safety risks that the person may have related to water safety and temperature control.* *Identify the level of support needed and any technology or equipment required for the person to ensure water safety and appropriate temperature control.* *If there is any significant health and safety risk(s) in this area, describe what type of assistance the person may need (verbal assistance, partial physical assistance or total physical assistance).* *If the individual has a seizure disorder, or other medical condition such as a peg tube, include precautions necessary for bathing or swimming.* *Include the level of support and assistance required for hot water usage and when around swimming pools, lakes or other bodies of water.*	enter text.

Safety Precautions *Record individual's ability to understand safety precautions including handling or storage of poisonous substances, danger signs, or warning labels. Will the individual ingest a poisonous substance or personal hygiene item if left unattended? Indicate if the person ingests nonfood items. Describe the type and level of assistance the individual needs when in such situations. For any identified risk, address the level of supervision needed for the individual's safety and record it in the Supervision Care Needs section.* *Record any significant risks that the person may have understanding safety precautions. Identify the level of support needed and any technology or equipment required for the person to ensure safe storage and handling of poisonous or dangerous substances, unattended items or to avoid possible ingestion of non- food items.* *If there is any significant health and safety risk(s) in this area, describe what type of assistance the person may need (verbal assistance, partial physical assistance or total physical assistance).*	enter text.
Knowledge of Self-Identifying Information *Record individual's ability to give self-identifying information, such as name, address, and phone number. If unable to do so, does the individual carry ID? Will he/she show ID to someone if lost? Will he/she ask for assistance if lost?* *Identify what support or technology the person needs to travel in the community, get help if needed, and ask for assistance if lost.* *If there is any significant health and safety risk(s) in this area, describe what type of assistance the person may need (verbal assistance, partial physical assistance or total physical assistance).*	enter text.
Stranger Awareness *Record individual's ability to interact with strangers. In which way is the individual vulnerable to victimization, such as opening doors to strangers? In public places, will the individual wander off with a stranger?* *Identify the level of support needed and any technology or equipment required for the person to make friends, meet people, develop relationships and participate in the community.*	enter text.

If there is any significant health and safety risk(s) in this area, describe what type of assistance the person may need (verbal assistance, partial physical assistance or total physical assistance).	
Sensory Concerns *Describe any sensory concerns and how to support the individual. Many individuals under or over respond to noise, touch, sights and other stimuli. For example, someone with a hearing loss may not hear an alarm clock so one option would be to equip it with a flashing light or vibration. Or, the individual may respond with anxiety to everyday sounds such as a plane flying in the sky.* *If there is any significant health and safety risk(s) in this area, describe what type of assistance the person may need (verbal assistance, partial physical assistance or total physical assistance).*	enter text.
Meals/Eating *Record information about the individual's ability to eat. Does the person exhibit signs or symptoms of a possible eating issue such as choking or gagging during meals, inadequate chewing or repeated attempts to swallow? If so, has screening been done, the HCQU been contacted and/or and assessment been conducted?* *This information should include specialized diets such as pureed, low salt, low fat, feeding protocols, etc. Is there a choking risk? List any required positioning necessary during/after meals. Should any food with particular consistencies be avoided such as peanut butter? Include information from dietary and nutritional appraisals, as well as information regarding adaptive equipment.* *If there is any significant health and safety risk(s) in this area, describe what type of assistance the person may need (verbal assistance, partial physical assistance or total physical assistance). Include the level of support and assistance needed during meals both at home and at a restaurant.* *Identify the level of support needed and any technology or equipment required when eating or during meals, both at home and at a restaurant.*	enter text.

If a specific support plan exists related to eating or meals indicate where the hard copy is kept and who should be trained in its application prior to working with the individual.	

Plan: Health And Safety: Supervision care needs

Supervision is the need to have a person present either within eyesight, the room, the building, within arm's length, or by a phone call or page system, etc. during the day, in their home, or in the community. Describe all three areas.

Day supervision *- normal day activities such as volunteering, working, attending a day program, etc.*

Home supervision *- activities at the individual's home, or the home of a family member. Residential staffing ratios are no longer required. For individuals who have 1:1, 2:1, SH, or an approved needs exception, complete section "Is Intensive supervision required".*

Community supervision *- activities that take place outside of the individual's home, but not including places where the individual typically or regularly spends his/her days (Monday-Friday). Community refers to places such as local shopping or recreational centers, the individual's neighborhood, places of worship or business, public transportation, walking to the neighborhood grocery etc.*

Describe the need for the service and its impact on the individual's health and welfare in the "Description" field for the following services; Supplemental Habilitation, Enhanced/Intensive Staffing (1:1 or higher staffing in a licensed home or day service), any day service except in-home services that are 14 hours or more per day requiring a variance.

***Supervision Care Need Type** (Indicate if Day, Home, or Community Supervision is required.) ☐ Day Supervision ☐Home Supervision ☐ Community Supervision	
Number of hours of supervision required *Describe if and how long the individual can be alone and any plans to increase time alone. If an individual can have two hours of alone time at home but requires supervision the remaining hours of the day, Home Supervision hours would be 22.*	enter text.
Describe below the days and times support will be provided, and supervision needs (such as…"individual needs one-on-one for bathroom use.") Describe any training needed beyond general staff orientation to support the individual, the need for the service, and its impact on the individual's health and welfare. enter text.	
***Is intensive supervision required:** *For individuals who have 1:1, 2:1, SH, or an approved needs exception, complete this section. If Yes, describe the reason for intensive supervision in the Reasons for Intensive Staffing area of the ISP.*	☐ YES ☐ NO
***Supervision Care Need Type** (Indicate if Day, Home, or Community Supervision is required.) ☐ Day Supervision ☐Home Supervision ☐ Community Supervision	
Number of hours of supervision required *Describe if and how long the individual can be alone and any plans to increase time alone. If an individual can have two hours of alone time at home but requires supervision the remaining hours of the day, Home Supervision hours would be 22.*	enter text.

Describe below the days and times support will be provided, and supervision needs (such as…"individual needs one-on-one for bathroom use.") Describe any training needed beyond general staff orientation to support the individual, the need for the service, and its impact on the individual's health and welfare.

enter text.

***Is intensive supervision required?** *For individuals who have 1:1, 2:1, SH, or an approved needs exception, complete this section. If Yes, describe the reason for intensive supervision in the Reasons for Intensive Staffing area of the ISP.*	☐ YES ☐ NO

***Supervision Care Need Type** (Indicate if Day, Home, or Community Supervision is required.)

☐ Day Supervision ☐Home Supervision ☐ Community Supervision

Number of hours of supervision required *Describe if and how long the individual can be alone and any plans to increase time alone. If an individual can have two hours of alone time at home but requires supervision the remaining hours of the day, Home Supervision hours would be 22.*	enter text.

Describe below the days and times support will be provided, and supervision needs (such as…"individual needs one-on-one for bathroom use.") Describe any training needed beyond general staff orientation to support the individual, the need for the service, and its impact on the individual's health and welfare. enter text.

***Is intensive supervision required?** *For individuals who have 1:1, 2:1, SH, or an approved needs exception, complete this section. If Yes, describe below reason for intensive supervision in the Reasons for Intensive Staffing area of the ISP.*	☐ YES ☐ NO

Plan: Health And Safety: Supervision Care Needs: Reasons for Intensive Staffing

☐ Requires help to administer medications	☐ Elopement risk
☐ Unable to evacuate independently	☐ Behavioral issue(s)
☐ Kitchen safety /assistance with meal preparation	☐ Roommate(s) require this staffing, this individual does
☐ Smoking safety	☐ Medical issue(s)
☐ Unable to recognize common household dangers	☐ Physical/Mobility issue(s)
☐ Other Dangers. enter text.	

Other Reasons for Intensive Staffing: enter text.

Plan for Reducing Intensive Staffing Supports:

Describe below specific role and purpose of the staff; when, where and how the enhanced support will occur (hours/days, location, etc.).

Include what other measures have been tried in addition to intensive staffing. Also include plan for eventual discontinuance or reduction of intensive staffing. Update annually to validate continued intensive staffing need. Include the date to maintain a staffing needs history. enter text.

☐	Requires help to administer medications	☐	Elopement risk
☐	Unable to evacuate independently	☐	Behavioral issue(s)
☐	Kitchen safety /assistance with meal preparation	☐	Roommate(s) require this staffing, this individual does
☐	Smoking safety	☐	Medical issue(s)
☐	Unable to recognize common household dangers	☐	Physical/Mobility issue(s)
☐	Other Dangers. enter text.		

Other Reasons for Intensive Staffing: enter text.

Plan for Reducing Intensive Staffing Supports:

Describe below specific role and purpose of the staff; when, where and how the enhanced support will occur (hours/days, location, etc.).

Include what other measures have been tried in addition to intensive staffing. Also include plan for eventual discontinuance or reduction of intensive staffing. Update annually to validate continued intensive staffing need. Include the date to maintain a staffing needs history.

enter text.

Plan: Health And Safety: Supervision Care Needs: Staffing

Ratio – Day

Record information here for all individuals that participate in a service during the day (i.e. community participation support). The staffing ratio should reflect the provider's scheduled staffing ratio and should match the level of service in Service Details . When an individual needs additional support, this should be noted in "Supervision Care Needs."

***Provider** enter text.

***Type** enter text.

***Day** (day of week) enter text.			
***Start Time** enter text.		***End Time**	enter text.
Comments enter text.			
***Provider** enter text.			
***Type** enter text.			
***Day** (day of week) enter text.			
***Start Time** enter text.		***End Time**	enter text.
Comments enter text.			

Plan: Health And Safety: Supervision Care Needs: Staffing Ratio – Home

Residential staffing ratios are no longer required.

***Day** (day of week) enter text.			
***Start Time** enter text.		***End Time**	enter text.
Comments enter text.			
***Day** (day of week) enter text.			
***Start Time** enter text.		***End Time**	enter text.
Comments enter text.			

Plan: Health And Safety: Supervision Care Needs: Staffing Ratio

Only answer the question "Is there Awake/Overnight staff in this individual's home?".

Is there Awake/Overnight (A/O) staff in this individual's home?	☐ YES ☐ NO
***Are the total number of full-time equivalent positions (FTEs), recommended in the staff ratio tables the same as the current approved staffing level?**	☐ YES ☐ NO
If not the same, is the difference more than the current approved staffing level?	☐ YES ☐ NO
If the difference is more than the current approved staffing level, give a specific explanation and justification for the need.	enter text.

Plan: Health And Safety: Behavioral Support Plan (BSP)

The BSP (Social, Emotional and Environmental Support Plan as per regulation) is a hard copy document that should be maintained in the individual's file. The BSP may also be included in other areas of the ISP. The BSP should include a plan for social, emotional and environmental support.

Complete this section if:

- *The individual has a mental health diagnosis for which psychotropic medication is prescribed –or-*
- *The individual receives behavior support services (either as part of their residential program or as a discrete service) –or-*
- *The individual has approval for the use of restrictive procedures*

***Is there a behavioral support plan in place?**	☐ YES ☐ NO

If yes, is it restrictive? ☐ YES ☐ NO

Restrictive is defined as limiting an individual's movement, activity, or function interfering with an individual's ability to acquire positive reinforcement, resulting in the loss of objects or valued activities, or requiring a particular behavior that the individual would not engage in if given freedom of choice.

Summary of behavioral support plan if a psychotropic medication is prescribed:

If a psychotropic medication is prescribed, document the psychiatric symptoms and plan to address the individual's social, emotional and environmental support.

Review the person's current behavioral health status and identify any significant health and safety risks that the person may have. Consider whether the person is at risk due to major mental health diagnoses/conditions. Some examples of diagnoses/conditions/situations which would indicate risk related to behavioral support include (but are not limited to):

- *Emergency room or Crisis Response Visits*
- *Psychiatric Hospitalizations*
- *Elopement*
- *Self-injurious behavior*
- *Aggression/violence towards others*
- *Suicide Attempts/Ideations*
- *Unhealthy/Unsafe Sexual Activity*
- *PICA/swallowing inedible objects*
- *Drug or Alcohol Abuse*
- *Law Enforcement involvement/arrest/probation/parole*
- *Fire Setting*
- *Property Destruction or Theft*

For each area of risk noted above, identify the level of support the person needs or technology that should be used to

- *Maintain or enhance their current status,*
- *Live a healthier lifestyle,*
- *Be more independent,*
- *Achieve outcomes that are important to the person as noted in this plan.*

Include any environmental changes that have occurred or are planned.

If there is any significant health and safety risk(s) in this area, describe what type of assistance the person may need (verbal assistance, partial physical assistance or total physical assistance).

If a restrictive plan exists, it should address regulations separately. Include a review of restraint data including patterns and trends, and interventions for minimizing the use of restraints.

Describe the plan to address the individual's social support.	enter text.
Describe the plan to address the individual's emotional support.	enter text.

Describe the plan to address the individual's environmental support	enter text.
Describe frequency and severity of psychiatric symptoms.	enter text.
Indicate who the behavioral support plan applies to.	enter text.
Indicate where the hardcopy is kept for access.	enter text.
Who should be trained in its application prior to working with the individual?	enter text.
Indicate documentation requirement.	enter text.
Who is responsible for collecting the information?	enter text.

Plan: Health And Safety: Crisis Support Plan

A crisis support plan is a reactive plan that is designed to protect the individual, other individuals, or valuable property. It is designed only for protection during a crisis and not as a means to limit future crises. It must address the individual's needs in and out of the provider's service area.

Record information here for those people who receive funding through the Adult Community Autism Program (ACAP). This is optional for those who do not have a formal crisis support plan, however it is mandatory for those that do have a formal crisis support plan.

***Is there a crisis support plan in place?**	☐ YES ☐ NO
Summary *Indicate who the crisis support plan applies to, where the hard copy is kept for access, who should be trained in its application prior to working with the individual, documentation requirements, and who is responsible for collecting the information.* ***Back-up Plan:** ***Indicate that the back-up plan(s) were shared and reviewed to ensure that the plan(s) meet ODP criteria, a copy of the plan(s) was given to the individual and where the original plan can be located (i.e.: individual file at Provider agency).***	enter text.

Plan: Health And Safety: Health Care	
***Name of Designated Health Support Person** *This is the person who is designated to help assist the coordination of the individual's health. This could be a family member, support coordinator, provider agency nurse, a specific staff person in the agency, etc. Include the role of the person who is designated. This may not be the health care decision maker (health care proxy).*	enter text.
***Address** enter text.	
***City, *State *ZIP** enter text.	
***Phone** (123) 456-7890 enter text.	
Pager Number enter text.	
Is the individual able to make health care decisions? *This means the individual is able to understand the options including the risks and benefits and make a decision.*	☐ YES ☐ NO

Is there an advance directive in place? *Advance directives are legal documents that convey decisions about end-of-life care ahead of time. They provide a way for individuals who can make medical decisions to communicate wishes about their care to family, etc. in the event that they develop an end stage condition. Advance directives also can be used to document a chosen decision maker (health care proxy) for individuals who cannot make their own medical decisions, but is able to choose someone to make decisions for and with them. Advance directives must be made by the individual themselves not by their family or guardian. Not all individuals will be able to complete an advance directive or choose a health care proxy.* *If "Yes", verify that the individual themselves completed the advance directive.*	☐ YES ☐ NO
If no advance directive is in place, describe below steps to assist the individual to complete an advance directive. *If the individual is not able to complete an advance directive or choose a health care proxy, indicate not applicable.* enter text.	
If the individual cannot make health decisions, has a substitute decision maker been identified?	☐ YES ☐ NO ☐ N/A
The substitute decision maker is identified as follows: (*Include health care proxy under "Other.")* ☐ **Facility director** ☐ **Family member** ☐ **Guardian** ☐ **Other:** enter text.	

Name, Contact information of decision maker enter text.

If no substitute decision maker exists, what steps will be taken to identify a substitute decision maker and by when? *Enter below the steps to be taken to identify a substitute decision maker, as well as when these steps need to be taken.* enter text.

Plan: Health And Safety: Health Promotion

Review the person's current health condition and medical status and identify any significant health and safety risks that the person may have. Consider whether the person is at risk due to major medical diagnoses/conditions. Some examples of diagnoses/conditions/situations which would indicate risk include (but are not limited to):

- *ER visits*
- *Hospitalizations*
- *Allergies/ Asthma/ Chronic Pulmonary Condition/Aspiration Pneumonia*
- *Bowel obstruction/ Chronic Constipation*
- *Diabetes*
- *Dementia/Progressive Neurological Disease*
- *GERD/Dysphagia*
- *Heart Condition*
- *Shunted Hydrocephalus*
- *Immune Deficiency or Autoimmune disorder*
- *Gross motor skills/ Frequent falls*
- *Seizure Disorder*
- *Obesity/rapid weight change (gain or loss)*
- *Pain management issues resulting from arthritis, degenerative joint disease, back pain, neuropathy or migraines*
- *Renal failure*
- *Pressure sore/skin breakdown*
- *Cancer*
- *Severe Mental Illness*
- *Recurring dental problems*

For each area of risk noted above, identify the level of support the person needs or technology that should be used to

- *Maintain or enhance their current status,*
- *Live a healthier lifestyle,*
- *Be more independent,*
- *Achieve outcomes that are important to the person as noted in this plan.*

Include any environmental changes that have occurred or are planned.

If there is any significant health and safety risk(s) in this area, describe what type of assistance the person may need (verbal assistance, partial physical assistance or total physical assistance).

Document any health conditions or issues for which there is currently a recommendation or any health practices that the individual currently engages in or would like to work on or engage in. These items may or may not lead to outcomes. Examples are weight reduction, toileting protocols, self-administration of medication, smoking cessation, increased exercise, recommendations from health professionals including those recommendations specific to particular diagnoses, refusals to accept routine exams or treatment (this includes either the individual or guardian's refusal), etc.

***Health Condition/Issue**	enter text.
***Promotion/Strategy Support Required** *Include information on what both the individual and staff need to know, do, and needed training.*	enter text.
***Frequency of Support**	enter text.
***Desired Outcome**	enter text.
***Person/Agency Responsible**	enter text.
***Health Condition/Issue**	enter text.
***Promotion/Strategy Support Required** *Include information on what both the individual and staff need to know, do, and needed training.*	enter text.
***Frequency of Support**	enter text.
***Desired Outcome**	enter text.
***Person/Agency Responsible**	enter text.
***Health Condition/Issue**	enter text.
***Promotion/Strategy Support Required** *Include information on what both the individual and staff need to know, do, and needed training.*	enter text.
***Frequency of Support**	enter text.
***Desired Outcome**	enter text.
***Person/Agency Responsible**	enter text.

Plan: Functional Information: Functional Level

Describe individual's abilities, where assistance is required, or any other types of needs. At times, one area of an individual's life can impact another. For example, communication skills or needs often can be observed in learning/cognition abilities, the ability to express emotions under social/emotional information, etc. If this occurs, record the details of support in the related functional area. (For example: for an individual who cannot express emotions verbally, the social/emotional area may have more detail of the support needed than the communication area.) In such situations, choose where the details fit best and refer to that in the related area. Include recommendations, where applicable, of what the individual may be interested in learning or expanding their abilities. Note progress or changes the individual has made in the past 12 months.

Physical Development *Describe current skills and needs.*

Include developmental statements from family and information regarding positioning and transfer needs if applicable.

gross and fine motor skills	enter text.
vision and hearing	enter text.
using assistive technology	enter text.
performing simple exercises	enter text.
mobility and stair travel	enter text.
ambulation and gait assessment	enter text.
developmental statements	enter text.
positioning and transfer needs	enter text.

Adaptive/Self Help *Self-help or hygienic information; ability to perform specific functions ; assistance/ adaptations needs.*

bathing/showering	enter text.
dressing	enter text.
drinking from a cup	enter text.
toileting	enter text.
being transported (seating, rails, supervision)	enter text.
self-administration of medications skills/needs	enter text.
is individual working toward self-administration? If no, explain why.	enter text.
strengths and needs for completing household chores	enter text.

Learning/Cognition *Describe skills and related needs and abilities of the individual. Add additional skill as needed.*

Skill	***Abilities***	***Needs***
learns and processes information	enter text.	enter text.
thinks	enter text.	enter text.
remembers	enter text.	enter text.
reasons	enter text.	enter text.
solves problem	enter text.	enter text.
makes decisions	enter text.	enter text.
manages money	enter text.	enter text.
enter text.	enter text.	enter text.

Communication - Select individual's Primary Mode of Communication (Select one.)

☐ American Sign Language	A visual/gestural language with vocabulary, grammar, idioms, and syntax different from English. The shape, placement, and movement of the hands, as well as facial expressions and body movements all play important parts in conveying information. ASL is the language of the Deaf community in the United States and Canada (except Quebec).
☐ Mixture ASL & Signed English	Individual uses sign language that combines ASL signs in English word order. An individual may also may not follow ASL grammar or English word order, yet elements of ASL and English are present in their sign language.
☐ Modified Sign Language	A mutual understanding is reached over hand and body motions.
☐ None Identified	A means of communication has not yet been identified for this person.
☐ Other	Provide explanation in the details section below.
☐ PECS	Individual communicates through the Picture Exchange Communication System.
☐ Picture Board	A visual aide/tool commonly used to help individuals comprehend verbal language. It generally consists of icons that represent specific words, actions, events or situations.
☐ Sign Exact English	A system of manual communication that strives to be an exact representation of English vocabulary and grammar; also known as pidgin signed English (PSE).
☐ Sign Language	Individual uses manual communication, body language and lip patterns instead of sound to convey messages
☐ Sign Lang Other Countries	A unique, visual/gestural language with vocabulary, grammar, idioms, and syntax different from the spoken language of the same country or region. This sign language is not ASL, PSE or VGC. It is the standard language used in the Deaf community in a country or unique region of the world.
☐ Tactile Sign	Used when an individual who is both deaf and blind (or has low vision), uses sign language to communicate but is not fluent in ASL or PSE and understands what others say by lightly placing his/her hands on top of the hands of the other signer and feeling his/her hand movements.
☐ Verbal	Individual communicates their messages verbally
☐ Visual-Gestural Communication	Not a language like English or American Sign Language, this communication mode uses gestures, facial expressions, and body language. This category should also be used when an individual uses some signs that he/she and his family, house staff, or house mates have agreed upon on their own. These "home-made" signs are also known as "home signs".
☐ Vocal Output Device	Individual uses an electronic device to communicate messages.

Communication Details - *Describe communication abilities and areas of need. It is important to consider both, as well as. Include description of. This information should also capture whether the individual speaks/understands English and/or another language.*

How does the individual understand others?	enter text.
How does the individual express or communicate with others?	enter text.
Should assistive technology (speech generating devices, letter boards, etc.) be included?	enter text.
Does individual speak/ understand English and/or another language?	enter text.

Social Emotional Information

Describe the skills and needs related to the process of learning to control emotions and having empathy and respect for others, and the ability to establish and maintain social interactions. enter text.

Plan: Functional Information: Functional Level: Educational/Vocational Information

Educational/Vocational Information is used to record if the individual is a student and/or an Office of Vocational Rehabilitation (OVR) Client. Include information on <u>current</u> educational enrollment or vocational abilities, and areas in which the individual needs assistance.

***Student** ☐ YES ☐ NO

Frequency ☐ Fulltime ☐ Part-time

Current Educational Status (If the individual is a student.)

current grade	enter text.
classroom level	enter text.
expected graduation date	enter text.
current status of his/her Individual Education Program (IEP)	enter text.
transition planning activities (for students fourteen years or older)	enter text.

School Name enter text.

Address enter text.

City, State, ZIP enter text.

Phone (123) 456-7890 enter text.

***OVR Client** ☐ Yes ☐ No

OVR Counselor Name enter text.

OVR Counselor Phone (123) 456-7890 Click here to enter text.

***Does this consumer have training goals** ☐ Yes ☐ No
If the individual is not currently a student or OVR client, it is still possible that he or she may have training goals.

List training goals

- enter text.
- enter text.
- enter text.

Additional Comments enter text.

Plan: Functional Information: Functional Level: Employment

Employment Information documents if the individual is engaged in competitive integrated employment or not employed. Related details such as full or part-time, employer, position, work address, work phone number, and employment goals is recorded. Include all information regarding individual's current abilities for obtaining and/or maintaining a competitive integrated job. If currently employed indicate the type and amount of support they require. Include current goals for employment and information learned from current and previous jobs and/or or volunteer experiences.

***Work Status** ☐ **Employed** ☐ Not Employed
Select "Employed" only when individual has competitive integrated employment (including self-employment) Competitive integrated employment is full or part-time work, in an integrated location where they can interact with co-workers without disabilities, making at least minimum wage or the same wage a person without a disability makes for performing the same job, with the same opportunities for benefits and advancement provided to workers without disabilities. If the individual participates in a vocational facility or adult training facility, answer "Not Employed".

Frequency ☐ Fulltime ☐ Part-time

Position enter text.

Employer enter text.

Address enter text.

City, State, ZIP enter text.

Phone (123) 456-7890 enter text.

Does this consumer have employment goals ☐ Yes ☐ No

Goals could be whether the individual would like to: explore competitive integrated employment, increase or decrease hours of current employment, change jobs, career advancement, etc.

List employment goals

*List employment goals whether or not the individual is currently working.*enter text.

Comments *Provide further explanations for any of the following:*

Notes regarding the individual's work experiences.	enter text.
Supervisor name.	enter text.
Details of his/her employment goals.	enter text.
Anticipated date of retirement.	enter text.
Retirement plans, including activities that the individual would like to do during his or her newly expanded free time.	enter text.

Plan: Functional Information: Understanding Communication

Record verbal or nonverbal, overt subtle behaviors that he/she uses to communicate needs, wants, likes/dislikes, what is important, when he/she is in pain, discomfort, or not feeling well, etc. All behavior is a form of communication. Communicative behaviors help others understand the individual and respect and respond in a helpful way. The information is gathered from important knowledge that people who know the individual will have from understanding and knowing the individual over time. Information regarding facilitated communication, assistive technology use/skill etc. should be included if appropriate. If the person's primary language is not English, include documentation noting his or her need for language assistance and resources utilized.

- ***When this is happening****…refers to the circumstances around the individual, the setting, the environment, the time of day, etc. For example, loud noises or eating.*
- ***The individual does****…refers to the observable actions in which the individual engages, or sounds/words or phrases the individual uses in those situations.*
- ***We think it means****…refers to the shared understanding and meaning of the action for the individual.*
- ***We should****…refers to the response or actions expected or to be avoided from the people providing support.*

***When this is happening…**	enter text.
***The individual does…**	enter text.
***We think it means…**	enter text.
***We should…**	enter text.
***When this is happening…**	enter text.
***The individual does…**	enter text.
***We think it means…**	enter text.

***We should…**	enter text.

Plan: Functional Information: Other Non-Medical Evaluation

Use the Evaluation area to capture detailed information about Non-Medical *evaluations completed, such as fine or gross motor skills that are not medically related*.

☐ Adaptive Skills	☐ Deaf Services Assessment	☐ Other (specify below)	☐ Standardized Needs Assessment
☐ Adaptive/Self Help	☐ Educational/Vocational	☐ Psychology	☐ Vision
☐ Cognitive	☐ Fine Motor	☐ Sexuality	
☐ Communication	☐ Gross Motor	☐ Social Emotional	

If Evaluation Area is "Other", Please Specify: "*Other" includes evaluations of mobility, functional vision, wheelchair evaluations and purchases, information on other adaptive equipment purchases, etc. Record evaluations and purchases completed within the last year, and those from which recommendations are still followed.* enter text.

***Name/Type of Evaluation**	enter text.
***Date of Evaluation** (mm/dd/yyyy)	Click here to enter a date.
In Need of Enhanced Communication Services?	☐ Yes ☐ No
Evaluator Name (Last Name, First Name)	enter text.
Evaluator Agency	enter text.

Plan: Functional Information: Other Non-Medical Evaluation

Use the Evaluation area to capture detailed information about Non-Medical *evaluations completed, such as fine or gross motor skills that are not medically related*.

☐ Adaptive Skills	☐ Deaf Services Assessment	☐ Other (specify below)	☐ Standardized Needs Assessment
☐ Adaptive/Self Help	☐ Educational/Vocational	☐ Psychology	☐ Vision
☐ Cognitive	☐ Fine Motor	☐ Sexuality	
☐ Communication	☐ Gross Motor	☐ Social Emotional	

If Evaluation Area is "Other", Please Specify: "*Other" includes evaluations of mobility, functional vision, wheelchair evaluations and purchases, information on other adaptive equipment purchases, etc. Record evaluations and purchases completed within the last year and those from which recommendations are still followed.* enter text.	
***Name/Type of Evaluation**	enter text.
***Date of Evaluation** (mm/dd/yyyy)	Click here to enter a date.
In Need of Enhanced Communication Services?	☐ Yes ☐ No
Evaluator Name (Last Name, First Name)	enter text.
Evaluator Agency	enter text.

Plan: Financial: Financial Information

Include the source of the individual's current income. If a representative payee exists, include his or her name and contact information. If more two sources exist, note in Financial Issues how asset limits will be maintained.

Income Source:

☐ Social Security	☐ Railroad Retirement Fund	☐ Veteran's Benefits
☐ Supplementary Security Income (SSI)	☐ Civil Service Annuity	☐ Other (Specify below)

Other income source enter text.

***Claim #**

If not the person's SSN, list the benefit tracking number. If the claim number is an SSN and the person does not wish to share it, please enter the person's name as the claim number. Example: Jane Nissley's SSN. enter text.

***Payee**	enter text.

Income Source:

☐ Social Security	☐ Railroad Retirement Fund	☐ Veteran's Benefits
☐ Supplementary Security Income (SSI)	☐ Civil Service Annuity	☐ Other (Specify below)

Other income source: enter text.

***Claim #**

If not the person's SSN, list the benefit tracking number. If the claim number is an SSN and the person does not wish to share it, please enter the person's name as the claim number. Example: Jane Nissley's SSN. enter text.

***Payee**	enter text.

Plan: Financial: Financial Management Issues

Section is required for individuals living in licensed settings and recommended for those who receive waiver funding to assure adherence to asset limits. Include responsible person's name (to assure compliance with assets to implement meaningful planning with the individual regarding use of their own resources.

This section is necessary for individuals who require assistance managing their finances. Designate who is responsible, how this person will assist the individual, and what documentation, if any, is needed.

(Optional for individuals not enrolled in a waiver program, or who manage their resources independently)

***Explanation of Issues**	enter text.
***How the provider proposes to address the issue(s)**	enter text.
***Start Date**	enter text.
***Completion Date**	enter text.
***Desired Outcome**	enter text.
***Person/Agency Responsible**	enter text.
***Explanation of Issues**	enter text.
***How the provider proposes to address the issue(s)**	enter text.
***Start Date**	enter text.
***Completion Date**	enter text.
***Desired Outcome**	enter text.
***Person/Agency Responsible**	enter text.

Plan: Financial: Fina ncial Resources

Indicate governmental benefits by selecting "Other Resources" and typing "Governmental Benefits" and the actual name of the resource in "Resource Name." Include the location and person responsible for maintaining the original documentation.

***Resource Type**

☐ Life Insurance	☐ Pre-paid Funeral Arrangements	☐ Trust/Guardianship	☐ Burial Reserve
☐ Burial Plot	☐ Bank Account Checking	☐ Bank Account Savings	☐ Bank Account Savings

Other Resources: ent er text.

Resource Value	enter text.
***Resource Name**	enter text.
Policy Number	enter text.

Address	enter text.
City, State Zip	enter text.
***Who has the original documentation?** enter text.	

***Resource Type**

☐ Life Insurance	☐ Pre-paid Funeral Arrangements	☐ Trust/Guardianship	☐ Burial Reserve
☐ Burial Plot	☐ Bank Account Checking	☐ Bank Account Savings	☐ Bank Account Savings

☐Other Resources e nter text.

Resource Value	enter text.
***Resource Name**	enter text.
Policy Number	enter text.
Address	enter text.
City, State Zip	enter text.
***Who has the original documentation?** enter text.	

Plan: Services And Supports: Outcome Summary	
***Outcome Phrase** *Enter a phrase to easily identify the outcome. The phrase is intended to assist with easily navigating through the ISP to search for all related information.* *The outcome phrase for individuals in the consolidated waiver who have a service need that cannot be met due to individual not selecting a willing and qualified provider should be "Provider not chosen."*	enter text.
***Outcome Start Date** (mm/dd/yyyy) *The date activity will begin to work toward achieving the outcome.* *The outcome start date should be the date when it is known that the service need cannot be met due to individual not selecting a willing and qualified provider.*	Click here to enter a date.
***Outcome End Date** (mm/dd/yyyy) *The estimated date of when the outcome should be achieved.*	Click here to enter a date.
Outcome Actual End Date (mm/dd/yyyy) *The actual date the outcome was completed.* *The outcome actual end date should be the date when the service need was met by selection of a willing and qualified provider.*	Click here to enter a date.

***Has the outcome been successfully accomplished?** ☐ YES ☐ NO

Note: When initially creating outcomes, this field should be "No." When this field is changed to "Yes," an Actual End Date should be entered for the outcome.

***Outcome Statement** *Represents what is currently important to the individual, what needs to be maintained for the individual, or what needs to be changed. The outcome should describe how it will make a difference in the individual's life. The outcome must build on information gathered during the ISP process and reflect a shared commitment to action. Remember that outcomes supported by ODP funding must be within the context of the health and safety of the individual and/or assuring their continued life within the community. Outcomes that address other priorities of the individual should be represented and supported with other community, family or non-traditional supports.* *Use the principles of Everyday Lives to develop outcomes with the individual: choice, control, quality, community inclusion, stability, accountability, safety, individuality, relationships, freedom, success, contributing to the community, collaboration, communication, and mentoring.* *Include health related outcomes only if there is a gap in the provision of support for the individual's health needs.*	enter text.
***Reason for Outcome** *This provides contextual information beyond the Outcome Statement for the team to understand how/why the outcome is important to the individual*.	enter text.
***Concerns Related to Outcome** *Describe any barriers (including health and safety issues) the team must address to successfully work towards the outcome. This may include information on what has been tried in the past but has not worked, what the individual's team has tried to figure out, or other concerns any team member may have. For therapy and nursing services, document here the denial from the State Plan and/or private insurance.*	enter text.
***Relevant Assessments Linked to Outcome** *List any relevant formal or informal assessments that directly affect the outcome. Informal assessment may include: direct observations, interviews with family or direct care staff and/or review of previous records. Formal assessments may include: statewide standardized assessments in addition to person-centered assessments utilized by provider agencies that have previously been approved by licensing agents. (If a formal assessment has been completed, it should be noted in the "Other Non-Medical Evaluations" section of the ISP.) Assessments may be utilized to assess whether an outcome has made an impact.*	enter text.

***Outcome Phrase** *Enter a phrase to easily identify the outcome. The phrase is intended to assist with easily navigating through the ISP to search for all related information.* *The outcome phrase for individuals in the consolidated waiver who have a service need that cannot be met due to individual not selecting a willing and qualified provider should be "Provider not chosen."*	enter text.
***Outcome Start Date** (mm/dd/yyyy) *The date activity will begin to work toward achieving the outcome.* *The outcome start date should be the date when it is known that the service need cannot be met due to individual not selecting a willing and qualified provider.*	Click here to enter a date.
***Outcome End Date** (mm/dd/yyyy) *The estimated date of when the outcome should be achieved.*	Click here to enter a date.
Outcome Actual End Date (mm/dd/yyyy) *The actual date the outcome was completed.* *The outcome actual end date should be the date when the service need was met by selection of a willing and qualified provider.*	Click here to enter a date.
***Has the outcome been successfully accomplished?** ☐ YES ☐ NO *Note: When initially creating outcomes, select "No." When this field is changed to "Yes," enter an Actual End Date for the outcome.*	
***Outcome Statement** *Represents what is currently important to the individual, what needs to be maintained for the individual, or what needs to be changed. Describe how it will make a difference in the individual's life.* *Build on information gathered during the ISP process and reflect a shared commitment to action. Remember that outcomes supported by ODP funding must be within the context of the health and safety of the individual and/or assuring their continued life within the community. Outcomes that address other priorities of the individual should be represented and supported with other community, family or non-traditional supports.* *Use the principles of Everyday Lives to develop outcomes with the individual: choice, control, quality, community inclusion, stability, accountability, safety, individuality, relationships, freedom, success, contributing to the community, collaboration, communication, and mentoring.* *Only include health related outcomes when there is a gap in providing support for the individual's health needs.*	enter text.
***Reason for Outcome** *This provides contextual information beyond the Outcome Statement for the team to understand how/why the outcome is important to the individual.*	enter text.

***Concerns Related to Outcome** *Describe any barriers (including health and safety issues) the team must address to successfully work towards the outcome. This may include information on what has been tried in the past but has not worked, what the individual's team has tried to figure out, or other concerns any team member may have. For therapy and nursing services, document here the denial from the State Plan and/or private insurance.*	enter text.
***Relevant Assessments Linked to Outcome** *List any relevant formal or informal assessments that directly affect the outcome. Informal assessment may include: direct observations, interviews with family or direct care staff and/or review of previous records. Formal assessments may include:* *statewide standardized assessments in addition to person-centered assessments utilized by provider agencies that have previously been approved by licensing agents. (If a formal assessment has been completed, it should be noted in the "Other Non-Medical Evaluations" section of the ISP.) Assessments may be utilized to assess whether an outcome has made an impact.*	enter text.

Plan: Services And Supports: Outcome Actions- Addressing Concerns Is Critical And Requires Team Support *The team must address any health and safety concern or any barriers. Team support attain outcomes .Collective problem solving and resources make the difference. Problem-solve to identify any needed actions. Each Outcome Summary needs an Outcome Action.*	
***Related Outcome Phrase** *Create in the Outcome Summary and include here, to link the Outcome Summary and Outcome Actions. It is a description to easily identify the outcome; this phrase is intended to assist with easily navigating through the ISP to find all related information.*	enter text.
***What are current needs** *Describe the current reality related to the outcome and relate it specifically to the individual – what they are able to do toward the outcome, including assistance that is necessary. This should crosswalk with previous sections of the ISP where needs are described*.	enter text.
****What actions are needed*** *Identify steps and actions provided by paid and non-paid people (such as family members or friends) to achieve the outcome.* *Include current actions which must continue. Describe any actions, including those provided by natural supports, non-paid support, and paid support. What happens currently to meet the need; is it adequate? Are parts of the individual's specific outcome being met, but not others? List any required specific services.* *Document steps to assure the individual's health and safety while working toward desired changes.*	enter text.

***Who's responsible** *Include the individual and/or other team members (name and relationship to the individual) involved who will assist with the implementation of the outcome and that will be responsible for seeing that the actions occur.*	enter text.
***Frequency and Duration of the actions needed** *Include the frequency (number of times) and the duration (length of time) for each of the needed actions. Include those provided by paid and non-paid people such as family members or friends.* *List specific information on total number of units on Service Details.* *ISP Teams must document an estimate of frequency and duration of actions needed until a willing and qualified provider is chosen. Please note, total number of units will be **NOT** be listed on the Service Detail screen since a willing and qualified provider was not chosen.*	enter text.
***By When** (mm/dd/yyyy) *List the anticipated date (or end of plan date) the actions will be accomplished; whichever is appropriate.*	enter text.
***How will you know that progress is being made towards this outcome?** *Progress links directly to outcome. Describes what is expected as a result of the services and supports. Identify how and who will give input about progress made over time.*	enter text.
***Related Outcome Phrase** *This is created in the Outcome Summary and selected here to link the Outcome Summary and Outcome Actions. It is a description to easily identify the outcome; this phrase is intended to assist with easily navigating through the ISP to find all related information.*	enter text.
***What are current needs** *Describe the current reality related to the outcome. This should be related specifically to the individual – what they are able to do toward the outcome, including assistance that is necessary. This should crosswalk with previous sections of the ISP where needs are described*.	enter text.
***What actions are needed** *Identify steps and actions to achieve the outcome. Include those provided by paid and non-paid people such as family members or friends.* *Include actions that currently occur and need to continue; this should describe any actions, including those provided by natural supports, non-paid support, and paid support. What happens currently to meet the need; is it adequate? Are there parts of the individual's specific outcome being met, and others not being met? If a specific service is required, it can be named here.* *Document steps to assure the individual's health and safety while working toward desired changes.*	enter text.

***Who's responsible** *Include the individual and/or other team members (name and relationship to the individual) involved who will assist with the implementation of the outcome and that will be responsible for seeing that the actions occur.*	enter text.
***Frequency and Duration of the actions needed** *Include the frequency (number of times) and the duration (length of time) for each of the needed actions. Include those provided by paid and non-paid people such as family members or friends.* *List specific information on total number of units on Service Details.* *ISP Teams must document an estimate of frequency and duration of actions needed until a willing and qualified provider is chosen. Please note, total number of units will be **NOT** be listed on the Service Detail screen since a willing and qualified provider was not chosen.*	enter text.
***By When** (mm/dd/yyyy) *List the anticipated date (or end of plan date) the actions will be accomplished; whichever is appropriate.*	Click here to enter a date.
***How will you know that progress is being made towards this outcome?** *Progress links directly to outcome. Describes what is expected as a result of the services and supports. Identify who will give input about progress made over time and how.*	enter text.

Plan: Plan Administration: Monitoring

Before submitting the ISP for approval, the Monitoring screen must be completed. Monitoring should meet the required standards of funding sources received by the individual or in accordance with county policy. See Waivers and/or ISP Manual for further description of appropriate monitoring frequency.

***Individual requires the following Monitoring frequency**: (Mark appropriate one)

☐ Statutory Frequency	☐ Non Statutory Frequency
(TSM and waivers)	(as per county policy)

Reason for Non-statutory frequency enter text.

Plan: Plan Administration: Draft Plan

***Consent to share plan:**	☐ YES	☐ NO
***Were life sharing options considered for Residential Services:**	☐ YES	☐ NO
Has the ISP signature sheet been completed?	☐ YES	☐ NO
Has the ISP Provider Choice information been shared with the individual?	☐ YES	☐ NO