



Name:	Date:
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Participant Information

Name of Participant (Last, First, Middle)		Date	
Address (Street, City, State)		Zip Code	County
Telephone Number	Birth Date	Sex	Social Security Number
		Recipient Number (MA ID)	
Race:	Email:	OLTL HCBS Waiver/Program:	

Directions to Participant's Residence

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Individual Back-Up Plan (support plan for unexpected disruption in service)

Individual's Name/Agency Name	Telephone Number/Email

Emergency Back-Up Plan (support plan in case of severe emergency)

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Representative Contact(s)/Relationship

Relationship	Telephone

Primary Language or Way of Communication

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Long Term Goals:

Short Term Goals:

Participant Strengths (including existing supports and resources):
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Household Composition (name of persons)

Household Composition (name of persons)	Relationship to Participant and Age



Name:	Date:
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List identified needs:	Met:	Partially met:	How is met?	Unmet:

Community Resources (Is the participant utilizing any community resources to assist with independence?):

List informal supports:

TPL (please list any other types of insurance(s):

If the participant is receiving any services that are not funded through OLTL waiver/program, please list below.

NON-WAIVER / PROGRAM SERVICES

Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences

Frequency/Duration (Hours/Days):	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Total Hours/Week:	Any Barriers/Risks:	Mitigation Strategy:	Agree/Disagree:
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Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences

Frequency/Duration (Hours/Days):	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Total Hours/Week:	Any Barriers/Risks:	Mitigation Strategy:	Agree/Disagree:
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Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences

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OLTL WAIVER / PROGRAM SERVICES

Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences			
Frequency/Duration (Hours/Days):	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Total Hours/Week:	Any Barriers/Risks:		Mitigation Strategy:		Agree/Disagree:		

Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences			
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OLTL WAIVER / PROGRAM SERVICES

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HAVE YOU ADDRESSED ALL OF YOUR NEEDS AND RISKS IN THE SERVICE PLAN? IF NO, COMPLETE THE NEXT SECTION.

YES NO

Unaddressed Needs/Risks/Barriers identified during the assessment process:

Mitigation Strategy (How are barriers being addressed/reduced?)

Additional Supports (Are additional supports needed?)

Discussion of Mitigation Strategies (Do you agree/disagree with the mitigation strategies?)

Service Plan Type:	Initial:	Annual:	Revision:	Date Completed:
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Your signature acknowledges that you received, reviewed and discussed the following information:

	NOTIFICATION OF RIGHT TO APPEAL
	PROVIDER CHOICE FORM
	FREEDOM OF CHOICE FORM
	TOLL FREE PARTICIPANT HELPLINE PHONE NUMBER
	HOW TO REPORT INCIDENTS OF ABUSE, NEGLECT/EXPLOITATION
	EMERGENCY BACK-UP PLAN (SEVERE WEATHER, ETC.)
	INDIVIDUALIZED BACK-UP PLAN
	AVAILABLE SUPPORTS (BOTH WAIVER/PROGAM AND NON-WAIVER/PROGRAM)
	MY INDIVIDUALIZED SERVICE PLAN
	I HAVE BEEN INFORMED OF, UNDERSTAND AND ACCEPT THE RISKS IDENTIFIED IN MY SERVICE PLAN

Date:	Participant signature:
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Date:	Representative signature designated by participant:
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Date:	Signature of others who participated in developing the plan:
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Date:	Signature of others who participated in developing the plan:
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Date:	Care Manager/Service Coordinator signature:
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Date:	Care Manager/Service Coordinator Supervisor signature:
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