INDIVIDUAL

SUPPORT PLANNING

Information gathered in this section 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:	
Supports Coordinator's Name:	
Date:	

Office of Developmental Programs

You can use the links below to quickly access an area of the ISP. Your web toolbar will appear which will allow you to use the [Back] and [Forward] buttons.

Instructions:

To **navigate** the table, use the mouse to click into the blank fields and enter information. The [Tab] button on the keyboard may also be used to tab from field to field in the table.

To **Enter Information** ensure the cursor is in the corresponding cell and begin typing. The cell will expand as the text is entered.

To **Create Additional Rows** for sections such as Important to Individual, Medications, Outcomes etc.

1. Highlight the second **set** of blank rows to be copied from the left hand margin.
   Note: If the first row is copied and pasted, the hyperlink from page 2 will no longer go to the first entry for that area of the ISP. Instead, the hyperlink will go to the last set of rows pasted into the section.
2. Click on Edit, Copy. Immediately click on Edit, Paste Rows.
3. Additional rows will appear below the highlighted rows.
4. Continue pasting rows until there are enough rows for the information.

***Annual Review Update Date** (mm/dd/yyyy)	
***Annual Review Meeting Date** (mm/dd/yyyy)	

***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.*

(Mark the appropriate box.)

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 or 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:	

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 people like and admire about the individual? *This is a list of attributes that other people like and find admirable about the individual, such as 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.*	

PLAN: INDIVIDUAL PREFERENCES: KNOW AND DO

What does consumer/family think someone needs to know to provide support? *Answering "What do people need to Know and Do to support the person?" describes information that people need to know and do in order for the individual to get 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 that those who support the individual need to know and do. Be sure to ask the individual and others who know the individual the best. 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 and exploration of avenues that are or would be enjoyable to the individual such as 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.*	

PLAN: INDIVIDUAL PREFERENCES: DESIRED ACTIVITIES

What are the activities that the individual would like to participate in or explore? *Activities that the individual would like to continue, to begin, or to explore further should be documented in Desired Activities. This information can help the Support Team (Circle) create outcomes with the individual that can assist the individual in exploring activities that are important to him or her, such as employment opportunities, establishing community connections, full participation in community life, voting, learning new skills or hobbies, things that are or would be enjoyable to the individual, connecting with other people, helping others (such as community volunteers), relationships, dating, etc.*	

PLAN: INDIVIDUAL PREFERENCES: IMPORTANT TO

The Important To section lists 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 changes that would be important for the team to address. Only things that are important TO the individual should be included here. What is important FOR the individual can be captured 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. In addition, consideration should be given 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 priority are tracked:

- *Essential: Those things listed 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** (Strongly Desired or Essential)	***Important to Individual**

PLAN: INDIVIDUAL PREFERENCE: WHAT MAKES SENSE

The What Makes Sense section of the plan is used to capture information about what experiences do and do not make sense in the life of the individual RIGHT NOW. For example, ask the question "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 is present and 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."

***Whose Perspective** *Identify whose view this is (individual, family, or other team members).*	
What Makes Sense *What works? What needs to be maintained/enhanced? What makes sense right now in the individual's current life experiences?*	
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).*	
***Whose Perspective** *Identify whose view this is (individual, family, or other team members).*	
What Makes Sense *What works? What needs to be maintained/enhanced? What makes sense right now in the individual's current life experiences?*	
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).*	

PLAN: MEDICAL: MEDICATIONS/SUPPLEMENTS (AND TREATMENTS)

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

***Diagnosis** *Record specific diagnosis or purpose of medication not the symptom. Examples: Arthritis not pain, GE Reflux not stomach acid.*	
***Medication/Supplement Name** *Include prescriptions and over-the-counter medications and herbal or food supplements.*	
***Dosage**	

***Frequency** (Mark correct one)

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

***Route** (Mark correct one)

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

***Blood Work Required?** (Yes or 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 and include the month, year and level of the drug.*	
If Yes, how frequently? *Document how often the physician wants the blood level checked.*	
***Does the Individual Self Medicate?** (Yes or No) *To be considered capable of self-administration of medications an individual shall be able to recognize and distinguish their medication from among other medications; know how much medication is to be taken either by communicating or picking up the correct amount; and know when medication is to be taken (after breakfast, before bedtime, etc.). Staff assistance to open the container and remove the medication is permitted.*	
Name of Prescribing Doctor (Last Name, First Name)	
***Special Instructions/Precautions** *Include 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.*	

***Diagnosis** *Record specific diagnosis or purpose of medication not the symptom. Examples: Arthritis not pain, GE Reflux not stomach acid.*	
***Medication/Supplement Name** *Include prescriptions and over-the-counter medications and herbal or food supplements.*	
***Dosage**	

***Frequency** (Mark correct one)
___ QD-1x a day ___ BID-2x a day ___TID-3x a day ___ QID-4x a day ___ HS-bedtime ___ Other (explain in special instructions) ___ PRN-as needed

***Route** (Mark the correct one)

___ By Mouth – *swallowed through the mouth*
___ NG Tube – *An NG Tube is a nasogastric tube that goes through the nose to the stomach.*
___ Intravenous – *IV, given into a vein through a port or catheter*
___ G Tube – *given through a tube that goes into the stomach*
___ Intramuscular – *given into a muscle*
___ 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*
___ Skin Patch – *applied to the skin with an adhesive patch*
___ Drops – *drops refers to medication given through the ear or eye*
___ Inhalant - *Inhalant includes all types of inhaled medications including inhalers, spin inhalers, nebulizers, etc.*
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___ Rectally – *put into the rectum*
___ Sublingual – *given under the tongue*
___ Vaginally – *put into the vagina*
___ Nasal – *sprays or drops given through the nose*
___ Other Means

***Blood Work Required?** (Yes or No) *Blood or other lab work as ordered by a prescribing physician.* *If you answer yes, record blood/lab work results in Current Health Status. Special Instructions/Precautions and include the month, year and level of the drug..*	
If Yes, how frequently? *Document how often the physician wants the blood level checked.*	
***Does the Individual Self Medicate?** (Yes or No) *To be considered capable of self-administration of medications an individual shall be able to recognize and distinguish their medication from among other medications; know how much medication is to be taken either by communicating or picking up the correct amount; and know when medication is to be taken (after breakfast, before bedtime, etc.). Staff assistance to open the container and remove the medication is permitted.*	
Name of Prescribing Doctor (Last Name, First Name)	
***Special Instructions/Precautions** *Include 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.*	

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. If there are no known allergies, sensitivities, adverse reactions or medication contraindications record N/A for all three responses/fields.

***Known Allergy**	
***Reaction**	
***Required Response**	
***Known Allergy**	
***Reaction**	
***Required Response**	

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** (Physical, Dental, Vision, Audiological, GYN, Mammogram, Prostate, TB – Mantoux, Hearing, Psychiatric, Other – if other, specify) *"Physical" should only be used for the annual physical.*	

***Specialist Type**	
***Medical Contact**	
***Was Diabetes Management Considered** (Yes, No, or 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 including blood glucose monitoring and control, diet, exercise, what to do during an illness, and screening for complications of diabetes such as eye and foot problems; or if the person works with a clinician around managing their diabetes.* • *Select "No" to indicate that the individual is diagnosed with diabetes, but diabetes management was not considered.*	
If Yes, enter details *Provide an explanation of the actions taken.*	
Date of Appraisal (mm/dd/yyyy)	
***Frequency of Appraisal** (Weekly, Monthly, Quarterly, Every 6 Months, Yearly, Every 2 Years, As Needed)	
Person Responsible for Arranging/Completing (Individual, Family, Provider, Other – if other, specify)	
***Type of Appraisal** (Physical, Dental, Vision, Audiological, GYN, Mammogram, Prostate, TB – Mantoux, Hearing, Psychiatric, Other – if other, specify)	
***Specialist Type**	
***Medical Contact**	
***Was Diabetes Management Considered** (Yes, No or 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 including blood glucose monitoring and control, diet, exercise, what to do during an illness, and screening for complications of diabetes such as eye and foot problems; or if the person works with a clinician around managing their diabetes.* • *Select "No" to indicate that the individual is diagnosed with diabetes, but diabetes management was not considered.*	
If Yes, enter details *Provide an explanation of the actions taken.*	
Date of Appraisal (mm/dd/yyyy)	

***Frequency of Appraisal** (Weekly, Monthly, Quarterly, Every 6 Months, Yearly, Every 2 Years, As Needed)	
Person Responsible for Arranging/Completing (Individual, Family, Provider, Other – if other, specify)	

PLAN: MEDICAL: MEDICAL CONTACTS

Include 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**	
***Last Name**	
Middle Initial	
Clinic *(name of practice or clinic)*	
Specialist Type	
Address	
City, State Zip	
***Phone Number** (123)456-7890	
Fax Number (123)456-7890	

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

PLAN: MEDICAL: MEDICAL HISTORY

Current Health Status: *List 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.*	
Developmental Information: *Record the following: 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; and cause or etiology of intellectual disability such as congenital or genetic syndrome, meningitis, traumatic brain injury, etc. Briefly describe how the disability and/or the diagnosis of the disability occurred. Include a brief family social history that may have impacted the individual's development. A lifetime medical history should be completed in accordance with MR Bulletin 00-94-32 and updated annually. Indicate where the lifetime medical history is kept and how it can be accessed.*	
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. 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, a psychiatric questionnaire should be completed 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.*	
Physical Assessment *Capture chronic diagnoses or conditions that do not require medication, i.e. those that are not listed under Medications/Supplements. Select all relevant body system areas and provide a description.*	

*** System Area** Vision: eyes Integumentary: skin Respiratory: lungs Endocrine: glands, hormones Lymphatic Cardiovascular: heart, blood vessels Dental Nervous System: nerves, brain function Hearing: ears Musculoskeletal: muscles, bones Digestive: stomach Genitourinary: genitals, urinary function Blood System	***Description** *Provide specifics about the body system issue and describe how to support the individual. Example: wears glasses, needs assistance putting on glasses.*

Immunization/Booster

Record all immunizations or boosters currently known that the individual has received. This section should be updated with new dates as the individual receives immunizations.

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

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. The Health and Safety areas of the plan can address the licensing requirements for residential and other licensed services. A summary of the assessment information and the skills and needs in each area should be recorded. Indicate if there is no assessment for a particular area. For any identified risk, address the level of supervision needed for the individual's safety and record it in Supervision Care Needs. If a review of incidents is specific to a health and safety focus area, then address that particular issue in that focus area. For example, document fire setting in the "fire safety" focus area.*	
General Health and Safety Risks *Include the team review of any injuries and accidents that may have occurred over the past year to look for trends in potential areas of concern. Note the need for protection from heat sources, electrical outlets, knives, etc., if applicable. Include any other information pertaining to health and safety other than what is recorded in the other Health and Safety focus areas.*	
Fire Safety *Record information about the individual's ability to react during a fire or fire drill. Include the level of supervision required and the assistance or device(s) needed to evacuate a building. 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 smoking safety. If the individual needs assistance to evacuate, document notification of the local fire company.*	
Traffic *Record information about the individual's traffic safety awareness, such as information about how and under what circumstances the individual can safely cross streets. Specific information regarding the individual's awareness of rural vs. urban streets, highways or side streets, parking lots, etc., should be provided. This information should include the level of supervision and assistance required.*	
Cooking/Appliance Use *Record information about the 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. This information should include the level of supervision and assistance needed when cooking or using appliances.*	

Outdoor Appliances *Record information about the individual's ability to use outdoor appliances, such as a lawn mower, weed whacker, gas grill, etc. This information should include the level of supervision and assistance required when using such appliances.*	
Water Safety (Including Temperature Regulation) *Record information about the 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, be alone in a bath and is the individual safe in a swimming pool? If the individual has a seizure disorder, or other medical condition such as a peg tube, include precautions necessary for bathing or swimming. This information should include the level of supervision and assistance required for hot water usage and when around swimming pools, lakes or other bodies of water.*	
Safety Precautions *Record information about the 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 non-food 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.*	
Knowledge of Self-Identifying Information *Record information about the individual's ability to give self-identifying information, such as name, address, and phone number. If unable to state identifying information, does the individual carry ID? Will he/she show ID to someone if lost? Will he/she ask for assistance if lost?*	
Stranger Awareness *Record information about the 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? This information should include the level of supervision and assistance the individual needs.*	
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 impairment 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.*	

Meals/Eating *Record information about the individual's ability to eat. 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. Include the level of supervision and assistance needed during meals both at home and at a restaurant. 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, in arms length, or by a phone call or page system, etc. during the day, in their home, or in the community. All three areas should be described.

- *Day supervision refers to normal day activities such as volunteering, working, attending a day program, etc.*
- *Home supervision refers to activities at the individual's home, or the home of a family member.*
- *Community supervision refers to 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, Additional Individualized Staffing, Enhanced/Intensive Staffing (1:1 or higher staffing in a licensed home or day service), any day service except in-home services, Home and Community Habilitation services greater than 64 units per day, describe the need for the service and its impact on the individual's health and welfare in the "Description" field.

***Supervision Care Need Type** (Indicate if Day Supervision, Home Supervision, or Community Supervision.)	
Number of hours of supervision *If an individual can have two hours of alone time while at home but requires supervision the remaining time, the number of hours for Home Supervision would be 22.*	
Description *Indicate if and how long the individual can be alone and any plans to increase time alone. Include the days and times the support will be provided as well as any additional supervision needs, such as…"individual needs one on one when going to the bathroom." Describe any training needed beyond general staff orientation to support the individual. Describe the need for the service and its impact on the individual's health and welfare.*	

***Is intensive supervision required in this setting?** (Yes or No) *Intensive supervision is defined as one-to-one supervision or a higher staff to individual ratio. If Yes, the reason for intensive supervision must be detailed in the Reasons for Intensive Staffing area of the ISP.*	
***Supervision Care Need Type** (Indicate if Day Supervision, Home Supervision, or Community Supervision.)	
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***Is intensive supervision required in this setting?** (Yes or No) *Intensive supervision is defined as one-to-one supervision or a higher staff to individual ratio. If Yes, the reason for intensive supervision must be detailed in the Reasons for Intensive Staffing area of the ISP.*	
PLAN: HEALTH AND SAFETY: SUPERVISION CARE NEEDS: REASONS FOR INTENSIVE STAFFING	

***Reason for Intensive Staffing** __Requires assistance with medication administration __Unable to evacuate independently __Kitchen safety or require assistance with meal preparation __Smoking safety __Unable to recognize common household Dangers __Elopement risk __Behavioral issue(s) __Roommate(s) require this staffing, this individual does not __Medical issue(s) __Physical/Mobility issue(s) __Other	
Other Reason:	
Plan for Reducing Intensive Staffing Supports: *The plan for reducing intensive staffing must include the specific role and purpose of the staff as well as 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. It must also include the plan for the eventual discontinuance or reduction of the intensive staffing. Update annually to validate the need for continued intensive staffing and include the date to maintain a history of the need for intensive staffing.*	
***Reason for Intensive Staffing** __Requires assistance with medication administration __Unable to evacuate independently __Kitchen safety or require assistance with meal preparation __Smoking safety __Unable to recognize common household Dangers __Elopement risk __Behavioral issue(s) __Roommate(s) require this staffing, this individual does not __Medical issue(s) __Physical/Mobility issue(s) __Other	
Other Reason:	

Plan for Reducing Intensive Staffing Supports: *The plan for reducing intensive staffing must include the specific role and purpose of the staff as well as 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. It must also include the plan for the eventual discontinuance or reduction of the intensive staffing. Update annually to validate the need for continued intensive staffing and include the date to maintain a history of the need for intensive staffing.*	

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. pre-vocational, community habilitation, etc.). The staffing ratio should reflect the provider's scheduled staffing ratio and should match the level of service in Service Details (i.e. if pre-vocational base level is attached, the staffing ratio should be 1:15). When an individual needs additional support, this should be noted in "Supervision Care Needs."

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

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

PLAN: HEALTH AND SAFETY: SUPERVISION CARE NEEDS: STAFFING RATIO – HOME

Record information here for all individuals living in residential settings. The staffing ratio should reflect the provider's scheduled staffing ratio. When an individual needs additional support such as enhanced residential staffing, this should be noted in "Supervision Care Needs."

***Day** (day of week)			
***Start Time**		***End Time**	

Comments			
***Day** (day of week)			
***Start Time**		***End Time**	
Comments			

PLAN: HEALTH AND SAFETY: SUPERVISION CARE NEEDS: STAFFING RATIO

Record information here for all individuals living in residential settings and for those who are part of litigation or a specific Class Action.

Is there Awake/Overnight (A/O) staff in this individual's home? (Yes or 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 or No)	
If not the same, is the difference more than the current approved staffing level? (Yes or No)	
If the difference is more than the current approved staffing level, give a specific explanation and justification for the need.	

PLAN: HEALTH AND SAFETY: BEHAVIORAL SUPPORT PLAN

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

This section must be completed if:

- *The individual receives a behavior support service*
- *A psychotropic medication is prescribed*

***Is there a behavioral support plan in place?** (Yes or No)	
Summary *Provide a summary of the individual's behavioral support plan. If a psychotropic medication is prescribed, document the plan to address the individual's social, emotional and environmental support, as well as frequency and severity of psychiatric symptoms. Indicate who the behavioral 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. 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.*	

If yes, is it restrictive? (Yes or 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.*	

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 mandatory for those that do have a formal crisis support plan.

***Is there a crisis support plan in place?** (Yes or 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.*	

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 is may not be the health care decision maker (health care proxy).*	
***Address**	
***City, *State *Zip**	
***Phone** (123) 456-7890	
Pager Number	
Is the individual able to make health care decisions? (Yes or No) *This means the individual is able to understand the options including the risks and benefits and make a decision.*	

Is there an advance directive in place? (Yes or No) *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", it should be verified that the individual themselves completed the advance directive.*	
If No, what steps will be taken 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.*	
If the individual cannot make health decisions, has a substitute decision maker been identified? (Yes, No, or NA)	
If substitute decision maker is identified, is it a (Facility Director, Family Member, Guardian, Other – specify) *Include health care proxy under "Other."*	
Name, Contact information of Decision Maker	
If substitute decision maker is not identified, then what steps will be taken to identify a substitute decision maker and by when? *Enter the steps to be taken to identify a substitute decision maker, as well as when these steps need to be taken.*	
PLAN: HEALTH AND SAFETY: HEALTH PROMOTION *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**	
***Promotion/Strategy Support Required** *Include information on what both the individual and staff need to know, do, and needed training.*	
***Frequency of Support**	
***Desired Outcome**	

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

PLAN: FUNCTIONAL INFORMATION: FUNCTIONAL LEVEL

In the functional areas of the plan, describe what the individual is able to do on his or her own, where assistance is required or any other types of needs. In some situations, one area of an individual's life can impact another. For example, communication skills or needs often can be observed in their learning/cognition abilities, their ability to express emotions under social/emotional information, etc. When this occurs, the details of support needed may be recorded 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 that include gross and fine motor skills, vision and hearing, use of assistive technology, ability to perform simple exercises, mobility, stair travel, and ambulation and gait assessment information. Include developmental statements from family and information regarding positioning and transfer needs if applicable.*	
Adaptive/Self Help *Document information pertaining to self-help or hygienic information. Include information about the person's ability to perform specific functions, assistance needs, and adaptations needed. Areas to consider are bathing/showering, dressing, drinking from a cup, eating, toileting, being transported (seating, rails, supervision, etc.), walking, etc. Record self-administration of medications skills, needs, and an explanation if the individual is not working toward self-administration. Include strengths and needs for completing household chores as well.*	
Learning/Cognition *Describe skills and needs about how an individual learns and processes information, thinks, remembers, reasons, problem solves, makes decisions, manages money, etc. Record the individual's ability to manage their own finances and property.*	
Communication	

Primary Mode of Communication (select one)

___ Verbal – Individual communicates their messages verbally
___ PECS – Individual communicates through the Picture Exchange Communication System
___ Sign Language – Individual uses manual communication, body language and lip patterns instead of sound to convey messages
___ Modified Sign Language – A mutual understanding is reached over hand and body motions
___ 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
___ Vocal Output Device – Individual uses an electronic device to communicate messages
___ Gestures and Facial Expressions – Individual uses gestures and facial expressions to communicate messages
___ None Identified – A means of communication has not yet been figured out for this person
___ Other – Provide explanation in the details section

Communication Details *Describe communication abilities and areas of need. It is important to consider both how the individual understands others, as well as how the individual expresses or communicates with others. Description of how assistive technology (e.g. speech generating devices, letter boards, etc.) is used should be included, if appropriate. This information should also capture whether the individual speaks/understands English and/or another language.*	
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.*	

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 current areas in which the individual needs assistance.

***Student** (Yes or No)	
Frequency (Fulltime or Part-time)	
Current Educational Status *If the individual is a student; indicate current grade, classroom level, expected graduation date, and current status of his/her Individual Education Program (IEP). Include transition planning activities for students fourteen years or older.*	
School	
Address	
City, State Zip	
Phone (123) 456-7890	
***OVR Client** (Yes or No)	
OVR Counselor Name	

OVR Counselor Phone (123) 456-7890	
***Does this consumer have training goals** (Yes or 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	
Comments	

PLAN: FUNCTIONAL INFORMATION: FUNCTIONAL LEVEL: EMPLOYMENT/VOLUNTEER

Employment/Volunteer Information is used to document if the individual is competitively employed or volunteers, and related details such as full or part-time, employer, position, work address, work phone number, and employment/volunteer goals. Include all information related to the individual's current abilities related to obtaining and/or maintaining a job or volunteer status. If currently employed or volunteering, indicate the type and amount of support they require. Include information related to any current goals for employment or volunteering, desire the individual has to be or continue to be, employed, and relevant notes on information learned from previous jobs, work or volunteer experiences.

***Work Status** (Employed, Volunteer, None) *Only select "Employed" if the individual has competitive community employment including self-employment where at least the minimum wage is earned. If the individual participates in a vocational facility or adult training facility, answer "None".*	

Frequency (Fulltime or Part-time)	
Position	
Employer	
Address	
City, State Zip	
Phone (123) 456-7890	

Does this consumer have employment/volunteer goals (Yes or No) *Employment/Volunteer goals could be whether the individual would like to: explore community employment or volunteer opportunities, increase or decrease hours of current employment/volunteer time, change jobs, increase responsibilities, etc. If an individual is not currently working or is working in a vocational facility, it is still possible that he/she may have employment goals.*	

List employment/volunteer goals *List employment/volunteer goals whether or not the individual is currently working or volunteering. Pre-vocational goals can also be included here.*	

Comments *Provide further explanations for any of the information on the Employment/Volunteer area, such as important notes regarding the individual's experiences in the work or volunteer place, supervisor name, or details of his/her employment/volunteer goals. Include information regarding the individual's anticipated date of retirement and retirement plans, including activities that the individual would like to do during his or her newly expanded free time.*	

PLAN: FUNCTIONAL INFORMATION: UNDERSTANDING COMMUNICATION

Record information in Understanding Communication about the individual's 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…**	
***The individual does…**	
***We think it means…**	
***We should…**	
***When this is happening…**	
***The individual does…**	
***We think it means…**	
***We should…**	

PLAN: FUNCTIONAL INFORMATION: OTHER NON-MEDICAL EVALUATION

Use the Evaluation area to capture detailed information about evaluations completed, such as fine or gross motor skills that are not medically related. ***The statewide standardized needs assessment should be documented as Other.***

***Evaluation Area**	___Fine Motor	___ Vision	___ Sexuality
	___Gross Motor	___ Cognitive	___ Communication
(non medical)	___ Adaptive Skills	___Social Emotional	___ Psychology
	___ Educational/Vocational	___ Adaptive/Self Help	___ Other

If Type is "Other" Specify *"Other" can include evaluations of mobility, functional vision, wheelchair evaluations, and purchases along with information on the purchase of other adaptive equipment, etc. Evaluations and purchases completed within the last year and those from which recommendations are still followed need only to be recorded.*	
***Name/Type of Evaluation**	
***Date of Evaluation** (mm/dd/yyyy)	
Evaluator Name (Last Name, First Name)	
Evaluator Agency	

***Evaluation Area** (non medical)	___Fine Motor	___ Vision	___ Sexuality
	___Gross Motor	___ Cognitive	___ Communication
	___ Adaptive Skills	___Social Emotional	___ Psychology
	___ Educational/Vocational	___ Adaptive/Self Help	___ Other

If Type is "Other" Specify *"Other" can include evaluations of mobility, functional vision, wheelchair evaluations, and purchases along with information on the purchase of other adaptive equipment, etc. Evaluations and purchases completed within the last year and those from which recommendations are still followed need only to be recorded.*	
***Name/Type of Evaluation**	
***Date of Evaluation** (mm/dd/yyyy)	
Evaluator Name (Last Name, First Name)	
Evaluator Agency	

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 than two sources exist, note in Financial Issues how asset limits will be maintained.

***Source** Social Security Supplementary Security Income (SSI) Veteran's Benefits	Railroad Retirement Fund Civil Service Annuity Other (Specify)	
***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.*		
***Payee**		

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

***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.*	
***Payee**	

PLAN: FINANCIAL: FINANCIAL MANAGEMENT ISSUES

This is required for individuals living in licensed settings, but recommended for all individuals who receive waiver funding to assure adherence to asset limits. Include who is responsible to assure compliance with assets and the implementation of meaningful planning with the individual about the use of his or her own resources.

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

For individuals not enrolled in a waiver program, or who manage their resources independently, this may be optional.

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

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

PLAN: FINANCIAL: FINANCIAL RESOURCES

Governmental benefits should be indicated by selecting "Other Resources" and typing in "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 Trust/Guardianship Burial Reserve Burial Plot	Pre-paid Funeral Arrangements Bank Account Checking Bank Account Savings Other Resources	
Resource Value		
***Resource Name**		

Policy Number	
Address	
City, State Zip	
***Who has the original documentation?**	

***Resource Type** Life Insurance Trust/Guardianship Burial Reserve Burial Plot	Pre-paid Funeral Arrangements Bank Account Checking Bank Account Savings Other Resources	

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

PLAN: SERVICES AND SUPPORTS: OUTCOME SUMMARY

***Outcome Phrase** *This 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.*	
***Outcome Start Date** (mm/dd/yyyy) *The date activity will begin to work toward achieving the outcome.*	
***Outcome End Date** (mm/dd/yyyy) *The estimated date of when the outcome should be achieved.*	
Outcome Actual End Date (mm/dd/yyyy) *The actual date the outcome was **completed**.*	

***Has the outcome been successfully accomplished** (Yes or No) *Select "Yes" or "No" to indicate whether the outcome has been successfully accomplished.* *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.*	
***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.*	
***Concerns Related to Outcome** *Describe any barriers (including health and safety issues) the team will need to 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.*	
***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.*	

***Outcome Phrase** *This 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.*	
***Outcome Start Date** (mm/dd/yyyy) *The date activity will begin to work toward achieving the outcome.*	
***Outcome End Date** (mm/dd/yyyy) *The estimated date of when the outcome should be achieved.*	
Outcome Actual End Date (mm/dd/yyyy) *The actual date the outcome was **completed**.*	
***Has the outcome been successfully accomplished** (Yes or No) *Select "Yes" or "No" to indicate whether the outcome has been successfully accomplished.* *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.*	
***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.*	

***Concerns Related to Outcome** *Describe any barriers (including health and safety issues) the team will need to 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.*	
***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.*	
PLAN: SERVICES AND SUPPORTS: OUTCOME ACTIONS *It is critical for the team to address any concerns related to health and safety issue or any other barriers. Individuals need team support to attain outcomes because collective problem solving and resources will make the difference. Problem-solve to identify any needed actions. Each Outcome Summary should have an Outcome Action.*	
***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.*	
***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.*	

***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.*	
***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.*	
***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.* *Specific information on total number of units is listed on Service Details.*	
***By When** (mm/dd/yyyy) *List the anticipated date (or end of plan date) the actions will be accomplished; whichever is appropriate.*	
***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.*	
***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.*	
***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.*	

***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.*	
***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.*	
***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.* *Specific information on total number of units is listed on Service Details.*	
***By When** (mm/dd/yyyy) *List the anticipated date (or end of plan date) the actions will be accomplished; whichever is appropriate.*	
***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.*	
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 (TSM and waivers) ___ Non Statutory Frequency (as per county policy)	
Reason for Non-statutory frequency	
PLAN: PLAN ADMINISTRATION: DRAFT PLAN	

***Consent to share plan:** (Yes or No)	
***Were lifesharing options considered for Residential Services:** (Yes, No or N/A)	
Has the ISP signature sheet been completed?: (Yes or No)	
Has the ISP Provider Choice information been shared with the individual?: (Yes or No)	