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 Mental Retardation

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

Begin Plan

Individual Preferences

- Like and Admire
- Know and Do
- Desired Activities
- Important to Individual
- What Makes Sense

Medical

- Medications/Supplements
- Allergies
- Health Evaluations
- Medical Contacts
- *Medical History*
  - Current Health Status
  - Developmental Information
  - Psychosocial Information
  - Physical Assessment
  - Immunization/Booster

Health and Safety

- *Focus Area*
  - General Health & Safety Risks
  - Fire Safety
  - Traffic
  - Cooking/Appliance Use
  - Outdoor Appliances
  - Water Safety
  - Safety Precautions
  - Knowledge of Self-Identifying Information
  - Stranger Awareness
  - Meals/Eating
- *Supervision Care Needs*
  - Reasons for Intensive Staffing
  - Staffing Ratio – Day
  - Staffing Ratio – Home
  - Staffing Ratio
- Behavioral Support Plan
- Health Care
- Health Promotion

Functional Information

- *Functional Level*
  - Physical Development
  - Adaptive/Self-Help
  - Learning/Cognition
  - Communication
  - Social/Emotional Information
  - Educational/Vocational Information
  - Employment
- Understanding Communication
- Other Non-Medical Evaluation

Financial

- Financial Information
- Financial Management Issues
- Financial Resources

Services and Supports

- Outcome Summary
- Outcome Actions

Monitoring

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 copy 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.

MCI Number		**Street Address**	
BSU Number		**City, State Zip**	
SSN Number		**Telephone Number**	
Date of Birth		**Gender**	
***Waiver/Program Type**			
***Proposed Start Date** (mm/dd/yyyy)			
***Proposed End Date** (mm/dd/yyyy)			

***Category of Plan Changes -** *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. The ISP shall be revised if there has been no progress on a goal, if a goal is no longer appropriate, or if a goal needs to be added.*

(Mark the appropriate box.)

Annual Review - *Used when performing an annual review. The plan must start after the existing plan ends. The annual review is the day the individual's team agrees that the outcome summaries and the outcome actions of the ISP are complete and appropriate. Monthly and quarterly reviews originate from this date. For those counties that use the fiscal year model, the start/end date refers to the fiscal year ISP.*	
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. 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. This form is utilized by the Program Specialist when conducting Quarterly Reviews.*	
General Update – *Used to update demographic or medical information. This should not be used when modifying services and supports.*	

***The individual/family requested a limited service and an abbreviated plan:** (yes or no)	
Reason for the abbreviated plan:	

INDIVIDUAL SUPPORT 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.*	
INDIVIDUAL SUPPORT 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.*	
INDIVIDUAL SUPPORT 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.*	

INDIVIDUAL SUPPORT 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**

INDIVIDUAL SUPPORT 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? Things that currently occur but do not work and need to be changed may express "What doesn't make sense".

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 we 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? The upside right now of the individual's current life experiences.*	
What Does Not Make Sense What doesn't work? What needs to change? What must be different? (the downside of 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? The upside right now of the individual's current life experiences.*	
What Does Not Make Sense What doesn't work? What needs to change? What must be different? (the downside of the individual's current life experiences).	

INDIVIDUAL SUPPORT 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, condition or potential – NOT symptoms.*	
***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 ___ PRN-as needed ___ Other (explain in special instructions)

***Route** (Mark correct one)
___ By Mouth ___ NG Tube ___ Intravenous ___ G Tube ___ Intramuscular ___ J Tube ___ Subcutaneously ___ Skin Patch ___ Drops ___ Inhalant ___ Topical ___ Rectally ___ Sublingual ___Vaginally ___ Nasal ___ 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. Psychotropic blood level results can appear in either Current Health Status or Psychosocial Information.*	
If Yes, how frequently?	
***Does the Individual Self Medicate?** (Yes or No)	

Name of Prescribing Doctor (Last Name, First Name)	
***Special Instructions/Precautions** *Include other medications that are contraindicated, supports that may be necessary, etc.*	
***Diagnosis** *Record specific diagnosis, condition or potential – NOT symptoms.*	
***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 correct one)
___ By Mouth ___ NG Tube ___ Intravenous ___ G Tube ___ Intramuscular ___ J Tube ___ Subcutaneously ___ Skin Patch ___ Drops ___ Inhalant ___ Topical ___ Rectally ___ Sublingual ___Vaginally ___ Nasal ___ 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. Psychotropic blood level results can appear in either Current Health Status or Psychosocial Information.*	
If Yes, how frequently?	
***Does the Individual Self Medicate?** (Yes or No)	
Name of Prescribing Doctor (Last Name, First Name)	
***Special Instructions/Precautions** *Include other medications that are contraindicated, supports that may be necessary, etc.*	

INDIVIDUAL SUPPORT PLAN: MEDICAL: ALLERGIES

Record all known sensitivities and allergies, including food, insect bite or stings, seasonal, animal, latex, medication allergies adverse, reactions, or contraindications, etc. Do not leave the spaces blank. If there are no known allergies, record NKA (no known allergies) for "Known Allergy" and N/A for "Reaction" and "Required Response".

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

INDIVIDUAL SUPPORT PLAN: MEDICAL: HEALTH EVALUATIONS

Include all known evaluations completed by any health care provider in the past 12 months including but not limited to medical doctors, dentists, psychiatrists, allied health specialists (therapists, dieticians, etc.). These would include routine, frequently scheduled, annual, check ups, as well as unexpected (acute care) evaluations. Medical contact information related to the exam should be included in Medical Contacts. Results of testing and the need for any follow up should be detailed in Current Health Status.

***Type of Appraisal** (Physical, Dental, Vision, Audiological, GYN, Mammogram, Prostate, TB – Mantoux, Hearing, Psychiatric, Other – if other, specify)	
***Specialist Type**	
***Medical Contact**	
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**	
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)	

INDIVIDUAL SUPPORT 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 or any specialist seen in the past IF the specialist may be seen in the future for a recurring condition. For group practices, indicate the preferred, assigned, or the name of the last physician seen in the practice.

***First Name**	
***Last Name**	
Middle Initial	
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	

INDIVIDUAL SUPPORT PLAN: MEDICAL: MEDICAL HISTORY

When completing the information in Medical History, include information from the lifetime medical history and noteworthy changes, as applicable. Indicate where the lifetime medical history is kept and how it can be accessed in Developmental Information.

Current Health Status: *Include a summary of health issues and resolutions that occurred within the past 12 months. Information should include a summary of health issues and resolutions such as hospitalizations, surgeries, new diagnoses, physician's recommendations, testing, blood work, and recommendations for adaptive equipment. Discuss results of recent medical appointments. Results of any testing listed under Health Evaluations should be included.*	
Developmental Information: *This section is used to record significant milestones of development which occurred up to the individual's 22nd birthday, if known, such as when the individual walked, talked, sat up, fed him or herself, and learned daily living skills such as dressing and feeding skills. Include a description of congenital or genetic syndrome or etiology, if applicable. Record any significant health issues that occurred at birth or other incidents that had an impact on the individual's development, such as hospitalizations, emergency room visits, surgeries, etc. Documentation of the presence of disability and date of diagnosis should be included. 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: *Describe significant behavioral, mental health or psychiatric issues, including diagnosis, especially within the past 12 months. List current symptoms related to mental health issues including level of irritability, mood swings and sleep patterns. Include a summary of recommendations to address these issues. If the individual has significant historical information, indicate the physical location of where this documentation can be found and summarize key points. 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.*	

Physical Assessment

Use this area of the plan to capture long term health history if it continues to be information that someone should know in order to support the individual. Record each diagnosis related to the individual's various body system areas; significant medical issues or surgeries, etc., When developing plans, review Current Health Status and Medications to determine applicable Body System Areas. Select any system areas that impact the individual's life.

*** System Area** *Only include those body system areas for which the individual has had or currently has an issue.* Vision: eyes Respiratory: lungs Lymphatic Dental Hearing: ears Digestive: stomach Blood System Integumentary: skin Endocrine: glands, hormones Cardiovascular: heart, blood vessels Nervous System: nerves, brain function Musculoskeletal: muscles, bones Genitourinary: genitals, urinary function	***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	
	Haemophilus Influenzae type B	
	Inactivated Polio	
	Measles	
	Mumps	
	Rubella	
	Varicella	
	Tuberculosis	
	Pneumovax	
	Other, explain	

INDIVIDUAL SUPPORT 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.

General Health and Safety Risks *Record self-administration of medications skills, needs, and an explanation if the individual is not working toward self-administration. Also 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. Include restraint usage, data, and identify interventions for supporting the individual during the crisis. If a review of incidents is specific to one of the other health and safety areas, then address that particular issue in that focus area. For example, document fire setting in the "fire safety" focus area. Note the need for protection from heat sources, electrical outlets, knives, etc., if applicable. Indicate if the person ingests non-food items. Include whether or not the individual has the skills to call 911 if necessary. Record the individual's ability to manage their own finances and property. 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, 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. If necessary, refer to Health Promotion for more information.*	

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? 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.*	
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 be avoided? 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.*	

INDIVIDUAL SUPPORT 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.

- *Day supervision refers to normal day activities such as volunteering, working, attending an adult training center, 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 plans, if they exist, to increase the time an individual spends alone. If intensive supervision is required, indicate so (defined as one to one supervision within arms length). Describe situations in which the individual can be alone. Other information that could be included in this section could include activities available for the individual in the community, how often the individual likes to be involved in community activities, what supports the individuals needs to participate in community activities, how those supports are provided, any barriers the individual might need to overcome to participate in the community activity, etc. If the individual does not spend time alone, indicate here.

***Supervision Care Need Type** (Indicate if Day Supervision, Home Supervision, or Community Supervision.)	
Number of hours of supervision	
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 by staff to support the individual.*	
***Is intensive supervision required in this setting?** (Yes or No) *Intensive supervision is defined as one-to-one supervision within arms length. Record information related to why an individual needs intensive staffing as indicated above. This is specific only to the individual for whom the plan is written.*	

***Supervision Care Need Type** (Indicate if Day Supervision, Home Supervision, or Community Supervision.)	
Number of hours of supervision	
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 by staff to support the individual.*	
***Is intensive supervision required in this setting?** (Yes or No) *Intensive supervision is defined as one-to-one supervision within arms length. Record information related to why an individual needs intensive staffing as indicated above. This is specific only to the individual for whom the plan is written.*	

***Supervision Care Need Type** (Indicate if Day Supervision, Home Supervision, or Community Supervision.)	
Number of hours of supervision	
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 by staff to support the individual.*	
***Is intensive supervision required in this setting?** (Yes or No) *Intensive supervision is defined as one-to-one supervision within arms length. Record information related to why an individual needs intensive staffing as indicated above. This is specific only to the individual for whom the plan is written.*	

INDIVIDUAL SUPPORT 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:	

***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:	

INDIVIDUAL SUPPORT PLAN: HEALTH AND SAFETY: SUPERVISION CARE NEEDS: STAFFING RATIO – DAY

Record information here for those people whom the information is required such as those who are part of litigation or a specific Class Action. For others, the information is optional.

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

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

Record information here for those people whom the information is required such as those who are part of litigation or a specific Class Action. For others, the information is optional.

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

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

Record information here for those people whom the information is required such as those who are part of litigation or a specific Class Action. For others, the information is optional.

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.	

INDIVIDUAL SUPPORT 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. If a medication is prescribed to treat maladaptive behavior, the behavioral support plan should include a plan for social, emotional, and environmental support.	
***Is there a behavioral support plan in place?** (Yes or No)	
Summary *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.*	
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.*	
INDIVIDUAL SUPPORT 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.*	
***Address**	
***City, *State *Zip**	
***Phone** (123) 456-7890	
Pager Number	
Is the individual able to make health care decisions? (Yes or No)	
Is there an advance directive in place? (Yes or No)	
If No, what steps will be taken to assist the individual to complete an advance directive?	
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) *Refer to OMR Bulletin 00-98-08 Procedures for Substitute Decision Making.*	
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?	

INDIVIDUAL SUPPORT PLAN: HEALTH AND SAFETY: HEALTH PROMOTION

Document any health conditions or issues that the individual currently practices, would like to work on or practice, or health issues for which there currently is a recommendation that it be addressed. These items may or may not lead to outcomes. Examples are weight reduction, weight charts, seizure charts, toileting protocols, other health related charting, smoking cessation, increased exercise, recommendations from Health Risk Profile (HRP), refusals to accept routine exams or treatment (this includes either the individual or guardian's refusal), conditions for which the individual takes medications etc. Use the Lifetime Medical History for background information and to assure that the information is current.

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

INDIVIDUAL SUPPORT 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. 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.*	
Communication *Describe current skills and needs related to expressive/receptive language and assistive technology skills and needs if appropriate. This information should also capture whether the individual speaks/understands English 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 initiate and maintain social contacts.*	
INDIVIDUAL SUPPORT PLAN: FUNCTIONAL INFORMATION: FUNCTIONAL LEVEL: EDUCATIONAL/VOCATIONAL INFORMATION *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)	
Comments	

INDIVIDUAL SUPPORT PLAN: FUNCTIONAL INFORMATION: FUNCTIONAL LEVEL: EMPLOYMENT

Include all information related to the individual's current abilities related to obtaining and/or maintaining a job. If currently employed, indicate the type and amount of support they require. Include information related to any current goals for employment, desire the individual has to be or continue to be, employed, and relevant notes on information learned from previous jobs or work experience. For example, loud and noisy environments don't work, works better with variation of job duties rather than continuous repetition etc. This section only refers to competitive employment issues.

***Employed** (Yes or No) *This question is meant to capture 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 No.*	

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

Does this consumer have employment goals (Yes or No) *Employment goals could be whether the individual would like to: explore community employment, increase or decrease hours of current employment, 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.*	

Comments *Provide further explanations for any of the information on the Employment screen, such as important notes regarding the individual's experiences in the workplace, supervisor name, or details of his/her employment 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.*	

INDIVIDUAL SUPPORT 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. 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 meaning of the action for the individual.
We should… refers to the response or action you expect 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…**	

INDIVIDUAL SUPPORT 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.

***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	

INDIVIDUAL SUPPORT 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 another person's SSN and they do 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 another person's SSN and they do not wish to share it, please enter the person's name as the claim number. Example: Jane Nissley's SSN.*		
***Payee**		

INDIVIDUAL SUPPORT PLAN: FINANCIAL: FINANCIAL MANAGEMENT ISSUES

This is required if the individual is enrolled in a waiver program 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**	

INDIVIDUAL SUPPORT 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	Pre-paid Funeral Arrangements	
Trust/Guardianship	Bank Account Checking	
Burial Reserve	Bank Account Savings	
Burial Plot	Other Resources	
Resource Value		
***Resource Name**		
Policy Number		
Address		
City, State Zip		
***Who has the original documentation?**		

***Resource Type**		
Life Insurance	Pre-paid Funeral Arrangements	
Trust/Guardianship	Bank Account Checking	
Burial Reserve	Bank Account Savings	
Burial Plot	Other Resources	
Resource Value		
***Resource Name**		
Policy Number		
Address		
City, State Zip		
***Who has the original documentation?**		

INDIVIDUAL SUPPORT 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 MR 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.*	
***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 MR 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.*	
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***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.*	

INDIVIDUAL SUPPORT 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.*	
***Related 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.*	
***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 (family, staff, etc…) involved who will assist with the implementation of the particular outcome.*	
***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.* *Include the specific name (and relationship to the individual if applicable) that will be responsible for seeing that the actions occur.* *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 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 (family, staff, etc…) involved who will assist with the implementation of the particular outcome.*	
***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.* *Include the specific name (and relationship to the individual if applicable) that will be responsible for seeing that the actions occur.* *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.*	
INDIVIDUAL SUPPORT PLAN: PLAN ADMINISTRATION: MONITORING *Before submitting the ISP for approval, the Monitoring screen must be completed. Monitoring should occur in accordance with County policy and meet the required standards of funding sources received by the individual.*	
***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	