INDIVIDUAL SERVICE PLAN (ISP)
FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES LIVING IN THE COMMUNITY
ISP Form Effective March 2013

IDENTIFYING INFORMATION	
INDIVIDUAL'S FULL NAME:	**DOB:**
ADDRESS:	
CITY AND ZIP:	**PHONE:**
DIRECTIONS TO HOME:	
INDIVIDUAL'S NATIVE LANGUAGE:	**INTERPRETER NEEDED: ☐ YES ☐ NO**

DATE OF ISP MEETING: _____	**DATE OF NEXT ISP MEETING: _____**	
EFFECTIVE DATES OF ISP: *FROM __ TO ____*	**TERM OF LEVEL OF CARE: *FROM __ TO ____***	
☐ DEVELOPMENTAL DISABILITIES WAIVER	**☐ ANNUAL**	**☐ JACKSON CLASS MEMBER**
☐ STATE GENERAL FUND	**☐ REVISION (DATE: ____ #:_____)**	**☐ NEW ALLOCATION**
☐ WAIVER ID #: _____	**☐ NEW MEXICO DDW GROUP:_____**	**☐ DATE OF SIS ASSESSMENT:_____**
☐ MEDICAID #: _____	**☐ MEDICARE #: _____**	
☐ SALUD! PROVIDER: _____	**☐ MEDICAID FEE FOR SERVICE:**	

CASE MANAGEMENT AGENCY: **ADDRESS:**	**CASE MANAGER:** **E-MAIL:**	**PHONE:** **FAX:**
RESIDENTIAL AGENCY: _____ SERVICE TYPE(S): _____ **ADDRESS:**	**CONTACT:** **E-MAIL:**	**PHONE:** **FAX:**
DAY SERVICES AGENCY: ____ SERVICE TYPE(S): _____ **ADDRESS:**	**CONTACT:** **E-MAIL:**	**PHONE:** **FAX:**
DAY SERVICES AGENCY: ____ SERVICE TYPE(S): _____ **ADDRESS:**	**CONTACT:** **E-MAIL:**	**PHONE:** **FAX:**
GUARDIAN: **AGENCY (IF APPLICABLE):** **ADDRESS:**	**☐ PLENARY** **☐ LIMITED** **☐ OTHER (SPECIFY): ____**	**PHONE:** **FAX:** **E-MAIL:**
EMERGENCY CONTACT(S): **ADDRESS:**	**RELATIONSHIP:**	**PHONE 1:** **PHONE 2:**
FAMILY: **ADDRESS:**	**RELATIONSHIP:** **E-MAIL:**	**PHONE:** **FAX:**
FRIEND/ADVOCATE: **ADDRESS:**	**RELATIONSHIP:** **E-MAIL:**	**PHONE:** **FAX:**
REPRESENTATIVE PAYEE: **ADDRESS:**	**E-MAIL:**	**PHONE:** **FAX:**
PRIMARY CARE PHYSICIAN: **ADDRESS:**	**E-MAIL:**	**PHONE:** **FAX:**
PHARMACY SUPPLIER: **ADDRESS:**	**E-MAIL:**	**PHONE:** **FAX:**
MEDICAL SUPPLIER(S): **ADDRESS:**	**EMAIL:**	**PHONE:** **FAX:**
MEDICAL PROVIDER 1: **ADDRESS:**	**E-MAIL:** **SPECIALITY:**	**PHONE:** **FAX:**
MEDICAL PROVIDER 2: **ADDRESS:**	**E-MAIL:** **SPECIALITY:**	**PHONE:** **FAX:**
OTHER: SERVICE TYPE(S): **ADDRESS:**	**RELATIONSHIP:** **E-MAIL:**	**PHONE:** **FAX:**
OTHER: SERVICE TYPE(S): **ADDRESS:**	**RELATIONSHIP:** **E-MAIL:**	**PHONE:** **FAX:**

Add as many lines as needed to include all the doctors, therapists, etc.

NARRATIVE SECTION

LIFE EXPERIENCES:
Provide background information, including successful past experiences and major life events. Describe what life is like now and important relationships. Include a description of the individual's values and beliefs that have resulted from these life experiences (e.g., personal, cultural, spiritual, political). Provide information regarding personal challenges when applicable. (Do not duplicate information for upcoming sections on work, education, health and safety, strengths/gifts, preferences and hobbies covered in later sections of this document.)

Significant Historical Information:

Briefly describe progress made since last year:

What life is like now (include where and with whom they live)**:**

Relationships (include family, friendships, community groups and staff with whom they are especially close. Also, clarify what relationships the individual is interested in forming, maintaining, re-establishing, expanding and/or ending.):

Important Values/Beliefs:

DESCRIPTION OF WHAT IS MEANINGFUL TO THIS INDIVIDUAL (Meaningful Day definition) – Describe age appropriate choices and activities (with approximate frequencies) that the individual finds Meaningful in their life. Include such things as purposeful desired work, opportunities for optimal health, self-empowerment, memberships, desired skill development, social, educational and community inclusion activities, valued roles, new things to try and hobbies. This description may be broader than the individual's vision statements, but should support progress toward achieving the visions and desired outcomes.

WORK, EDUCATION, AND/OR VOLUNTEER HISTORY: EMPLOYMENT FIRST-IDT members are required to offer Community Integrated Employment Services as a priority service over other day service options for all working age adults.
Describe the individual's successes and goals in school (past and/or current), including his/her areas of interest (e.g., favorite subjects and activities) and particular learning style. Provide detailed information about the individual's complete volunteer and paid work history (e.g., length of employment, job responsibilities, strengths, preferences, and dislikes). Mention any awards or certifications the individual has received. This section is reviewed on an annual basis to update/integrate vocational assessments into the ISP. Individuals receiving Supported Employment services are required to have a VAP.

Most current vocational assessment date: _____

Type of vocational assessment performed :
- _____**Vocational Assessment Profile**
- _____**Personal Profile**
- _____**MAP**
- _____**PATH**
- _____**Community Integration Profile**
- _____**Agency Developed assessment**

Is VAP Current:_____Relevant_____Functional_____Needs re-assessment?_____

Volunteer and Work History:
- **Current Job Description Of Duties And Hours Per Week:_____**
- **Past Jobs/Duties: _____**
- **Length In Each Position: _____**
- **Reason They Left: _____**
- **Current And Past Volunteer Experience: _____**

Learning Style and Communication Mode Considerations:

Related to Employment, What are the Individuals Interests, Strengths/Skills and Dislikes/Challenges/Concerns:

Related to Volunteering and/or Education, What are the Individuals Interests, Strengths/Skills and Dislikes/Challenges/Concerns:

WORK, EDUCATION, AND/OR VOLUNTEER HISTORY: EMPLOYMENT FIRST-IDT members are required to offer Community Integrated Employment Services as a priority service over other day service options for all working age adults.
Describe the individual's successes and goals in school (past and/or current), including his/her areas of interest (e.g., favorite subjects and activities) and particular learning style. Provide detailed information about the individual's complete volunteer and paid work history (e.g., length of employment, job responsibilities, strengths, preferences, and dislikes). Mention any awards or certifications the individual has received. This section is reviewed on an annual basis to update/integrate vocational assessments into the ISP. Individuals receiving Supported Employment services are required to have a VAP.

Personal Connections/Contact People/Relationships Relevant to Work/Education and/or Volunteering:

Is the individual currently employed?_____Yes_____No. (If Yes, a career development plan must be reflected in this ISP through outcomes, action plans and TSS to address how the individual will maintain and grow in their current position.**)**

☐ **Requesting additional hours of Individual Community Integrated Employment. (Explain below the reason additional hours are needed and a plan for fading supports.)**

☐ **If not currently employed, is employment desired? _____Yes_____No**
If Yes, a career development plan must be reflected in this IP through outcomes, action plans and TSS to address opportunities and supports to obtain employment or obtain VAP and/or DVR referral.

List Employment Service Options Discussed which best supports the individual:
_____Job Development
_____Self-Employment
_____Individual Community Integrated Employment
_____Group Community Integrated Employment

DVR Referral needed:_____Yes_____No (If yes, list in the action step the person or agency who will refer the individual to DVR)

☐ **No If no, develop work/education/volunteer vision, outcomes and action plans for supports for activities linked to their meaningful day description and that may lead to work in the future.**

- Consider whether the individual would like to participate in a VAP to more fully explore future vocational possibilities.
- Consider personal planning processes such as: MAP,PATH, Personal Profile or agency developed assessment
- Give a detailed explanation of the reason why work is not desired at this time here: (How did the IDT ensure that these decisions are based on informed choice made by the individual with assistance from the guardian?)

HEALTH & SAFETY:
Provide summary information about **significant** health/medical/dental/behavioral/environmental concerns (past and present) and diagnosis(es) that have **implications for planning or impact on the individual's health and safety**, including what has been done to date to address these concerns. If the person's health or skills are regressing, include that information here.

☐ **If Supported Living, justification should go here to address why natural supports with Respite and Customized In-Home supports will not meet the individuals needs.**

☐ **For individuals in Family Living, indicate choices regarding Adult Nursing Services here.**

☐**Reason for Referral for Adult Nursing Services for individuals who receive only Customized Community Supports and/or Community Integrated Employment (without accessing any Living Supports) and those who receive Customized In-Home Supports are made here (Prior authorization using the ANSPAR required)**

☐ **Community Inclusion Aid justification:**

☐ **Referral for Personal Support Technology: (Prior authorization from Regional Office required)**

☐ **Referral for Therapy Services and BSC Services here: (Prior authorizations using the TSPAR and BSCPAR required unless it is an initial evaluation)**

☐ **Individual Intensive Behavioral Customized Community Supports Referral: (Prior authorization from OBS required)**

☐ **Does this individual have an existing Assistive Technology Inventory? ____Yes____No**

HEALTH & SAFETY:

Provide summary information about **significant** health/medical/dental/behavioral/environmental concerns (past and present) and diagnosis(es) that have **implications for planning or impact on the individual's health and safety**, including what has been done to date to address these concerns. If the person's health or skills are regressing, include that information here.

☐ **Referral for new Assistive Technology**

☐ **Environmental Modification Referral:**

☐ **Intensive Medical Living Services Referral: (Prior authorization from DDSD required)**

☐ **Preliminary Risk Screening (See Consultation notes)**

☐ **Risk Management Plan**

☐ **Supervision required: (The presumption is that individuals can be alone. Provide here specific timeframes, situations and environments where supervision is required to ensure the individuals health and safety.)**

☐ **Customized In-Home Services: clarify schedule and types of supports to be provided**

Also, any issues not yet addressed should be included in Health and Safety Action Plan.

STRENGTHS, GIFTS, PREFERENCES, AND HOBBIES:

Describe what makes the individual unique. Provide detailed information about each of the sections below.

TALENTS, HOBBIES, AND INTERESTS:
STRENGTHS AND GIFTS:
PREFERENCES:
WHAT WORKS FOR AND MOTIVATES THE INDIVIDUAL:

VISION (WHAT I WANT IN MY FUTURE):

Describe what the individual desires for the future (i.e., dreams and aspirations without limits). Use relevant information from previous sections of the narrative (e.g., desires regarding relationships and potential jobs and roles), and team input. Describe what the vision means to the person in terms of how they define success. **Analyze** existing skills and resources available to achieve this vision and additional supports and skills needed, including Assistive Technology if relevant.

LIVE: _____
WHAT DOES SUCCESSFUL ACHIEVEMENT OF THIS VISION LOOK LIKE? _____
WHICH OF THE INDIVIDUAL'S STRENGTHS/TALENTS AND/OR EXISTING SKILLS CONTRIBUTE TO ACHIEVEMENT OF THIS VISION? _____
WHAT PROGRESS HAS ALREADY BEEN MADE TOWARD THIS VISION? (include Assistive Technology the individual already uses) _____
WHAT STILL NEEDS TO OCCUR TO OVERCOME ANY BARRIERS AND ACCOMPLISH THIS VISION? (e.g. skill development needed, Assistive Technology needed) _____

WORK/EDUCATION/VOLUNTEER: _____
WHAT DOES SUCCESSFUL ACHIEVEMENT OF THIS VISION LOOK LIKE? _____
WHICH OF THE INDIVIDUAL'S STRENGTHS/TALENTS AND/OR EXISTING SKILLS CONTRIBUTE TO ACHIEVEMENT OF THIS VISION? _____
WHAT PROGRESS HAS ALREADY BEEN MADE TOWARD THIS VISION? (include Assistive Technology the individual already uses) ___
WHAT STILL NEEDS TO OCCUR TO OVERCOME ANY BARRIERS AND ACCOMPLISH THIS VISION? (e.g. skill development needed, Assistive Technology needed) _____

DEVELOP RELATIONSHIPS/ HAVE FUN: ____
WHAT DOES SUCCESSFUL ACHIEVEMENT OF THIS VISION LOOK LIKE? _____
WHICH OF THE INDIVIDUAL'S STRENGTHS/TALENTS AND/OR EXISTING SKILLS CONTRIBUTE TO ACHIEVEMENT OF THIS VISION? _____
WHAT PROGRESS HAS ALREADY BEEN MADE TOWARD THIS VISION? (include Assistive Technology the individual already uses) _____
WHAT STILL NEEDS TO OCCUR TO OVERCOME ANY BARRIERS AND ACCOMPLISH THIS VISION? (e.g. skill development needed, Assistive Technology needed) _____

HEALTH AND/OR OTHER: (Note: This section is for a health related vision the individual has for themselves, such as "stop smoking," "get in shape to run a marathon" or "learn to take my medication" or a vision that does not fit under one of the other 3 areas. It is optional.) _____
WHAT DOES SUCCESSFUL ACHIEVEMENT OF THIS VISION LOOK LIKE? _____
WHICH OF THE INDIVIDUAL'S STRENGTHS/TALENTS AND/OR EXISTING SKILLS CONTRIBUTE TO ACHIEVEMENT OF THIS VISION? _____

VISION (WHAT I WANT IN MY FUTURE):

Describe what the individual desires for the future (i.e., dreams and aspirations without limits). Use relevant information from previous sections of the narrative (e.g., desires regarding relationships and potential jobs and roles), and team input. Describe what the vision means to the person in terms of how they define success. **Analyze** existing skills and resources available to achieve this vision and additional supports and skills needed, including Assistive Technology if relevant.

WHAT PROGRESS HAS ALREADY BEEN MADE TOWARD THIS VISION? (include Assistive Technology the individual already uses) _____

WHAT STILL NEEDS TO OCCUR TO OVERCOME ANY BARRIERS AND ACCOMPLISH THIS VISION? (e.g. skill development needed, Assistive Technology needed) _____

DESIRED OUTCOMES:

Focusing on the individual's priorities, identify outcomes that the individual wants to achieve during the next 1 – 3 years. Areas to consider include future desires and anticipated achievements for each life area. Outcome statements need to include measurable criteria for determining success. If a life area will not include a desired outcome statement, provide the rationale for this decision in the space provided. Work/Learn outcome statements should include desired outcome(s) from the Vocational Assessment if applicable.

LIVE: _____

WHAT IS COMPLETION CRITERIA? ____

WORK/EDUCATION/VOLUNTEER: ____

WHAT IS COMPLETION CRITERIA? _____

DEVELOP RELATIONSHIPS/HAVE FUN: ____

WHAT IS COMPLETION CRITERIA? _____

HEALTH AND/OR OTHER: _____

WHAT IS COMPLETION CRITERIA? _____

ACTION PLAN FOR A DESIRED OUTCOME IN THE LIVE AREA

NOTE: USE A SEPARATE FORM FOR EACH OUTCOME

DATE OF ACTION PLAN: ____ TARGET DATE FOR COMPLETION/ACHIEVEMENT: ____

OUTCOME STATEMENT #____

PERSONAL CHALLENGES AND OBSTACLES THAT NEED TO BE ADDRESSED IN ORDER TO ACHIEVE THIS DESIRED OUTCOME (All listed challenges and obstacles must be addressed through action steps, teaching and support strategies and/or support plans)
_____

SUPPORTS AND ACTION STEPS NEEDED TO REACH THE DESIRED OUTCOME

Identify the actions that the individual will take to reach the desired outcome, including things that the person wants to do and learn. In addition, include how natural, community, and specialized supports and services will assist the individual in reaching his/her desired outcome. Include the use of existing assistive technology or environmental modifications used to achieve this outcome, as appropriate (please refer to the AT Inventory for additional AT information.) Include the use of therapy (or other) evaluation or services needed to identify additional AT or environmental modifications to achieve this outcome. Note: If the individual had a NM DDW Group A or B and will be transitioning out of their current residential model over the next year, consider incorporating skills to develop to live more independently in the outcomes if related to their vision. Note: If Assistive Technology Service is being requested it must meet a desired outcome related to the person's vision.

ACTION STEPS *SKILLS TO LEARN AND TASKS TO DO*	**FREQUENCY** *HOW OFTEN, HOW LONG*	**STRATEGIES/WDSIs NEEDED**	**RESPONSIBLE PARTY (IES)**	**TARGET DATE(S)**	**MEASUREMENT/CRITERIA DOCUMENTATION AND REPORTING REQUIREMENTS**
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			

UNAVAILABLE SERVICES OR SUPPORTS	**STEPS TO OBTAIN NEEDED SERVICES OR SUPPORTS**

After implementing steps to obtain unavailable specialty services, if the services are still unavailable, complete a regional office intervention form and submit it to the local regional office.

ACTION PLAN FOR A DESIRED OUTCOME IN THE WORK/EDUCATION/VOLUNTEER

NOTE: USE A SEPARATE FORM FOR EACH OUTCOME

DATE OF ACTION PLAN: _____ TARGET DATE FOR COMPLETION/ACHIEVEMENT: ___

OUTCOME STATEMENT #____

PERSONAL CHALLENGES AND OBSTACLES THAT NEED TO BE ADDRESSED IN ORDER TO ACHIEVE THIS DESIRED OUTCOME (All listed challenges and obstacles must be addressed through action steps, teaching and support strategies and/or support plans)

SUPPORTS AND ACTION STEPS NEEDED TO REACH THE DESIRED OUTCOME

Identify the actions that the individual will take to reach the desired outcome, including things that the person wants to do and learn. In addition, include how natural, community, and specialized supports and services will assist the individual in reaching his/her desired outcome. Include the use of existing assistive technology or environmental modifications used to achieve this outcome, as appropriate (please refer to the AT Inventory for additional AT information.) Include the use of therapy (or other) evaluation or services needed to identify additional AT or environmental modifications to achieve this outcome. Note: If Assistive Technology Service is being requested it must meet a desired outcome related to the person's vision.

ACTION STEPS *SKILLS TO LEARN AND TASKS TO DO*	**FREQUENCY** *HOW OFTEN, HOW LONG*	**STRATEGIES/WDSIs NEEDED**	**RESPONSIBLE PARTY (IES)**	**TARGET DATE(S)**	**MEASUREMENT/CRITERIA DOCUMENTATION AND REPORTING REQUIREMENTS**
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			

UNAVAILABLE SERVICES OR SUPPORTS	**STEPS TO OBTAIN NEEDED SERVICES OR SUPPORTS**

After implementing steps to obtain unavailable specialty services, if the services are still unavailable, complete a regional office intervention form and submit it to the local regional office.

ACTION PLAN FOR A DESIRED OUTCOME IN THE DEVELOP RELATIONSHIPS/HAVE FUN

NOTE: USE A SEPARATE FORM FOR EACH OUTCOME

DATE OF ACTION PLAN: ____ TARGET DATE FOR COMPLETION/ACHIEVEMENT: ___

OUTCOME STATEMENT #____

PERSONAL CHALLENGES AND OBSTACLES THAT NEED TO BE ADDRESSED IN ORDER TO ACHIEVE THIS DESIRED OUTCOME (All listed challenges and obstacles must be addressed through action steps, teaching and support strategies and/or support plans)

SUPPORTS AND ACTION STEPS NEEDED TO REACH THE DESIRED OUTCOME

Identify the actions that the individual will take to reach the desired outcome, including things that the person wants to do and learn. In addition, include how natural, community, and specialized supports and services will assist the individual in reaching his/her desired outcome. Include the use of existing assistive technology or environmental modifications used to achieve this outcome, as appropriate (please refer to the AT Inventory for additional AT information.) Include the use of therapy (or other) evaluation or services needed to identify additional AT or environmental modifications to achieve this outcome. Note: If Assistive Technology Service is being requested it must meet a desired outcome related to the person's vision. If you are requesting Socialization and Sexuality Services, there must be an outcome related to the individual's vision.

ACTION STEPS *SKILLS TO LEARN AND TASKS TO DO*	**FREQUENCY** *HOW OFTEN, HOW LONG*	**STRATEGIES/WDSIs NEEDED**	**RESPONSIBLE PARTY (IES)**	**TARGET DATE(S)**	**MEASUREMENT/CRITERIA DOCUMENTATION AND REPORTING REQUIREMENTS**
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			

UNAVAILABLE SERVICES OR SUPPORTS	**STEPS TO OBTAIN NEEDED SERVICES OR SUPPORTS**

After implementing steps to obtain unavailable specialty services, if the services are still unavailable, complete a regional office intervention form and submit it to the local regional office.

ACTION PLAN FOR A DESIRED OUTCOME IN THE HEALTH/OTHER

NOTE: USE A SEPARATE FORM FOR EACH OUTCOME

DATE OF ACTION PLAN: ___ TARGET DATE FOR COMPLETION/ACHIEVEMENT: ___

OUTCOME STATEMENT #____

PERSONAL CHALLENGES AND OBSTACLES THAT NEED TO BE ADDRESSED IN ORDER TO ACHIEVE THIS DESIRED OUTCOME (All listed challenges and obstacles must be addressed through action steps, teaching and support strategies and/or support plans)

SUPPORTS AND ACTION STEPS NEEDED TO REACH THE DESIRED OUTCOME

Identify the actions that the individual will take to reach the desired outcome, including things that the person wants to do and learn. In addition, include how natural, community, and specialized supports and services will assist the individual in reaching his/her desired outcome. Include the use of existing assistive technology or environmental modifications used to achieve this outcome, as appropriate (please refer to the AT Inventory for additional AT information.) Include the use of therapy (or other) evaluation or services needed to identify additional AT or environmental modifications to achieve this outcome.

ACTION STEPS *SKILLS TO LEARN AND TASKS TO DO*	**FREQUENCY** *HOW OFTEN, HOW LONG*	**STRATEGIES/WDSIs NEEDED**	**RESPONSIBLE PARTY (IES)**	**TARGET DATE(S)**	**MEASUREMENT/CRITERIA DOCUMENTATION AND REPORTING REQUIREMENTS**
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			

UNAVAILABLE SERVICES OR SUPPORTS	**STEPS TO OBTAIN NEEDED SERVICES OR SUPPORTS**

After implementing steps to obtain unavailable specialty services, if the services are still unavailable, complete a regional office intervention form and submit it to the local regional office.

ACTION PLAN FOR ADDITIONAL DESIRED OUTCOME RELATED TO THE __ VISION

NOTE: USE A SEPARATE FORM FOR EACH OUTCOME

DATE OF ACTION PLAN: ___ **TARGET DATE FOR COMPLETION/ACHIEVEMENT: ___**

OUTCOME STATEMENT #____

PERSONAL CHALLENGES AND OBSTACLES THAT NEED TO BE ADDRESSED IN ORDER TO ACHIEVE THIS DESIRED OUTCOME (All listed challenges and obstacles must be addressed through action steps, teaching and support strategies and/or support plans)

SUPPORTS AND ACTION STEPS NEEDED TO REACH THE DESIRED OUTCOME

Identify the actions that the individual will take to reach the desired outcome, including things that the person wants to do and learn. In addition, include how natural, community, and specialized supports and services will assist the individual in reaching his/her desired outcome. Include the use of existing assistive technology or environmental modifications used to achieve this outcome, as appropriate (please refer to the AT Inventory for additional AT information.) Include the use of therapy (or other) evaluation or services needed to identify additional AT or environmental modifications to achieve this outcome.

ACTION STEPS *SKILLS TO LEARN AND TASKS TO DO*	**FREQUENCY** *HOW OFTEN, HOW LONG*	**STRATEGIES/WDSIs NEEDED**	**RESPONSIBLE PARTY (IES)**	**TARGET DATE(S)**	**MEASUREMENT/CRITERIA DOCUMENTATION AND REPORTING REQUIREMENTS**
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			

UNAVAILABLE SERVICES OR SUPPORTS	**STEPS TO OBTAIN NEEDED SERVICES OR SUPPORTS**

After implementing steps to obtain unavailable specialty services, if the services are still unavailable, complete a regional office intervention form and submit it to the local regional office.

ACTION PLAN FOR HEALTH AND SAFETY RELATED SUPPORTS

DATE OF ACTION PLAN: _____

EXPECTED HEALTH AND SAFETY RESULTS: _____

PERSONAL CHALLENGES AND OBSTACLES THAT NEED TO BE ADDRESSED (All listed challenges and obstacles must be addressed through action steps, teaching and support strategies and/or support plans)

SUPPORTS AND ACTION STEPS NEEDED FOR BASIC HEALTH AND SAFETY OUTCOME STATEMENTS

Identify supports the individual needs beyond those already addressed in action plans for other desired outcomes in order to stay as healthy and safe as possible. These include action steps that have not yet been completed (i.e., actions that are past due) and action steps related to newly identified areas of support (e.g., needed specialized assessments or adaptive equipment). Action steps should be included which address adequate supports for 1) a condition that is worsening, 2) a new diagnosis, 3) new symptoms, and/or 4) the need to obtain medical tests or evaluations. If steps address an Assistive Technology device, refer to the Assistive Technology Inventory. This Is not intended for tracking routine medical appointments, or to duplicate supports detailed in the individual's healthcare plan(s).

ACTION STEPS *SKILLS TO LEARN AND TASKS TO DO*	**FREQUENCY** *HOW OFTEN, HOW LONG*	**STRATEGIES/WDSIs NEEDED**	**RESPONSIBLE PARTY (IES)**	**TARGET DATE(S)**	**DOCUMENTATION AND REPORTING REQUIREMENTS**
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			
		☐ YES ☐ NO			

UNAVAILABLE SERVICES OR SUPPORTS	**STEPS TO OBTAIN NEEDED SERVICES OR SUPPORTS**

After implementing steps to obtain unavailable specialty services, if the services are still unavailable, complete a regional office intervention form and submit it to the local regional office.

HEALTHCARE COORDINATION INFORMATION

COORDINATION INFORMATION	
NAME OR <u>SPECIFIC</u> TITLE OF THE DESIGNATED HEALTHCARE COORDINATOR: ____ *A healthcare coordinator must be designated for all individuals; if the individual has a Low e-CHAT acuity level, and they are their own guardian, they may choose to designate themselves to do this independently, or another member of the team may be designated. If the individual has a Moderate or High e-CHAT acuity level a team member other than the individual must be designated to fulfill this role – assisting the individual to be involved to the maximum extent possible. The Healthcare Coordinator is the designated individual on the team who arranges for and monitors health care services for the individual. This includes scheduling appointments, follow-up recommendations and assuring that blood work, preventative screening and diagnostic testing is done.*	**PHONE:** _____
DOES THE INDIVIDUAL HAVE AN ADVANCED DIRECTIVE FOR MEDICAL CARE? ☐ **YES** ☐ **NO**	
IF THE INDIVIDUAL HAS AN ADVANCED MEDICAL DIRECTIVE, WHERE IS IT LOCATED? ___	
IF APPLICABLE, WHO IS THE SURROGATE HEALTH DECISION MAKER? _____ Note: A surrogate health decision maker is either a guardian with legal powers to make health decisions or the person the individual has chosen to make health decisions in the event they become incapacitated.	**PHONE:** _____
DOES THE INDIVIDUAL WANT MORE INFORMATION ABOUT ADVANCED DIRECTIVES? ☐ **YES** ☐ **NO**	
IF MORE INFORMATION IS DESIRED, WHO WILL ASSIST THE INDIVIDUAL? _____ *Information about advanced directives can be obtained through the Health Decisions Resource Team. Contact Continuum of Care for information at 1-877-684-5259.*	**BY WHEN?** _____

MEDICATION DELIVERY	
WHO COMPLETED THE MEDICATION ADMINISTRATION ASSESSMENT TOOL? *A nurse must complete the Medication Administration Assessment Tool (MAAT) for all adults receiving community living, day habilitation, employment services or private duty nursing services; for adults who do not receive any of these services and for children it is assumed that the parent/guardian takes full responsibility for medication delivery and completion of the tool is optional.* **NAME:** _____ **DATE**: _____	**AGENCY:** _____ **PHONE:** _____
AFTER CONSIDERING THE RESULTS OF THE MAAT, WHAT RECOMMENDATIONS HAVE BEEN MADE TO THE IDT REGARDING MEDICATION DELIVERY? _____	
WHAT IS THE TEAM'S FINAL DETERMINATION? ☐ SELF-ADMINISTRATION ☐ SELF-ADMINISTRATION WITH PHYSICAL ASSISTANCE ☐ ASSISTANCE BY STAFF ☐ ADMINISTRATION BY LICENSED/CERTIFIED PERSONNEL *If more than one category applies, include the explanation in the rationale below* **RATIONALE FOR DECISION:** _____	
RESPONSIBLE PARTY(IES) FOR FILLING AND REFILLING PRESCRIPTIONS: **CONTACT(S):** _____ **PHONE NUMBER(S):** _____	
RESPONSIBLE PARTY(IES) FOR UPDATING THE MEDICATION ADMINISTRATION RECORD: **CONTACT(S):** _____ **PHONE NUMBER(S):** _____	

INDIVIDUAL-SPECIFIC TRAINING REQUIREMENTS: SUPPORT PLANS

For each targeted area, document the **urgency** of training, as follows:
- 1 – Prior to working with the individual
- 2 – Prior to working alone with the individual
- 3 – Within 30 days of working with the individual
- 4 – Other (specify)

For each IDT member who must complete training, specify the **type**, as follows:
- A – Awareness level (e.g., obtains basic familiarity with the plan)
- K – Knowledge level (e.g., learns specifics strategies/techniques)
- S – Skill level (e.g., demonstrates ability to implement the plan)

SUPPORT PLAN (ATTACH TO ISP)	WHO RECEIVES TRAINING	URGENCY	TYPE	WHO PROVIDES TRAINING
☐ **COMPREHENSIVE ASPIRATION RISK MANAGEMENT PLAN**	☐ Case Manager			_____
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Ancillary Supports: ___			
	☐ Others: ___			
☐ **POSITIVE BEHAVIORAL SUPPORT PLAN** ☐ **POSITIVE BEHAVIORAL CRISIS PLAN**	☐ Case Manager			_____
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Ancillary Supports: ___			
	☐ Others: ___			
☐ **THERAPY PLAN (COMMUNICATION)** ☐ *ASSISTIVE TECHNOLOGY* ☐ *COMMUNICATION DICTIONARY* ☐ *24-HOUR COMMUNICATION SYSTEM* ☐ *INTERACTIVE COMMUNICATION ROUTINES* ☐ *OTHER:* _____	☐ Case Manager			_____
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Ancillary Supports: ___			
	☐ Others: ___			
☐ **THERAPY PLAN (OCCUPATIONAL)** ☐ *ASSISTIVE TECHNOLOGY* ☐ *SENSORY ISSUES* ☐ *THERAPEUTIC POSITIONING* ☐ *GENTLE MOVEMENT OF LIMBS/ROM* ☐ *OTHER:* _____	☐ Case Manager			_____
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Ancillary Supports: ___			
	☐ Others: ___			
☐ **THERAPY PLAN (PHYSICAL)** ☐ *ASSISTIVE TECHNOLOGY* ☐ *THERAPEUTIC POSITIONING* ☐ *LIFTING AND TRANSFERRING* ☐ *GENTLE MOVEMENT OF LIMBS/ROM* ☐ *OTHER:* _____	☐ Case Manager			_____
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Ancillary Supports: ___			
	☐ Others: ___			
☐ **NUTRITIONAL/DIETARY PLAN**	☐ Case Manager			_____
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Ancillary Supports: ___			
	☐ Others: ___			
☐ **HEALTHCARE PLANS**	☐ Case Manager			_____
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Ancillary Supports: ___			
	☐ Others: ___			
☐ **OTHER (SPECIFY):** _____	☐ Case Manager			_____
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Ancillary Supports: ___			
	☐ Others: ___			

INDIVIDUAL-SPECIFIC TRAINING REQUIREMENTS: MEDICAL CRISIS PREVENTION/INTERVENTION PLANS

For each targeted area, document the **urgency** of training, as follows:
- 1 – Prior to working with the individual
- 2 – Prior to working alone with the individual
- 3 – Within 30 days of working with the individual
- 4 – Other (specify)

For each IDT member who must complete training, specify the **type**, as follows:
- A – Awareness level (e.g., obtains basic familiarity with the plan)
- K – Knowledge level (e.g., learns specifics strategies/techniques)
- S – Skill level (e.g., demonstrates ability to implement the plan)

CRISIS PLAN (ATTACH TO ISP)	WHO RECEIVES TRAINING	URGENCY	TYPE	WHO PROVIDES TRAINING
☐ **SEIZURES**	☐ Case Manager			_____
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Ancillary Supports: ___			
	☐ Others: ___			
☐ **CARDIAC CONDITION**	☐ Case Manager			_____
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Ancillary Supports: ___			
	☐ Others: ___			
☐ **GASTROINTESTINAL**	☐ Case Manager			_____
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Ancillary Supports: ___			
	☐ Others: ___			
☐ **RESPIRATORY/ASTHMA**	☐ Case Manager			_____
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Ancillary Supports: ___			
	☐ Others: ___			
☐ **DIABETES**	☐ Case Manager			_____
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Ancillary Supports: ___			
	☐ Others: ___			
☐ **ALLERGIES**	☐ Case Manager			_____
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Ancillary Supports: ___			
	☐ Others: ___			
☐ **ASPIRATION**	☐ Case Manager			_____
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Ancillary Supports: ___			
	☐ Others: ___			
☐ **OTHER (SPECIFY):** _____	☐ Case Manager			_____
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Ancillary Supports: ___			
	☐ Others: ___			
☐ **OTHER (SPECIFY):** _____	☐ Case Manager			_____
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Ancillary Supports: ___			
	☐ Others: ___			

INDIVIDUAL-SPECIFIC TRAINING REQUIREMENTS: OTHER SUPPORTS

For each targeted area, document the **urgency** of training, as follows:

- 1 – Prior to working with the individual
- 2 – Prior to working alone with the individual
- 3 – Within 30 days of working with the individual
- 4 – Other (specify)

For each IDT member who must complete training, specify the **type**, as follows:

- A – Awareness level (e.g., obtains basic familiarity with the plan)
- K – Knowledge level (e.g., learns specifics strategies/techniques)
- S – Skill level (e.g., demonstrates ability to follow procedures)

TOPIC AREA	WHO RECEIVES TRAINING	URGENCY	TYPE	WHO PROVIDES TRAINING
☒ **SAFETY** ☒ *EMERGENCY PROCEDURES* ☒ *EMERGENCY CONTACTS* ☒ *INCIDENT REPORTING* ☒ *EVACUATION AND ESCAPE ROUTES* ☒ *STATUS OF RIGHTS (E.G., PRIVACY)* ☐ *OTHER (SPECIFY):* _____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ___			_____
☒ **CHOICE** ☒ *SKILL LEVEL* ☒ *LEVEL OF INFORMED CONSENT* ☒ *LIKES, DISLIKES, AND PREFERENCES* ☐ *OTHER (SPECIFY):* _____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ___			_____
☒ **COMMUNICATION** ☒ *METHODS OF COMMUNICATION* ☒ *EXPRESSIVE AND RECEPTIVE PREFERENCES* ☒ *KEY VOCABULARY* ☒ *PERSONAL SPACE AND TOUCH* ☐ *OTHER (SPECIFY):* _____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ___			_____
☒ **STRENGTHS AND CAPABILITIES** ☒ *ACTIVITIES OF DAILY LIVING* ☒ *INTERESTS AND HOBBIES* ☒ *SUPPORT STRATEGIES* ☐ *OTHER (SPECIFY):* _____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ___			_____
☒ **LEARNING STYLE** ☒ *ENVIRONMENTAL FACTORS* ☒ *MOTIVATORS* ☒ *PROMPT LEVELS* ☒ *VISUAL/AUDITORY/TACTILE PREFERENCES* ☐ *OTHER (SPECIFY):* _____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ___			_____
☒ **INDIVIDUAL SERVICE PLAN** ☒ *IDT MEMBER ROLES AND RESPONSIBILITIES* ☒ *NARRATIVE SECTION* ☒ *ACTION PLANS* ☒ *STRATEGIES* ☐ *OTHER (SPECIFY):* _____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ___			_____
☒ **SUPPORT NETWORK** ☒ *NATURAL SUPPORTS* ☒ *COMMUNITY SUPPORTS* ☒ *VISITATION RIGHTS* ☐ *OTHER (SPECIFY):* _____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ___			_____
☒ **CULTURAL/SPIRITUAL VALUES AND BELIEFS** ☒ *SPIRITUALITY* ☒ *CULTURAL PREFERENCES* ☒ *TRADITIONS AND CELEBRATIONS* ☐ *OTHER (SPECIFY):* _____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ___			_____
☒ **MEDICATIONS** ☒ *LEVEL(S) OF SUPPORT* ☒ *ROUTE-SPECIFIC INFORMATION* ☒ *PURPOSES* ☒ *SIDE EFFECTS* ☒ ALLERGIES ☐ *OTHER (SPECIFY):* _____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ___			_____

INDIVIDUAL-SPECIFIC TRAINING REQUIREMENTS FOR OTHER SUPPORTS (CONTINUED)

For each targeted area, document the **urgency** of training, as follows:
- 1 – Prior to working with the individual
- 2 – Prior to working alone with the individual
- 3 – Within 30 days of working with the individual
- 4 – Other (specify)

For each IDT member who must complete training, specify the **type**, as follows:
- A – Awareness level (e.g., obtains basic familiarity with the plan)
- K – Knowledge level (e.g., learns specifics strategies/techniques)
- S – Skill level (e.g., demonstrates ability to follow procedures)

TOPIC AREA	WHO RECEIVES TRAINING	URGENCY	TYPE	WHO PROVIDES TRAINING
☒ **SEXUALITY AND RELATIONSHIPS** ☒ *INFORMED CONSENT* ☒ *PAST HISTORY* ☒ *SUPPORTS* ☐ *OTHER (SPECIFY):* _____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ___			_____
☒ **DECISION MAKING** ☐ *INDEPENDENT* ☐ *GUARDIANSHIP STATUS* ☐ *SURROGATE HEALTH DECISION MAKER* ☐ *POWER OF ATTORNEY/CONSERVATOR* ☐ *OTHER (SPECIFY):* _____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ___			_____
☒ **SPECIAL CONCERNS REGARDING ROUTINES** ☒ *WEEKDAYS* ☒ *EVENINGS* ☒ *WEEKENDS* ☒ *LEISURE PREFERENCES* ☐ *OTHER (SPECIFY):* _____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ___			_____
☐ **DAILY ORAL CARE SUPPORTS:** _____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ___			_____
☐ **OTHER (SPECIFY):** _____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ____			_____
☐ **OTHER (SPECIFY):** ____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ____			_____
☐ **OTHER (SPECIFY):** ____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ____			_____
☐ **OTHER (SPECIFY):** ____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ___			_____
☐ **OTHER (SPECIFY):** ____	☐ Case Manager ☐ Residential Staff ☐ Day Support Staff ☐ Ancillary Supports: ___ ☐ Others: ___			_____

ISP MEETING PARTICIPANTS

DATE OF MEETING: ______

By signing below, I am indicating that I participated in the development of this individual service plan and will be responsible for implementing relevant portions of the plan. **Individuals who participated in a manner other than attendance at the meeting must be listed by the case manager with the method of participation stated in the signature column.**

MEETING PARTICIPANTS (PRINT NAME AND AGENCY)	SIGNATURE	CONTACT INFORMATION
INDIVIDUAL:		PHONE: ______________ FAX: ______________ E-MAIL: ______________
GUARDIAN:		PHONE: ______________ FAX: ______________ E-MAIL: ______________
FAMILY (SPECIFY RELATIONSHIP):		PHONE: ______________ FAX: ______________ E-MAIL: ______________
FRIENDS/ADVOCATES:		PHONE: ______________ FAX: ______________ E-MAIL: ______________
CASE MANAGER (SPECIFY AGENCY):		PHONE: ______________ FAX: ______________ E-MAIL: ______________
RESIDENTIAL STAFF (SPECIFY AGENCY): SERVICE COORDINATOR: DIRECT STAFF:		CONTACT INFO: ______________ CONTACT INFO:______________ CONTACT INFO:______________
DAY SERVICES STAFF (SPECIFY AGENCY): SERVICE COORDINATOR: DIRECT STAFF:		CONTACT INFO: ______________ CONTACT INFO:______________ CONTACT INFO:______________
DAY SERVICES STAFF (SPECIFY AGENCY): SERVICE COORDINATOR: DIRECT STAFF:		CONTACT INFO: ______________ CONTACT INFO:______________ CONTACT INFO:______________
OTHER (SPECIFY RELATIONSHIP AND AGENCY):		PHONE: ______________ FAX: ______________ E-MAIL: ______________
OTHER (SPECIFY RELATIONSHIP AND AGENCY):		PHONE: ______________ FAX: ______________ E-MAIL: ______________
OTHER (SPECIFY RELATIONSHIP AND AGENCY):		PHONE: ______________ FAX: ______________ E-MAIL: ______________
OTHER (SPECIFY RELATIONSHIP AND AGENCY):		PHONE: ______________ FAX: ______________ E-MAIL: ______________
OTHER (SPECIFY RELATIONSHIP AND AGENCY):		PHONE: ______________ FAX: ______________ E-MAIL: ______________