Individual Service Plan (ISP)

Demographic Information

Full Name:	
Preferred Name/Nickname:	
Pronouns:	
Date of Birth:	
Phone Number(s):	
Email(s):	
Address:	
City, State and Zip:	
Preferred Language(s):	☐By checking this box, I consent to using my photo in this ISP
Interpreter Needed: ☐ Yes ☐ No	☐By checking this box, I decline to have my photo used in this ISP

Region: ☐ Metro ☐ Northeast ☐ Southeast ☐ Northwest ☐ Southwest

Waiver ID:	**Medicaid ID**:	**Medicare ID**:

Directions to Home:

ISP Type and Date: ☐ Annual ISP, Meeting Date:	**ISP Effective Date**:
☐ ISP Revision Number , Meeting Date:	**LOC Date**:
☐ New Allocation, Meeting Date:	**Date of Next ISP Meeting**:

Important Contacts

NAME	RELATION TO PERSON	PHONE	EMAIL	ADDRESS

Emergency Contacts

CONTACT	NAME	PHONE	EMAIL	ADDRESS
Hospital				
Urgent Care				
Crisis Hotline				
Other:				
Other:				
Other:				
Other:				

Providers				
SERVICE	**NAME/AGENCY**	**PHONE & FAX**	**EMAIL**	**ADDRESS**
Case Management				
Residential Agency				
Day Services Agency				
Representative Payee				
Primary Care Physician				
Dental Provider				
Health Care Coordinator				
Pharmacy Supplier				
Medical Supplier				
Physical Therapist				
Occupational Therapist				
Speech Language Pathologist				
Behavior Support Consultant				
Employment Services Agency				
Other:				
Other:				
Other:				
Other:				
Other:				

Managed Care Organization (MCO) Information	
MCO:	**MCO Care Coordinator Name**:
MCO Care Coordinator Phone:	**MCO Care Coordinator Email**:
Date of Last Comprehensive Needs Assessment:	**Care Coordination Level**:

Overview of Me

1. **My Strengths**:

2. **My Hobbies**:

3. **My Dreams**:

4. **Cultural, Spiritual, and/or Religious Considerations**:

How to Best Support Me

1. How I communicate: ☐ Verbal ☐ Written ☐ Gestures ☐ Sign Language

☐ Augmentative and Alternative Communication Device, *specify*:

☐ Other, *specify*:

2. I let people know how I'm feeling or thinking about something when I (speak, gesture, act in this way, etc.):

3. I need help with:

4. I learn best when:

5. Things that don't work/things I dislike/don't like to do:

6. I get scared, nervous, angry, and/or anxious when:

7. When I am scared, nervous, angry, and/or anxious, it helps me calm down when:

8. I get frustrated when:

9. When I am frustrated, it helps me calm down when:

10. When people contact me, I prefer they: ☐Call ☐Text ☐Email ☐ Standard mail (letters, paper)

☐ Other *specify*: ☐ I prefer to not be contacted directly

What to Know About My Past

What to Know About My Life Today: Activities, Relationships, and Community Participation

1. Where I Live and Who I Live With:

2. My Important Relationships:

3. Daily Routines/Activities:

4. My Life in My Community:

5. My Community Supports:

6. How I get to and from places in my community:

7. What do you want out of the Developmental Disabilities Waiver?

8. Is there anything else you want people to know about you?

My Education Status and History

1. Current Education Status:

☐ Not Currently Enrolled in Any School
☐ Not in School but Want to Enroll in School
☐ High School Graduate
☐ Enrolled in Trade School
☐ Trade School Graduate
☐ Enrolled in Higher Education/College, Part-time
☐ Enrolled in Higher Education/College, Full-time
☐ Higher Education/College Graduate
☐ Other, *specify:*

2. Education History:

Employment

1. Are you currently employed?

☐ Yes ☐ No

My Current Job

1. Type of employment: ☐ Employed in the community ☐ Self-employed ☐ Other, *specify:*

2. Current Employer:

3. Current Job Title:

4. **How is your job**:

5. How do you get to and from work?

6. Do you have any employment supports? What is it like working with them?

7. What other jobs might you be interested in, if any:

8. Do you want to explore other job opportunities?

Job Exploration

1. Which option best describes your thoughts or feelings about having a job/working:

☐ I do not have a job, but I want to have a job

☐ I do not have a job, and I am unsure whether or not I want to have a job

☐ I do not have a job, and I am not interested in working or having a job

Volunteering

1. Do you currently volunteer? ☐Yes ☐No

2. Where do you volunteer:

3. What are your volunteer duties:

4. What do you like about volunteering:

5. Where are other places you have volunteered:

Retirement

1. Are you retired? ☐ Yes ☐ No ☐ Not Applicable

2. Date of retirement:

3. What job(s) did you have when you worked:

4. Why did you retire:

My Health, Behavior, and Safety

1. Describe anything you want those who work with you to know about your health, behavior, or safety:

2. Describe any supervision requirements:

Safety and Risk Assessment

Risk	Risk Present	Description of Risk	Discussion of Risk Mitigation
Overall Health and Medical			
1. Aspiration: I am at risk of aspirating. (I have a feeding tube; someone else puts food, fluids or medications into my mouth; I have a diagnosis of dysphagia; or I have been identified to be at risk for aspiration by IDT members or a qualified medical professional.)	☐Yes ☐No ☐History		
2. Dehydration: I am at risk of dehydration. (I often need help to get something to drink, or I receive fluids through a tube, or I need intravenous (IV) fluids due to dehydration in the past year).	☐Yes ☐No ☐History		
3. Choking: I am at risk of choking. (I ingest non-edible objects, or place non-edible objects in my mouth, or I have a diagnosis of Pica. I may eat or drink too rapidly frequently or more than occasionally cough or choke while eating or drinking.)	☐Yes ☐No ☐History		
4. Constipation: I am at risk of constipation. (I take bowel medications routinely or more than twice a month within the past year or have required a suppository or enema for constipation within the past year.)	☐Yes ☐No ☐History		
5. Seizures: I am at risk of having a seizure. (I have a diagnosis of seizures or epilepsy and/or have taken medication to control seizures within the past five years.)	☐Yes ☐No ☐History		
6. Complications of Diabetes: I have been diagnosed with prediabetes or diabetes and want help managing this issue.	☐Yes ☐No ☐History		

7. Complications associated with having an ostomy or tube, such as a urinary catheter, colostomy, etc.: I have an ostomy or tube and want help managing complications associated with it.	☐Yes ☐No ☐History		
8. Unreported Pain or Illness: I want help reporting pain, signs of illness, or where it is located. (I can have difficulty reporting or describing pain and illness.)	☐Yes ☐No ☐History		
9. Injury Due to Falling: I want support to avoid an injury due to falling. Have you suffered any falls or accidents that have resulted in hospitalization in the last 12 months? (Consider risk due to mobility or transfer support needs.)	☐Yes ☐No ☐History		
10. Respiration: I need help managing breathing issues, asthma, oxygen consumption, or other respiratory concerns.	☐Yes ☐No ☐History		
11. Allergies and Intolerances: I have allergies or intolerances, and I want help avoiding or managing my exposure to these allergens and intolerant things (What are you allergic or intolerant to, what happens when you are exposed to these things.)	☐Yes ☐No ☐History		
12. Other Serious Health or Medical Issues: I want help with a health issue that was not listed above. List specific additional risks (if any).	☐Yes ☐No ☐History		
Mental Health			
13. I want support managing or coping with my mental health. (Consider all mental health areas including past trauma, depression, anxiety disorder, addiction, mood disorders, suicide ideation, etc.)	☐Yes ☐No ☐History		
14. Do you have any mental health diagnoses? If "Yes" or "History", what are/were they and how is your mental health being managed?	☐Yes ☐No ☐History		
Substance Use			
15. I want help managing my substance use (i.e. drugs or alcohol. Have you tried to cut down using substances but failed?)	☐Yes ☐No ☐History		
Behaviors			
16. Do you have any behaviors that you don't understand, make you uncomfortable, or cause a risk to	☐Yes ☐No ☐History		

yourself or others? If "Yes", how are these being addressed?			
Overall Safety			
17. Fire Evacuation Safety: I need assistance to evacuate when a fire or smoke alarm sounds.	☐Yes ☐No ☐History		
18. Household Chemical Safety: I want support to avoid any serious injury from household chemicals.	☐Yes ☐No ☐History		
19. Vehicle Safety: I want assistance to remain safe around traffic while getting in or out of a vehicle or while riding in vehicles.	☐Yes ☐No ☐History		
20. Safety and Cleanliness of the Residence: There are some conditions where I live that may lead to injury, illness, eviction, or significant loss of property.	☐Yes ☐No ☐History		
21. Other Safety Issues: Consider any other important, serious safety issues at home or in any other setting that you want help with (workplace, in your community, etc.)	☐Yes ☐No ☐History		
Personal Safety and Finances			
22. Court Involvement: Do you have any court orders in place (such as protective orders or restraining orders to keep you safe) or current court involvement?	☐Yes ☐No ☐History		
23. Abuse, Neglect, and Exploitation (ANE): In your opinion (opinion of the waiver recipient), have you been abused, neglected or exploited in the last 12 months? If "Yes" or "History" How was this situation handled? Was a safety plan put in place?	☐Yes ☐No ☐History		
24. Potential for Financial Abuse: Do you have someone that manages your money? If "Yes", who? Does this person have legal authority to assist you?	☐Yes ☐No ☐History		
25. Potential for Financial Abuse: Are you included in your financial decisions?	☐Yes ☐No ☐History		
26. Abuse, Neglect, and Exploitation (ANE): Do you want or need training on abuse, neglect, or exploitation (ANE)?	☐Yes ☐No ☐History		
Determinants of Health			

27. Housing: Within the past 12 months, have you ever stayed: outside, in a car or tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing), or been unable to get utilities (heat, electricity) when it was really needed?	☐Yes ☐No ☐History		
28. Food: Within the past 12 months, did you worry that your food would run out before you got money to buy more?	☐Yes ☐No ☐History		

Medication Management and Delivery

1. Does this person need a Medication Administration Assessment Tool (MAAT)? ☐Yes ☐ No

2. Who completed the last Medication Administration Assessment Tool (MAAT)?

Name: **Date**: **Agency**: **Phone**:

3. After considering results of the MAAT, what recommendations have been made regarding medication delivery:

4. What is the final determination:

☐ Self-administration ☐ Self-administration with physical assistance

☐ Assistance by staff ☐ Administration by licensed/certified personnel

5. *(If more than one category applies, include the explanation in the rationale)* **What is the rationale for this decision determination**:

6. Responsible party(ies) for filling & refilling prescriptions:

Contact(s): **Phone(s)**:

7. Responsible party(ies) for updating the Medication Administration Record (MAR):

Contact(s): **Phone(s)**:

Do Not Resuscitate (DNR) Order and Advanced Directive

1. Do you have a Do Not Resuscitate (DNR) order, Advanced Directive, and/or Medical Power of Attorney in place?

☐ DNR ☐ Medical Power of Attorney ☐ Advanced Directive ☐ I have none of these

Where is each located:

2. Do you have a Surrogate Health Decision Maker?

☐ Yes ☐ No

If "Yes" list their name and relation to waiver recipient. Also include type of guardianship: Full, Limited, or Joint.

3. Do you have a Supported Decision Maker/a Supported Decision-Making Agreement?

☐ Yes ☐ No

If "Yes" list the Supported Decision Maker's name and relation to waiver recipient:

4. Do you want more information about DNRs, Advanced Directive, and/or Medical Power of Attorney (POA) in place?

☐ Yes ☐ No

If "Yes", what information do you want:

Enabling Technology - Assistive Technology (AT) & Remote Personal Support Technology (RPST)

1. Do you have reliable access to the Internet?

☐ Yes ☐ No

2. Do you have devices to access the internet?

☐ Yes ☐ No

3. Do you have an Assistive Technology (AT) inventory?

4. Are you familiar with using technology? In what ways?

5. For what purpose do you need Assistive Technology (AT), or Remote Personal Support Technology (RPST)?

Vision for My Life

Vision:	
Outcome:	**Outcome Start Date**:
Obstacles:	

Action Steps	Frequency	Measurement Criteria, Documentation and Reporting Requirements	Target Completion Date	Who Will Support Me	TSS/WDSI Needed?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Enabling Technology (includes AT and RPST):

What Technology is Needed	How Technology will be Used	Who/What Roles will Help with Technology Use	Who will Get Technology Alerts	How will They be Alerted

Considerations for Technology Backup & Connectivity Issues:

Vision for My Education, Employment, and/or Volunteering

Vision:	
Outcome:	**Outcome Start Date**:
Obstacles:	

Action Steps	Frequency	Measurement Criteria, Documentation and Reporting Requirements	Target Completion Date	Who Will Support Me	TSS/WDSI Needed?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Enabling Technology (includes AT and RPST):

What Technology is Needed	How Technology Will be Used	Who/What Roles will Help with Technology Use	Who will Get Technology Alerts	How will They be Alerted

Considerations for Technology Backup & Connectivity Issues:

Vision for My Relationships/Things to Have Fun

Vision:	
Outcome:	**Outcome Start Date**:
Obstacles:	

Action Steps	Frequency	Measurement Criteria, Documentation and Reporting Requirements	Target Completion Date	Who Will Support Me	TSS/WDSI Needed?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Enabling Technology (includes AT and RPST):

What Technology is Needed	How Technology Will be Used	Who/What Roles will Help with Technology Use	Who will Get Technology Alerts	How will They be Alerted

Considerations for Technology Backup & Connectivity Issues:

Vision for My Health/Other Visions I Have

Vision:	
Outcome:	**Outcome Start Date**:
Obstacles:	

Action Steps	Frequency	Measurement Criteria, Documentation and Reporting Requirements	Target Completion Date	Who Will Support Me	TSS/WDSI Needed?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

Enabling Technology (includes AT and RPST):

What Technology is Needed	How Technology Will be Used	Who/What Roles will Help with Technology Use	Who will Get Technology Alerts	How will They be Alerted

Considerations for Technology Backup & Connectivity Issues:

Individual Specific Training Requirements				
PLANS/SUPPORT	**WHO RECEIVES TRAINING**	**TYPE**	**URGENCY**	**WHO PROVIDES TRAINING**
☐ Comprehensive Aspiration Risk Management Plan (CARMP)	☐ Case Manager			
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Service Coordinators			
	☐ Ancillary Supports			
	☐ Employment Support Staff			
	☐ Others			
☐ Positive Behavioral Support Plan (PBSP)	☐ Case Manager			
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Service Coordinators			
	☐ Ancillary Supports			
	☐ Employment Support Staff			
	☐ Others			
☐ Positive Behavioral Crisis Plan	☐ Case Manager			
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Service Coordinators			
	☐ Ancillary Supports			
	☐ Employment Support Staff			
	☐ Others			
☐ Communication/ Speech Therapy Written Direct Support Intructions (WDSI)	☐ Case Manager			
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Service Coordinators			
	☐ Ancillary Supports			
	☐ Employment Support Staff			
	☐ Others			
☐ Physical Therapy Written Direct Support Intructions (WDSI)	☐ Case Manager			
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Service Coordinators			
	☐ Ancillary Supports			
	☐ Employment Support Staff			
	☐ Others			
☐ Occupational Therapy Written Direct Support Intructions (WDSI)	☐ Case Manager			
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Service Coordinators			
	☐ Ancillary Supports			
	☐ Employment Support Staff			
	☐ Others			
☐ Nutritional/ Dietary Plan	☐ Case Manager			
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Service Coordinators			
	☐ Ancillary Supports			
	☐ Employment Support Staff			

	☐ Others			
☐ Healthcare Plans	☐ Case Manager			
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Service Coordinators			
	☐ Ancillary Supports			
	☐ Employment Support Staff			
	☐ Others			
☐ Other, *specify*:	☐ Case Manager			
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Service Coordinators			
	☐ Ancillary Supports			
	☐ Employment Support Staff			
	☐ Others			
☐ Other, *specify*:	☐ Case Manager			
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Service Coordinators			
	☐ Ancillary Supports			
	☐ Employment Support Staff			
	☐ Others			
☐ Other, *specify*:	☐ Case Manager			
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Service Coordinators			
	☐ Ancillary Supports			
	☐ Employment Support Staff			
	☐ Others			
☐ Other, *specify*:	☐ Case Manager			
	☐ Residential Staff			
	☐ Day Support Staff			
	☐ Service Coordinators			
	☐ Ancillary Supports			
	☐ Employment Support Staff			
	☐ Others			

Relatives and Legally Responsible Individuals (LRIs)

1. Will a Legally Responsible Individual (LRI) or relative provide one or more waiver services: ☐ Yes ☐ No

LRI or Relative	Service	Best Fit Justification	Recipients Choice in Decision	Backup Plan
☐ LRI ☐ Relative				
☐ LRI ☐ Relative				

☐ LRI ☐ Relative				
☐ LRI ☐ Relative				
☐ LRI ☐ Relative				
☐ LRI ☐ Relative				

Discussion of Service Settings	
1. Does the person receive services in a provider-owned or controlled residential setting? ☐ Yes ☐ No	
Service Setting Requirement	**Verification of Compliance Status**
2. Does the person have a lease, legally enforceable agreement, or other written living agreement: ☐ Yes ☐ No	
3. Does the person have lockable doors, with only appropriate staff having keys: ☐ Yes ☐ No	
4. Does the person have a choice of roommates: ☐ Yes ☐ No	
5. Does the person have freedom to furnish and decorate their sleeping or living units within the lease or other agreement: ☐ Yes ☐ No	
6. Does the person have the freedom and support to control their own schedule and activities: ☐ Yes ☐ No	

7. Does the person have the freedom to access food at any time: ☐ Yes ☐ No	
8. Can the person have visitors of their choosing at any time: ☐ Yes ☐ No	
9. Is the setting physically accessible to the person: ☐ Yes ☐ No	

Successor Guardianship and Caregiver Planning

Waiver Recipients Participation in ISP Development

Signatures		
Meeting Participant Name	**Role**	**Signature**

Appendix A: Employment Exploration

1. **What's your biggest question about working or having a job:**

2. **Imagine yourself working. What would you be doing:**

3. **What worries you about getting a job:**

4. **What's the best thing that can happen if you get a job:**

5. **What strengths, skills, or interests do you have that you could use at a job:**

6. **How do your family and friends feel about you getting a job:**

7. **Do problems with transportation affect your ability to work?** ☐ Yes ☐ No ☐ Unsure

8. **Do you have any other thoughts about getting a job that we have not already discussed? If yes, briefly describe:**

9. **Are you interested in supports for getting and keeping a job?** ☐ Yes ☐ No ☐ Unsure

10. **List any vocational assessments performed:**

11. **Next steps:**