**[Manager]’s**

**Individual Service Plan**

**[Publish Date]**

This cover page is customizable but **must present** information regarding the individual and provide **a quick snapshot** of who they are.

* This could be five quick facts
* Photo of the individual, or photos they took
* How to support the individual
* Vision for the future
* Medical awareness
* Effective communication



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# Demographics

|  |  |  |  |
| --- | --- | --- | --- |
| **LEGAL NAME:** | Legal Name | **PREFERRED NAME:** | Preferred Name |
| **DMH ID #:** | DMH # |  **PRONOUNS:** | Choose an item. |
| **IMPLEMENTATION DATE:** | [ISP Date | **DATE OF ANNUAL MEETING:** |  |
| **VOTER STATUS:** | Choose an item. | **DOB:** | DOB |
| **LEGAL ISSUE:** |  | **RIGHTS RESTRICTIONS:** | Choose an item. |
| Choose an item.:  | [Date or N/A] | **LOC:** | [Date or None] |
| **LAST HRST SCREENING:** | [Date or None] | **DRIVER’S LICENSE/STATE ID:** | Choose an item. |
| **PROGRAM:**  | Choose an item. Choose an item. |
| **MEDICAID WAIVER:** | Choose an item. | **WAIVER SLOT #:** |  |
| **PRIMARY CIMOR Dx:**  |  |

|  |  |
| --- | --- |
| **Individual’s Address:** |  |
| **County:** |  |
| **Phone Number:** |  |
| **Email:** |  |

|  |  |
| --- | --- |
| **Legal Guardian:** | Legal Guardian |
| **Address:** |  |
| **Phone Number:** |  |
| **Email:** |  |
| **Relationship:** |  |
| **Legal Status:** | Define Guardianship |

|  |  |
| --- | --- |
| **Interested Party:** |  |
| **Address:** |  |
| **Phone number:** |  |
| **Email:** |  |
| **Relationship:** |  |

|  |  |
| --- | --- |
| **SERVICE COORDINATOR:** | [Abstract] |
| **SC PHONE:** |  |
| **SC EMAIL:** | @chs-mo.org  |
| **TCM AGENCY:** | Center for Human Services |
| **TCM AGENCY CONTACT:** | 314.978.5833 |
| **REGIONAL OFFICE** | SLRO |

# [Subject]’s Vision for a Good Life

## What does a good life look like for [Subject]?

1. Description of what the individual thinks is important to have a good life. (Example questions: **What does it mean to have a good life?** What do you like about your life? What would you like to change in your life? Example: It’s important people are kind to me OR because Joe is nonverbal, his mother’s best guess is expressing himself through drawing is important to him).

## What is the best way to support [Subject]?

1. A description of how supports should be delivered: Describe what works and does not work in supporting the individual. What does staff need to do to keep the individual safe and healthy? Characteristics of preferred support. (Example: Individual does not want to follow doctor’s orders, but staff should encourage individual to follow them. OR the individual has no fear when crossing the street. It is important for staff to hold individual’s hand when crossing the street. OR individual doesn’t answer questions right away, so staff need to give them more time to respond).
2. How to best support the individual in learning a new skill? (How do you want staff to interact with you? How do you want to learn something new? (example: shown then watch; read about it)

## Who is important to [Subject]?

1. Relationships which can help individuals achieve outcomes and goals: natural supports (friends, spouses, children), paid staff, etc. (Who do you hang out with who are not staff?)
2. These are question prompts to start a conversation. Use when appropriate.
	1. Are there any relationships that [Subject] may want to enhance or explore?
	2. Does [Subject] have a way to express their sexuality and choices regarding love and intimacy?
	3. Does [Subject] want to get married and/or have children?

## Vision for the Future:

1. What would the individual like to try?(This is a mandatory question to ask).
2. Individual’s goals, dreams, hopes, wants?
	1. Question prompts to start a conversation to see what they would like their future to look like: What would the individual like to learn? What would the individual like to improve? Are there any skills the individual would like to obtain? What are the steps you need to take?
	2. If person is total care or nonverbal, state the person cannot communicate their vision due to \_\_\_\_\_\_, so family/caregivers’ best guess/belief is person wants \_\_\_\_\_\_\_\_\_\_\_\_.
3. Guardian/Family’s vision of present and future care (If they have a guardian this is a mandatory question to ask).
	1. What does the family see as the individual’s goals, dreams, etc.?
	2. What supports does the guardian envision for the individual in the future?
	3. Differentiate what is important to the guardian/family if different from the individual.

|  |  |
| --- | --- |
| Likes and Preferred Activities | Dislikes and Non-Preferred Activities |
|  |  |

## Cultural Information:

1. Information that “reflects cultural considerations of the individual…” – religious preferences, cultural preferences, favorite holidays, or traditions, etc.

## Personal Strengths and Assets:

1. Skills, abilities, knowledge, attributes, passions, hobbies, etc.

# Daily Life and Employment

## Living Arrangement:

1. Are they living at home, with roommates, group home, etc.?
2. Residential Only: State if overnight staff is awake or asleep. OR if they do not have overnight staff.

## Typical Routine: (Delete if not needed)

Is there anything the person needs to do each day at a specific time or in a particular order?

## Supports Needed within the Home:

1. Write a summary of supports needed for ADLs and IADLs, address:
2. Self-care (what they cannot do)
3. Support preferences (how to help with what they cannot do)
4. Describe what supports are effective
5. What adaptive equipment do they use? - Wipes, diapers, glasses, braces,

medical bed, etc.

1. Sanitizing supports

**OPTIONAL TOOL**: Use the table in the template. If the person is independent in the areas, leave blank. If they are not independent, within the box next to the support need write the needed support.

|  |
| --- |
| **Activities of Daily Living**[Subject] is independent in skill area if left blank. |
| Bathing |  |
| Toileting |  |
| Grooming |  |
| Dressing |  |
| Extension of therapies and exercise |  |
| Skin care |  |
| Care of adaptive equipment |  |
| Meal preparation |  |
| Feeding |  |
| Incidental household cleaning and laundry |  |
| Cleaning and sanitization and infectious disease supports |  |
| Assistive technology |  |
| Other |  |

## Communication:

1. Primary language used: mandatory if primary language is anything other than spoken English.
2. Method of communication: mandatory if primary mode of communication is other than speaking such as communication boards, interpreters, etc.
3. Communication chart may be used to describe supports when they are trying to figure out how an individual is using their communication: contingent. Use the table for any nonverbal communications if needed.

|  |  |  |
| --- | --- | --- |
| If [Subject] does this… | It means this… | Then do this… |
|  |  |  |
|  |  |  |
|  |  |  |

## Socialization Skills:

1. Can they obtain a friendship? What supports are needed to maintain the friendship?
2. Social media, are supports needed?
3. How do you interact with people around you?

## **Education**: (Delete if not applicable)

\*\*If the individual is currently in school or if educational information is relevant to understand the individual’s current needs.

What grade is the individual in?

What educational supports are in place and why? (e.g., IEP, 504 Plan, Speech Therapy, etc.)

**Employment is required. Please choose a section based on the individual’s age.**

*If your person is 13 or under (generally, this is kids in Pre-K, K-5 and 6, 7, and 8 grade) please, use the following.*

## Employment:

* What do you want to be when you grow up? How are you exploring that career?
* Do you know what education you need to be able to do that career?
* Who in your life might be able to teach you more about this career?
* Are you choosing any of your classes at school?

What is being done with the individual, schools, family to:

* Develop self-determination skills? Develop social and other “soft skills” that are critical to success? Develop, improve, and practice independent living skills?
	+ Are you provided the opportunity to complete tasks/chores on your own or at school?
	+ Are you involved in any community service club that builds life skills like Boy Scouts, Girl Scouts, 4-H, or Campfire?
* Explore interests, aptitudes, abilities, and understanding adult roles?
	+ Have you had the opportunity to observe and explore potential careers? Have you visited any businesses with these careers?
	+ Have you done any skills assessments with school or your clubs?

**Mandatory Canned Statement**: The individual and caregivers have been given information and resources to support their understanding of disability benefits and employment to make informed choices on asset development and financial literacy.

* Disability Benefits 101 - <https://mo.db101.org/>
* Promoting Employment: <https://dmh.mo.gov/dev-disabilities/programs/promoting-employment>
* My Next Move: <https://www.mynextmove.org/>

**(End of Employment Section for People under 13)**

*\*\*If your person is 14 and older (people in generally 9 – 12 grade and beyond), please use the following.*

## Employment:

* What do you want to do for a living? How are you exploring that job?
* Do you have a job now?
* Do you know what education you need to be able to do that job?
* Who in your life might be able to teach you more about this job?
* Are you choosing any of your classes at school?

What is being done with the individual, schools, family to:

* Develop self-determination skills? Develop social and other “soft skills” that are critical to success? Develop, improve, and practice independent living skills?
	+ Are you provided the opportunity to complete tasks/chores on your own or at school?
	+ Are you involved in any community service club that builds life skills like Boy Scouts, Girl Scouts, 4-H, or Campfire?
* Explore interests, aptitudes, abilities, and understanding adult roles?
	+ Have you had the opportunity to observe and explore potential careers? Have you visited any businesses with these careers?
	+ Have you done any skills assessments with school or your clubs?
* Do you have a driver’s permit, driver’s license, or are you learning to drive?
	+ Identify accommodations that will be needed
* Are you able to communicate your wants, needs, and desires with others?
* Have you utilized DB101 or completed other benefits planning consultation?
* Do you understand your education and employment rights?
* Are you knowledgeable of the support and services available to you through:
	+ School Transition Teams?
	+ Vocational Rehabilitation?
	+ Centers for Independent Living?
	+ Division of Developmental Disabilities?
* Do you know the types of jobs available in your community?
* Do you know the accommodations or support you need to assist you with maximizing your independence?
* Do you have a preferred learning style?
* Are you supported in having instruction which is aligned with this learning style?
* Do you have enough information to be empowered with potential career decisions?
* Do you have a specific job goal?
* Do you know the specific skills you would need to perform your job goal?
* Is additional training and assistance needed to develop your skills for employment?
* If you have a job, do you like your job?
* Is the career planning/employment activity you currently participate in your choice, reflect your preference, and optimize your independence?
* Do you know how to complete an application form?
* Do you have a current written or video resume?
* Are you able to contact potential employers on your own?

If adult (finished with school) and NOT working:

•Describe rationale for excluding employment as an outcome.

•Outline the activities, experiences, and conversations that will occur with the individual in promoting future career planning outcomes.

•Reference how a person can start exploring career options if they change their mind in the future.

TABLE IS MANDATORY If adult (finished with school) and working

|  |  |
| --- | --- |
| **Status:** | Choose an item. |
| **Name of Current Employer:** |  |
| **Job Title:** |  |
| **Average Hours Worked Per Week:** |  |
| **Competitive and Integrated Setting?** | Yes or No If not in an integrated setting, state why.  |

Contingent mandatory if receiving waivered employment services (Career Planning, Supported Employment, Job Development, Prevocational Services, Supported Employment.)

* What other resources were attempted or used to show the waiver is the payer of last resort?
* Describe how natural supports are being developed and specific-targeted job skills are being developed. Include the methodology for evaluating the need for continuation of services.
* Individuals in Group-Supported Employment: document the justification for Group-Supported Employment if the individual demonstrates the capacity to work in an individual setting similar to those not receiving HCBS services.

Mandatory Canned Statement: The individual and caregivers have been given information and resources to support their understanding of disability benefits and employment to make informed choices on asset development and financial literacy.

* Disability Benefits 101 - <https://mo.db101.org/>
* Promoting Employment: <https://dmh.mo.gov/dev-disabilities/programs/promoting-employment>
* My Next Move: <https://www.mynextmove.org/>

**(End of Employment Section for People over 14)**

# Safety and Security

## Supports for Potential Dangers:

1. Kitchen safety skills, adjusting water temperature, chemicals: contingent – only address issues not age appropriate and define the supports needed. If the person is left at home alone for any length of time, what could be a potential danger? What is the individual’s capability to respond to emergencies (medical or weather-related), answering the door to strangers, calling 911, releasing personal information over the phone, elopement concerns, etc.

## Mobility Needs:

1. Mobility support needs, falls, supports and adaptations for evacuations, etc., in the home and community. Define mobility needs or supports required to access the community, include any frequency data, precautions, and/or supports needed outside the home. Mandatory if those supports are needed. What assistance do they need walking in community-based settings indoor or outdoor?

## Altered Levels of Supervision or Restrictions: (Delete if not applicable)

1. Use the Altered Levels of Supervision or Restrictions table and/or Rights Restriction table found in the Appendices section of ISP template on SharePoint.

# Healthy Living

|  |  |
| --- | --- |
| **CIMOR Dx:** |  |
| **MEDICAID:** | Choose an item. | **PRIVATE INSURANCE:** | Name of plan  |
| **MEDICARE:** | Choose an item. | **DENTAL:** | Name of plan  |
| **OTHER:** | (Burial, life insurance, etc.) |

|  |  |
| --- | --- |
| Allergies and Sensitivities | Reaction |
|  |  |
|  |  |
|  |  |

|  |  |  |
| --- | --- | --- |
| **Physician/Specialist** | **Contact** | **Frequency** |
|  |  |  |
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|  |  |  |

## Current Health:

1. Current Health History (within the last two years) – this includes any OT, PT, Speech, Vision, etc.
2. Who assists the individual with medical appointments? Can they schedule their own appointments or who/how are they assisted?
3. Is the individual able to communicate when they are not feeling well, in pain, or illness? What level of support do they need?
4. COVID-19 information applicable to the individual.
5. Is StationMD an appropriate service for this individual?
	1. If they decline: The Health Assessment and Coordination (HAC) service, a consultative telemedicine service provided by StationMD and available through the Medicaid waiver, has been offered to Preferred Name and has been declined, so StationMD should not be contacted for Preferred Name.

**Health Risk Screening Tool:** *Please note HRST information can be left out of plans for individuals without waivers*.

Choose one:

Canned Statement: The HRST was declined on DATE and the declination form is in the HRST system. Delete if not applicable.

Complete the table regarding the documents attached to this document when submitting the ISP to your team’s Admin. The SC will create and download these files from the HRST system for clients in natural homes. For individuals in residential, the SC will download documents from the HRST system and attach to the ISP.

|  |  |
| --- | --- |
| **Diagnosis and Undiagnosed Conditions Listing** | Choose an item. |
| **Medication Listing** | Choose an item. |
| 1. **HRSP: Functional Status**
 | Choose an item. |
| 1. **HRSP: Behavior**
 | Choose an item. |
| 1. **HRSP: Physiology**
 | Choose an item. |
| 1. **HRSP: Safety**
 | Choose an item. |
| 1. **HRSP: Frequency of Services**
 | Choose an item. |
| **HRST Scoring Summary**  | Choose an item. |

\*\*Scoring summary should always be included if the HRST was completed. On the Scoring Summary Page, click on PDF page below the last rating update date. This will give you the Scoring Summary that will include the areas of risk for the person and any notes specific to that person in the screen.

## Emergency and Safety Needs:

1. Choking precautions (with any protocol), skin breakdowns, bowel problems, dehydration, seizures, etc.: mandatory if known or suspected
2. Is there a DNR? If appropriate to ask.
	1. Do they have hospice care?

## Medications, Treatments, or Procedures:

1. Must identify purpose of medications, treatments, or procedures: contingent if they have them. You do not need to list out medication names.
2. Self-administration of medications/first aid or supports needed (is the person learning to do on their own?): contingent on if they take medications or age appropriate to apply first aid
3. Location of detailed instructions on equipment or medical care (seizure, dietary, medication management): contingent
4. Canned statements. Prompt 1 *and* this canned statement must be in the ISP.
	1. If residential, it can say: Updated list of medications can be found in the Medication Administration Record (MAR).

## Adaptive Equipment:

1. What adaptive equipment do they use? - Wipes, diapers, glasses, braces, medical bed, etc.

## Health History:

1. History not present at the current time but is still relevant for caregivers to know – such as: past physical illnesses (examples; past surgeries, healed wounds, past fractures or other significant injuries, bowel obstructions or impactions, etc.).
2. Past mental illnesses, traumatic experiences, or lifestyle stressors.

Canned Statement if there is no applicable history: [Subject] does not have health history relevant to support or improve his/her/their care.

*Family Medical History:* Delete if not applicable

Anything pertinent and relevant to the person’s care.

## Individuals with Residential Services: (Delete this section if no residential services)

*Annual Screenings:*

1. Medical, vision, hearing, oral care conditions, supports per HIPS process including immunizations and cancer screenings: mandatory. Canned statement can be used: Individual is supported by the provider to attend all medical, vision, hearing, and dental appointments. Provider will assist individual to be current on all immunizations, cancer screenings, and any specialized appointments required by the doctor.
2. Indicate how dental is paid for.

*Professional Assessment Monitoring (PAM):*

1. Discuss the need for monthly RN services.
2. Canned statement can be used:
	1. [Subject] receives the standard amount of time of community RN services, which is 1.25 hours per month. The RN service will oversee medication administration, provide staff training, monitor overall health management, and ensure DMH compliance.
	2. Agency RN will also have and follow policy and procedure for monitoring [Subject] for side effects of psychotropic medications.

## Fitness and Nutrition:

1. Dietary or fitness needs: mandatory if they have a specific health diet or health order prescribed by a doctor. Canned statement can be used if there is no specific fitness or nutritional need: [Subject] is on a regular diet and exercise regimen.

## Behavioral and Mental Health:

1. If no behavioral health concerns, state There are no current behavioral or mental health concerns. This must be addressed. You may stop in this section if no further information is valid.
2. Sensory information: mandatory if applicable
	1. Light, sound/noise, touch, texture, food, etc.
3. Behavioral
	1. Self-injurious, bolting, wandering, aggressive behaviors, elopement, property destruction, etc.
	2. Counseling/therapy, psychiatry, or other
4. PRN psychotropic medication protocol: contingent
5. Behavioral Planning (mandatory if applicable)
	1. Location of Crisis Safety Plan: contingent
	2. Functional Behavior Assessment attached to ISP: contingent
	3. Behavioral Support Plan attached to ISP: contingent

# Community Living

## Community Access:

1. Can the individual communicate their need for assistance?
2. If the person were left alone in the community, what could be a potential danger?
3. Does the individual need support with social distancing?
4. How does the individual get to different places? Can they do so independently or need assistance?
5. What places would they like to go? Community resources (gyms, clubs, etc.), that may be used by the individual to achieve outcomes and goals.
6. Are there mobility supports needed while in the community? What supports or adaptations are needed?
7. Does the individual understand emergency and evacuation procedures in the community?

## Housing Choice: (Delete if no residential services)

1. Reflect that the setting in which the individual resides is chosen by the individual. The housing is documented in the ISP based on the individual’s needs and preferences.
2. What resources were considered when given options for residential room and board? What housing resources were explored (vouchers, etc.)? Was the individual informed of necessary information about all choices? Are they knowledgeable of other providers who provide the services they receive? Do they know how and to who to make a request for a new provider?
	1. In addition to addressing the above questions, canned statement can be used: Individual/Guardian were provided various choices on residential options, and they make the choice on what residence best meets the individual’s needs. Individual’s income is limited, and individual/guardian takes this into account when making housing decisions.
3. Do you like who supports you? If not, do you know how to request a change?
4. For HCBS Rule, the Service Coordinator must go over Community Living and Choice Housing ISP Questions for all residential for the first year and for all residential moves: The Service Coordinator reviewed the *Community Living and Choice of Housing ISP exploratory questions* to ensure the individual has chosen where they live, has privacy, and has the support they need within their home.

## Community Transition: (Delete if not applicable – Refer to the *Community Transition Guide*)

*Community Transition Guide* can be found on the DMH website.

1. Include current information regarding the change in living situation. It must include adequate supports for health and safety and to minimize difficulty in adjusting to any changes in their life that may occur with the change in living arrangements or supports.
2. “Money follows the person” paragraph if transitioning from nursing home or habilitation center and participating in “money follows the person.”
3. Additional back-up plans should be noted.
4. Identify all supports, services, accommodations, equipment, furnishing, etc., needed for the individual to be successful in the community.
5. The Service Coordinator must review the Housemate Compatibility Tool during the planning process to ensure a smooth transition and it will be shared with the planning team.

# Citizenship and Advocacy

## Rights and Advocacy:

1. How did the individual participate in the ISP meeting?
	1. If they did not attend, state why they did not participate AND how you obtained their input into the plan.
2. Do they have a guardian? Full or limited guardianship? Power of Attorney?
3. If they have a guardian, are they interested in obtaining their rights back? Are they aware of how to gain their rights?
4. Voting rights if 18 and older: Are they interested in voting? Do they understand and want to participate in the process or specific causes? Are there any causes/issues the individual would like to participate in?
5. Handbook Conflict Resolutions – mandatory canned statement:

Resolution Strategies and individual rights information for [Subject] are in the CHS Service Coordination Handbook and reviewed annually. Anonymous complaints can be made to the DMH Office of Constituent Services:

* + - 1-800-364-9687
		- TTY: 573-526-1201
	1. Handbook Reminder – The SC needs to offer alternatives in reading or understanding the Handbook (reading, hitting the highlights, offering Braille, or audio)
1. Provide dissenting opinions of team members: mandatory if dissenting opinion. (Example: Individual wants to work, but residential staff cannot go with them to check blood sugar; so individual is kept at home because there is no one at the workshop to assist the individual with checking their blood sugar. Half the team wants the individual to work and other half does not).

### Transition to Adulthood (Delete if individual is an adult or under 16 but can discuss earlier if appropriate)

1. If the individual is near 18, was the family provided guardianship or alternative [guardianship information](http://moguardianship.com/) (supported decision-making, etc.)?
2. If they have a waiver, discuss the waiver transition.
3. Medicaid, discuss the transition from child to adult, or applying for Medicaid as an adult.
4. Supports needed in preparation of application for SSI: mandatory for School Transitional age 17.

## Financial Awareness and Support:

|  |  |  |
| --- | --- | --- |
| **FINANCIAL INFORMATION:** |  |  |
| **SSI:** | $ | **CHECKING/SAVINGS:** | N/A |
| **SSA:** | $ | **OTHER: (LIST WHAT IS RECEIVED):** | Examples: HUD, HEAP, SNAP, METRO, etc. |
| **PAYEE:** |  | **SPENDDOWN:** | $ |
| **PAYEE CONTACT INFORMATION:** | List the phone number or email address | **PERSONAL SPENDING:** | $ |

1. What money skills do they have/need to work on? Are there financial needs not being met? Is the individual vulnerable to financial exploitation?
2. Supports needed to maintain benefits (EBT, SSI, SSA, Medicaid, Medicare, Special Needs Trust Funds, ABLE account, etc.): mandatory (who is helping to reapply, etc.?)
3. Is the person aware they can request a change to their payee?
	1. If SLRO is the payee, are discussions occurring regarding changing to a different payee?

## Financial Information for Individuals with Residential Services: (Delete this section if no residential services)

### Supports needed to manage funds:

1. For NAFS with RO as payee – Regional Office (RO) is [Subject]’s payee, and [Subject] has access to monies left over after paying expenses, which are kept in a NAFS account at RO. If [Subject] has any needs or wants, such as new clothes, household items, personal items, or fees for activities, the Service Coordinator will make a request for expenditures and send to RO to complete a NAFS request.
2. Information regarding how the individual wants to spend/save their excess funds after daily living expenses are paid (dental insurance, leisure activities, etc.). Mandatory
3. Personal Spending Money – how is it controlled and how can the individual access the money?

### Personal Finances: If the person has someone other than the Regional Office as payee, please enter information into the sentence below and then delete the personal finances budget table.

\_\_\_\_\_\_\_\_is the individual’s representative payee. All financial obligations and decisions will be made between the provider of service and \_\_\_\_\_\_\_\_, the representative payee. CHS case management will not monitor nor be responsible for these funds.

### Personal Finances:

|  |  |  |  |
| --- | --- | --- | --- |
| Monthly Income Source | Amount | Monthly Expense | Amount |
|  | $.00 | Rent: | $.00 |
|  |  .00 | Utilities: |  .00 |
|  |  .00 | Food and Household supplies: |  .00 |
|  |  .00 | Laundry: |  .00 |
|  |  .00 | Maintenance: |  .00 |
|  |  .00 | Other regular monthly expenses: |  .00 |
|  |  .00 | Spenddown:  |  .00 |
|  |  .00 | Personal spending:  |  .00 |
|  |  .00 | Ongoing medical/pharmacy:  |  .00 |
| **Estimated Total** | **$.00** | **Estimated Total** | **$.00** |

# Review of Previous Year Outcomes

1. Review the previous plan’s outcomes and general review of budget.
	1. Include information on increases or decreases.
2. If there is a reason why they did not use funds, include the reasoning here – if they couldn’t find a PA provider, day program didn’t work, or asking for medical exception, etc.).
3. Brief review of services that were tried but not effective.
4. For new intakes, canned statement: This is [Subject]’s initial ISP, and there are no outcomes to review.

# Personal Outcomes

1. One outcome MUST be identified in the plan. Person-Centered Outcomes need to reflect what the person wants to learn or improve over the ISP year. The outcomes must reflect who the person is.
2. To determine if a Person-Centered Outcome is required, visit: [CHS - STLMetro - Services Requiring Personal Outcome.pdf - All Documents (sharepoint.com)](https://chsmoorg.sharepoint.com/sites/CHS-STLMetro/Shared%20Documents/Forms/AllItems.aspx?id=%2Fsites%2FCHS%2DSTLMetro%2FShared%20Documents%2FService%20Coordinator%20Resources%2FUR%20Forms%20%26%20Info%2FServices%20Requiring%20Personal%20Outcome%2Epdf&parent=%2Fsites%2FCHS%2DSTLMetro%2FShared%20Documents%2FService%20Coordinator%20Resources%2FUR%20Forms%20%26%20Info) If the service does not require a Personal Outcome, describe what the goals for the service are under *Services Requested* section.
3. If the Provider is CHS for Service Coordination, refer to *ISP – Support Outcomes, ISP Service Coordination Imp Strategies, or the Personal Outcomes – CHS Training* documents in the Appendices section of the ISP Template folder on SharePoint.

|  |  |
| --- | --- |
| **Provider** | **Service** |
|  |  |
|  |  |

|  |  |
| --- | --- |
| **Personal Outcome:** |  |
| **Individual’s definition of the outcome:**  |  |
| **Current Situation:** |  |

|  |  |
| --- | --- |
| Goal 1 |  |
| Strategies for Implementation | Per ISP Guide effective February 15, 2018, the provider responsible for providing the service(s) used to help the individual to achieve the personal outcome and related goals will develop the implementation strategies. This can be found at the provider service location and will not necessarily be part of this document. |
| Measure of Success: |  |
| Who is Responsible? |  |
| Estimated Completion Date |  |

|  |  |
| --- | --- |
| Goal 2 |  |
| Strategies for Implementation | Per ISP Guide effective February 15, 2018, the provider responsible for providing the service(s) used to help the individual to achieve the personal outcome and related goals will develop the implementation strategies. This can be found at the provider service location and will not necessarily be part of this document. |
| Measure of Success: |  |
| Who is Responsible? |  |
| Estimated Completion Date |  |

# Self-Directed Services (Delete if not applicable)

* SDS template can be found in the appendices section of the ISP template file in SharePoint.

# Services Requested (Delete if no services)

Does this require Utilization Review?

1. Justification
2. Is there an exception to the funding budget?
3. If the service requested does not require a Person-Centered Outcome, describe what the goal(s) are of the service. This is not required if there is a Person-Centered Outcome completed for the service.
4. If a new service, how does the individual feel about the services being requested?
5. Information about State Plan services - These supports shall be accessed prior to Division-funded Personal Assistance supports-mandatory. Canned statement may be used: The Service Coordinator/Resource Specialist/Family called State Plan Services to complete the referral with (name) on (date and time), and individual did not qualify.
6. Information about enrollment in non-division waiver programs: mandatory – VR support, DESE, DHSS, etc. Include if they applied to any of these programs, but they do not qualify.
7. Information about community-based supports being accessed or used (clubs, gyms, library, etc.): mandatory

# Choice of Provider and Option of Self-Directed Services (Delete if no waiver)

1. How was the individual educated and informed of the options list in the Medicaid Waiver Choice form: mandatory for all waivered recipients?
2. How the individual was educated and informed of the full range of HCBS available to support achievement of personally identified goals: mandatory for all waivered recipients
3. Records the alternative home- and community-based settings that were considered by individual: mandatory for all waivered recipients
4. The below canned statement should satisfy 1 – 4 (MAKE SURE YOU CHANGE INDIVIDUAL TO THE PERSON’S NAME): The individual and/or guardian were given the Provider Choice Listing and self-directed services information during the annual plan meeting and selected Provider Name for \_\_\_\_\_\_\_ services. The CHS Service Coordination Handbook is given out annually listing all waivers and services. Furthermore, the individual and/or guardian were given choices for alternative home- and community-based settings including living in a natural home, Individual Supportive Living, Shared Living, and/or Host Home.

# Budget Summary of DMH-Funded Services for Date Range

(Delete below statement if Personal Assistance is **not** authorized).

Division of DD-funded services will not supplant or duplicate those of State Plan services. Referrals for state plan Personal Assistance will not be made when the intent is to teach, prompt, or accompany the individual into the community.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **FUNDING SOURCE** | **PROVIDER** | **SERVICE** | **UNITS** | **COST/UNIT** | **TOTAL** |
|  |  |  |  |  | $0.00 |
|  |  |  |  |  | $0.00 |
|  |  |  |  |  | $0.00 |
|  |  |  |  |  | $0.00 |
|  |  |  |  |  | $0.00 |
|  |  |  |  |  | $0.00 |
|  |  |  |  |  | $0.00 |
|  |  |  |  |  | $0.00 |
|  |  |  |  |  | $0.00 |
|  |  |  |  |  | $0.00 |
|  |  |  |  |  | $0.00 |
|  |  |  |  |  | $0.00 |
|  |  |  |  |  | $0.00 |
|  |  |  |  |  | $0.00 |
|  |  |  |  |  | $0.00 |
|  |  |  | **TOTAL COST** | **$0.00** |

* No need to recap the table of units and dollars above but use this space to define the frequency of service delivery - how many hours per week/per month expected.

 Examples:

* + Personal Assistance: 12 hours per week, not to exceed 624 hours annually.
	+ Community Networking: Eight hours per month on average; not to exceed 96 per year.

# [Subject]’s Summary of Non-DMH Services

|  |  |  |  |
| --- | --- | --- | --- |
| **FUNDING SOURCE** | **PROVIDER** | **SERVICE** | **UNITS** |
| Medicaid (if the person has it) | Center for Human Services | Service Coordination | As Needed |
| DESE | Vocational Rehabilitation | Employment Services |  |
| DESE | School District | Education, IEP, etc. | Ongoing |
| County Funding |  | Respite, ILAP, Horseback riding, etc. |  |
| Medicaid |  | Nursing | Frequency |
|  |  |  |  |
|  |  |  |  |

[Subject] receives service coordination from Center for Human Services. Service Coordinators will maintain contact by Choose an item. throughout the ISP year as required to monitor the plan and make changes as requested. At any time, the Service Coordinator can be contacted by any team member to make needed changes to the ISP. If at any time [Subject] is unhappy with the services, the Service Coordinator should be contacted. Center for Human Services, as a provider of service coordination, will ensure all employees will act in the best interest of [Subject] and no conflict of interest occurs.

## Individuals who participated in the planning meeting:

(List the name and title/role of all people who participated in the meeting).

cc: Proofed:

|  |
| --- |
| Designated Record Set |
| Individual | [Manager] | Email: |
| Guardian |  | Email: [Company Phone] |
| Provider(s) |  |  |

# Historical Appendix

This is optional and needs pertinent information only.

My signature below gives consent for the delivery of services as outlined in [Manager]’s Individual Support Plan dated [Publish Date], which I have reviewed, approved, and received a copy.

|  |  |
| --- | --- |
|  |  |
| Individual’s Signature, if applicable | Date |
| [Manager] |  |
|  |  |
|  |  |
| Service Coordinator Signature | Date |
| [Abstract] |  |
|  |  |
|  |  |
| Guardian Signature, if applicable | Date |
| [Title] |  |
| Guardian Printed Name |  |

I have reviewed and agreed to implement the [Publish Date] Individual Support Plan for [Manager] as written.

|  |  |
| --- | --- |
|  |  |
| Provider Signature | Date |
|  |  |
| Agency Name |  |
|  |  |
| Provider Signature | Date |
|  |  |
| Agency Name |  |
|  |  |
| Provider Signature | Date |
|  |  |
| Agency Name |  |