SOUTHERN ALLEGHENIES
Service Management Group

157 Lakemont Park Blvd. Altoona, PA 16602
Phone: 814-949-2912 Fax: 814-949-2916

Blair County
Best Practice ISP

2025 Version

Information gathered in this document includes an assessment of health and safety issues, personal preferences, priorities and needs that promotes a person centered planning process in developing outcomes, and positive approaches in supporting the person.

Color Code:
Red and Blue are Blair County added tips
Yellow Highlights are Blair County reminders

Office of Developmental Programs

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You can use the links below to quickly access an area of the ISP.

Instructions

Begin Plan

Individual Preferences

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

Medical

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

Health and Safety

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

Functional Information

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

Financial

- Financial Information
- Financial Management Issues
- Financial Resources

Services and Supports

- Outcome Summary
- Outcome Actions

Monitoring

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***Annual Review Update Date** (mm/dd/yyyy)	**Match date with ISP Signature Page (END of plan year)**
***Annual Review Meeting Date** (mm/dd/yyyy)	**Match date with ISP Signature Page (current plan year)**

***Category of Plan Changes** – The ISP shall be revised if there has been no progress on an outcome, if an outcome is no longer appropriate, or if an outcome needs to be added. If the plan changes are a result of changes in the person's circumstances, determine if a revised Prioritization of Urgency for Needs (PUNS) is necessary.

Select the appropriate checkbox:

ISP Status	
Fiscal Year Renewal – Used to renew the ISP for the following FY. The ISP service details will reflect a FY Begin date of July 1 and a FY end date of June 30.	☐
Critical Revision – Used when supports, services, or funding change in the existing or future plan. **DOCUMENT WHY IN WHAT MAKES SENSE/DOESN'T MAKE SENSE and in the COMMENT box prior to submission. (SC DOES THIS.)**	☐
Bi-annual Review – Used for ISPs requiring reviews 2x a year such as for Pennhurst Class members. Can be used to edit or update an existing plan. This option will not allow the Supports Coordinator role to modify the plan start and end dates.	☐
Plan Creation – Used when the plan is being created for the first time.	☐
Quarterly Review – Used for ISPs that must be reviewed at least every 3 months originating from the date of the Annual Review.	☐
General Update – Used to update information such as medical information. This should not be used when modifying services and supports.	☐
Annual Review Update – Used to update information from the annual review ISP meeting. The ARUD is based on when each person's initial plan was created – not FY dates.	☐
The person/family requested a limited service and an abbreviated plan: ☐ YES ☐ NO An abbreviated plan can be used for a person who is not enrolled in a waiver and receives limited services and supports under $2000.	
Reason for the abbreviated plan:	

BE SURE TO COMPLETE THE MONITORING FREQUENCY. IT IS LOCACTED IN CUSTOMER DEMOGRAPHICS.

The entire ISP is to be person centered, written for readers who do not know the person well, and a current and accurate description of what the person needs and wants to be healthy, successful, and be satisfied with their life. Teams are expected to include all people important to the person in the planning and writing of the ISP.

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PLAN: INDIVIDUAL PREFERENCES

The Preferences section provides an opportunity for the ISP team (and the reader) to learn and know more about the specific wants, desires, and ways to best support the person. It should identify what has been learned about the person's personality, desires, and priorities. The Preferences section is based on Person Centered Planning and is an excellent resource in guiding and supporting the rest of the planning process, including development of outcomes, and the identification of meaningful services and supports that are necessary to meet the person's needs.

PLAN: INDIVIDUAL PREFERENCES: LIKE AND ADMIRE	
What do people like and admire about the person? This is a list of attributes that other people like and find admirable about the person, such as positive traits, characteristics, ways of interacting, accomplishments, and strengths. This information sets the tone for the plan and should be gathered from multiple viewpoints. It is intended to highlight a person's admirable qualities and should only present his or her positive reputation.	**Should not be related to disability.** **Write as if you are introducing a friend.** **Keep positive and current – review/update yearly.** **Ask the person what they think people like and admire about them.**

PLAN: INDIVIDUAL PREFERENCES: KNOW AND DO	
What does the person/family think someone needs to know to provide support? Answering "What do people need to Know and Do to support the person?" describes information that people need to know and do in order for the person to get what is important to him/her or for him/her to stay safe and healthy. Consider everything that is important to the person to determine if there is something that those who support the person need to know and do. Be sure to ask the person and others who know the person the best. Discover what traits, habits, coping strategies, preferences for interaction and communication, relationships, types of activities, approaches, or reminders have been helpful to the person. Include supports needed for daily living skills and exploration of avenues that are or would be enjoyable to the person such as employment opportunities, establishing community connections, full participation in community life, voting, learning new skills or hobbies, connecting with other people, helping others (such as community volunteers), relationships, dating, etc. If more detailed information is elsewhere in the plan, such as in Health Promotion or Communication, include a statement that refers to that area of the plan. This section will be written a little differently for kids (under 18). Team can add a note that the section was reviewed and not changed much this year (due to…).	**Consider using outline concept or grouping details by heading (personal hygiene, employment, food, routines, etc.).** **Differentiate between need to know/need to do, OK to use bullets to identify CORE responsibilities. Organize this into themes such as health, activities, etc.** **Important "for" could go here also. Should list significant DISLIKES of the person. Things to avoid, possible triggers, things that haven't worked well, etc.** **Identify characteristics of the support staff best suited to work with this person; give real qualities needed for a good staff match. If the person needs male/female staff for specific reasons, can list that here.** **Consider this section the main training resource for supporters. If they read nothing else in the plan, what has to go in here so they can positively and successfully support the person?**

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PLAN: INDIVIDUAL PREFERENCES: DESIRED ACTIVITIES	
What are the activities that the person would like to participate in or explore? Activities that the person would like to continue, to begin, or to explore further should be documented in Desired Activities. This information can help the Support Team create outcomes with the person that can assist the person in exploring activities that are important to him or her, such as employment opportunities, establishing community connections, full participation in community life, voting, learning new skills or hobbies, things that are or would be enjoyable to the person, connecting with other people, helping others (such as community volunteers), relationships, dating, etc. Update this section at least yearly. Do not keep the info for years at a time (without checking with the person on what they want to do).	**Focus on EXPLORE – anything the person wants to try should be captured, even if it may not be feasible or successful immediately.** **If the person is already doing a desired activity and wants to continue, then put that in important to. Put details in an outcome.** **STRATEGIES to help identify potential desired activities:** **Create New Stretch** **Explore What else? Imagine** **Respectful guesses** **Address INCLUSION – paid and nonpaid with nonpaid friends?** **Licensed programs can add assessment info.**

PLAN: INDIVIDUAL PREFERENCES: IMPORTANT TO

The Important To section lists and prioritizes things that are important to the person. It describes things that need to stay the same in the person's life, and/or changes that would be important for the team to address. Only things that are important TO the person should be included here. What is important FOR the person can be captured in other areas of the plan such as in Health and Safety. For kids only (under 18): you can add important for them in this section. Add "FOR" in front of the entry.

This information should reflect who and what is important to the person in relationships with others and their interactions, in things to do or have, in rhythm or pace of life, or in positive rituals or routines. In addition, consideration should be given to: caring relationships, current job situations, employment opportunities, living arrangements, recreational community connections, spiritual needs, and faith preferences. These could include volunteering in the community and getting to know neighbors, etc.

Things that are important to a person should be linked to outcomes. **THIS IS THE HEART OF PERSON CENTERED PLANNING.**

Two levels of priority are tracked:

- Essential: Those things listed which must/must not be present in the person's life in order for a good day to occur.
- Strongly desired: Those things listed which would strongly contribute to the person's happiness but would not be detrimental to their well-being if not present.

When people seem/are content (especially as they age), this section may not change much from year to year.

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***Priority** (Strongly Desired or Essential)	***Important to Person**

PLAN: INDIVIDUAL PREFERENCE: WHAT MAKES SENSE

The What Makes Sense section of the plan is used to capture information about what experiences do and do not make sense in the life of the person RIGHT NOW. For example, ask the question "What currently makes the person's life experiences more meaningful or easier?" When referring to "what makes sense", an alternative expression may be, what is the "upside" right now in the person's current life experience that is present and needs to be maintained? "What doesn't make sense" may express things that currently occur but do not work and need to be changed.

"What makes sense" and "What Does Not Make Sense" are not necessarily opposites of each other. For example, a person may indicate what works in a day is having a nap and it doesn't work when the person does not get a nap. However, it may make sense that the person has a glass of milk every morning, but it is not necessarily true that it doesn't make sense when the person does not have a glass of milk in the morning.

This section is the aspect of planning that bridges the gap between the assessments of what is important to and for the person and the specific actions that will be taken to ensure those things occur in balance. This information helps to set the agenda for what should be changed and what needs to continue. It is based on the perspectives of multiple people who care about the person. This section is the groundwork for negotiating around areas of disagreement. It is NOT a wish list, nor is it a collection of things that are currently not happening, but what team members think might be helpful or enjoyable to the person. It is designed to be a "picture of current reality from multiple perspectives." **REVIEWED and UPDATED BY THE TEAM AT THE ANNUAL MEETING!**

This section can be easy to forget or not spend much time on. It is important! The person's opinion is separate from the team's and should be labeled as such. The team will need to use respectful guessing if the person doesn't communicate easily or clearly. This section should also relate to the outcome sections. The person and the team need to be honest. If there are differing opinions about what makes or doesn't make sense, create entries for each person/faction so that all information is captured. Create as many entries as needed.

***Whose Perspective** Identify whose view this is (person, family, or other team members).	**Write in PRESENT tense. What is happening NOW?**
What Makes Sense What works? What needs to be maintained/enhanced? What makes sense right now in the person's current life experiences?	**Develop themes to figure out how the plan will help.** **Supervisors will ask SCs to do a more extensive process for people not yet receiving supports (SC only plans or those in intent to enroll for waiver).**
What Does Not Make Sense What doesn't work? What needs to change? What must be different? (what does not make sense in the person's current life experiences).	**Do NOT write the opposite of what makes sense.**

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ALL INFORMATION IN THE MEDICAL SECTIONS MUST MATCH ANY PROVIDER ASSESSMENTS OR MEDICAL DOCUMEMENTATION FOR LICENSING PURPOSES.

PLAN: MEDICAL: MEDICATIONS/SUPPLEMENTS (AND TREATMENTS)

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

***Diagnosis** Record specific diagnosis or purpose of medication not the symptom. Examples: Arthritis (not pain), GE Reflux (not stomach acid), etc.	**Residential staff and primary caregivers are to provide this initial information, as well as updates. This includes family members and natural supports.** Check with prescribers for full diagnosis/ reason for medications. Autism is not a diagnosis for medication. Medication is used to treat symptoms of Autism – aggression, anxiety, etc.
***Medication/Supplement Name** Include prescriptions and over-the-counter medications and herbal or food supplements.	
***Dosage**	

***Frequency** (Mark correct one)

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

***Route** (Mark correct one)

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

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***Blood Work Required?** (Yes or No) Blood or other lab work as ordered by a prescribing physician. If you answer yes, record blood/lab work results in Special Instructions/Precautions. Include the month, year, and level of the drug. **Most recent on record. Indicate if it's low, high, or at a therapeutic level.**	
If Yes, how frequently? Document how often the physician wants the blood level checked.	
***Does the Person Self-Medicate?** (Yes or No) To be considered capable of self-administration of medications an person shall be able to recognize and distinguish their medication from among other medications; know how much medication is to be taken either by communicating or picking up the correct amount; and know when medication is to be taken (after breakfast, before bedtime, etc.). Staff assistance to open the container and remove the medication is permitted.	**DO NOT FORGET THIS**

Name of Prescribing Doctor (Last Name, First Name)	**REMEMBER to complete this section**
***Special Instructions/Precautions** Include situations in which not to use the medication, precautions when taking the medication, when to call the physician, parameters for use (example: heart rate over 70), and drug levels (including month and year).	**Add comment to VERIFY meds with MAR/EMR if applicable.**

PLAN: MEDICAL: ALLERGIES

Record all known

- **Allergies**- an allergy is a physical reaction to a substance that results in an itchy rash, hives or wheezing. Include allergies to food, insect bites or stings, seasonal, animal, latex, medications, etc.
- **Sensitivities and adverse reactions** – these are unusual reactions to a substance such as stomach bleeding with aspirin or nausea associated with particular medications such as Amoxicillin and other antibiotics
- **Medication contraindications** – these are medications that the person cannot take due to a known diagnosis such as if the person has peptic (stomach) ulcers, ibuprofen should not be taken. "For the Required Response," enter not applicable.

Do not leave the spaces blank. If there are no known allergies, sensitivities, adverse reactions, or medication contraindications record N/A for all three responses/fields.

Contraindications can include medications that the person or their team reports adverse reactions to – even if not medically verified – from historical experience. Always verify medically when possible.

***Known Allergy**	
***Reaction**	**Be as descriptive as possible.**
***Required Response**	**Make sure response is correct medically. Is it doctor ordered?**

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PLAN: MEDICAL: HEALTH EVALUATIONS

Include all known visits to any health care practitioner in the past 12 months. Examples include routine/scheduled or acute visits to practitioners such as primary care practitioners, cardiologists, dentists, etc. Medical contact information related to visits should be included in Medical Contacts.

Information should be 1 to 5 years old (preferably 1-2 at most).

Historically relevant treatment, appointments, diagnoses, etc. should be moved from this section to Physical Assessment. These should be written in past tense and not as currently happening.

***Type of Appraisal** (Physical, Dental, Vision, Audiological, GYN, Mammogram, Prostate, TB – Mantoux, Hearing, Psychiatric, Other – if other, specify) "Physical" should only be used for the annual physical.	**Show response to each type based on sex of person. General physical may contain screenings for some areas.**
***Specialist Type**	
***Medical Contact**	
***Was Diabetes Management Considered** (Yes, No, or N/A) Select "N/A" if the person does not have diabetes or it is not an appropriate question for this appraisal. If the person has been diagnosed with diabetes: • Select "Yes" if the person attended a diabetes education class; was taught how to manage their diabetes including blood glucose monitoring and control, diet, exercise, what to do during an illness, and screening for complications of diabetes such as eye and foot problems; or if the person works with a clinician around managing their diabetes. • Select "No" to indicate that the person is diagnosed with diabetes, but diabetes management was not considered.	
If Yes, enter details *Provide an explanation of the actions taken.*	
Date of Appraisal (mm/dd/yyyy)	**Need the most RECENT date.** **Can include the upcoming appointment date, if current date is close to expiring.**
***Frequency of Appraisal** (Weekly, Monthly, Quarterly, Every 6 Months, Yearly, Every 2 Years, As Needed)	**Must match the Health Evaluation/Appraisal Date and dates/info that are listed in any other section of the ISP.**
Person Responsible for Arranging/Completing (Person, Family, Provider, Other – if other, specify)	If provider is listed, update as often as necessary if/when provider is changed.

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PLAN: MEDICAL: MEDICAL CONTACTS

Include contact information for any current medical contacts such as doctors, dentists, psychiatrists, allied health professionals, specialists, etc. seen in the past 12 months.

The names of the doctors in the previous two screens should be listed in this section.
Update when doctors retire, change locations or practices, change phone numbers, etc.
Include Consultants (as appropriate) along with frequency of visits.

Be sure to delete contacts, when necessary, not just add/revise.

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

PLAN: MEDICAL: MEDICAL HISTORY

Current Health Status: List the date and reason for hospitalizations, surgeries, emergency room visits, and new adaptive equipment. Include any new diagnoses and related recommendations. List results of health evaluations, screenings, testing and blood work other than drug levels. Examples include: TB-Mantoux – normal or abnormal, hearing – normal or abnormal. If abnormal, include related recommendations. Briefly describe how the person's health compares to previous years.	**Do NOT record too much detail about minor health related events.** **Keep information to the past/current year.** **Anything older than five years should be deleted from the plan or moved to Physical Assessment.** **The fatal 5+1 can be listed in this section.**

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Developmental Information: Record the following: mother's pregnancy and the person's birth history; developmental milestones such as when the person walked, talked, sat up, fed him or herself, and learned daily living skills such as dressing and feeding skills; and cause or etiology of intellectual disability such as congenital or genetic syndrome, meningitis, traumatic brain injury, etc. Briefly describe how the disability and/or the diagnosis of the disability occurred. Include a brief family social history that may have impacted the person's development. A lifetime medical history should be completed in accordance with MR Bulletin 00-94-32 and updated annually. Indicate where the lifetime medical history is kept and how it can be accessed.	**Ok to expand beyond age 21, IF it makes sense and provides pertinent historical information; history of living/discharge from State Center. Major events that might be needed to support someone now, e.g. victim of abuse, trauma. Indicate presence of disability, first date of diagnosis, educational placement, etc.** **← Licensing requirements for residential and day programs to be completed by them.**
Psychosocial Information: Include all behavioral, mental health or psychiatric diagnoses, current symptoms such as mood and sleep patterns and related interventions and recommendations including medication changes (indicate if increased, decreased or different medication) and responses. List the date and reason for hospitalizations or emergency room visits related to behavioral health. Briefly describe how the person's behavioral health compares to previous years. For people that have either a diagnosis of a mental illness or receive psychotropic medication for treating a mental illness or problematic behavior and continue to have active symptoms or challenging behaviors, a comprehensive review should be completed as referenced in the OMHSAS & OMR Bulletin 00-02-16. Information from the review should be summarized here.	**When a person has a behavior support plan the Behavior Specialist should be the lead in providing info in this section.** **Any psych meds that are noted in this section must be current and align with what is listed in previous sections of the ISP.** **Information in this section needs to be current and necessary for successful supports and services. Do not keep information if it's not historically relevant.** **Do not promote a negative reputation "just in case" something would happen again.**

Physical Assessment

Capture chronic diagnoses or conditions that do not require medication, i.e. those that are not listed under Medications/Supplements. Select all relevant body system areas and provide a description.

Include historical information (more than a year old if not relevant to daily support and anything more than five years old). Important appointments from past issues can be housed here.
HCQU referrals and information can also go in this section.

* System Area		*Description
Vision: eyes	Integumentary: skin	Provide specifics about the body system issue and describe how to support the person. Example: wears glasses, needs assistance putting on glasses. **List NEWEST diagnosis at the top.** **Do NOT indicate treatment here.** **Use HCQU Focus Areas as references.**
Respiratory: lungs	Endocrine: glands, hormones	
Lymphatic	Cardiovascular: heart, blood vessels	
Dental	Nervous System: nerves, brain function	
Hearing: ears	Musculoskeletal: muscles, bones	
Digestive: stomach	Genitourinary: genitals, urinary function	
Blood System		

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Put "no known history" in areas without a diagnosis.	

Immunization/Booster

Record all immunizations or boosters currently known that the person has received. This section should be updated with new dates as the person receives immunizations. **Each Covid vaccination/booster should be listed.**

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

PLAN: HEALTH AND SAFETY: FOCUS AREA UPDATE EACH FOCUS AREA AT LEAST YEARLY

When completing the Health and Safety area of the plan, include the source of the information such as the role of the person or if it was provided through an assessment. The Health and Safety areas of the plan can address the licensing requirements for residential and other licensed services. A summary of the assessment information and the skills and needs in each area should be recorded. Indicate if there is no assessment for a particular area. For any identified risk, address the level of supervision needed for the person's safety and record it in Supervision Care Needs. If a review of incidents is specific to a health and safety focus area, then address that particular issue in that focus area. For example, document fire setting in the "fire safety" focus area.

This section should include abilities, positive traits, person centered details, etc. in each area. Describing the positives is as important as detailing needs, lack of/decrease in skills, etc. Keep it positive, accurate, and respectful.

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General Health and Safety Risks Include the team review of any injuries and accidents that may have occurred over the past year to look for trends in potential areas of concern. Note the need for protection from heat sources, electrical outlets, knives, etc., if applicable. Include any other information pertaining to health and safety other than what is recorded in the other Health and Safety focus areas. The Fatal 5+1 can be put in this section.	**SC should do, or make sure a team member does, an IM4Q & Incident data pull for team review.** **Reference another focus area for DETAILS of risk as needed.** **If details from other sections are included here, they must match/be consistent.**
Fire Safety Record information about the person's ability to react during a fire or fire drill. Include the level of supervision required and the assistance or device(s) needed to evacuate a building. If relevant, include information about fire safety training, including understanding of smoke detectors, evacuation plan at the home, where to meet, whether or not the person has the skills to call 911 if necessary, etc. If the person smokes, include his or her level of awareness of smoking safety. If the person needs assistance to evacuate, document notification of the local fire company.	**List current training dates and fire drill information for licensed programs.** **Get details about what the person would do or the level of support needed.** **For people who live in private homes, include who lives with them, their evacuation plans/schedule, etc.**
Traffic Record information about the person's traffic safety awareness, such as information about how and under what circumstances the person can safely cross streets. Specific information regarding the person's awareness of rural vs. urban streets, highways or side streets, parking lots, etc., should be provided. This information should include the level of supervision and assistance required.	**Include if the person drives, wants to get their license, if they have a car, insurance, etc.** **Can include any issues/preferences with riding in a car (takes off seatbelt, likes window down, etc.).**
Cooking/Appliance Use Record information about the person's ability to use cooking and kitchen appliances, such as a stove, toaster, regular or microwave oven. Indicate the person's ability to prepare a basic meal, get hot and cold drinks, get a snack, peel fruit, chop, stir, pour beverages, scoop ice cream, etc. Indicate the person's understanding of safe food storage. This information should include the level of supervision and assistance needed when cooking or using appliances.	**Think about if the person can do certain things at home but does not transfer skills/ information to other settings.** **Appliance use can include washer/dryer, iron, vacuum, blender, air fryer, hair dryer, etc.**
Outdoor Appliances Record information about the person's ability to use outdoor appliances, such as a lawn mower, weed whacker, gas grill, etc. This information should include the level of supervision and assistance required when using such appliances.	**Add this information even if they haven't tried or aren't interested in outdoor appliances.**

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Water Safety (Including Temperature Regulation) Record information about the person's ability to understand water safety and temperature safety: Can the person: temper bath water or water to wash his/her hands, be alone in a shower, be alone in a bath and is the person safe in a swimming pool? If the person has a seizure disorder, or other medical condition such as a peg tube, include precautions necessary for bathing or swimming. This information should include the level of supervision and assistance required for hot water usage and when around swimming pools, lakes, or other bodies of water.	**Teams can include information pertaining to water play (if the person will be interested in any container of water such as the toilet, pet dish, fish bowl/aquarium, etc.).** **Do they have preference for a water temperature – always chooses hot or cold for hands? Will only shower in cool water?**
Safety Precautions Record information about the person's ability to understand safety precautions including handling or storage of poisonous substances, danger signs, or warning labels. Will the person ingest a poisonous substance or personal hygiene item if left unattended? Indicate if the person ingests non-food items. Describe the type and level of assistance the person needs when in such situations. For any identified risk, address the level of supervision needed for the person's safety and record it in the Supervision Care Needs section.	**Be sure to reference changes from environment to environment (they will not answer the door or phone at home but will rush to open the door at day program or will pick up a ringing cell phone regardless of who it belongs to).** **Some people have varying supervision needs based on being at home, work, CPS, etc.**
Knowledge of Self-Identifying Information Record information about the person's ability to give self-identifying information, such as name, address, and phone number. If unable to state identifying information, does the person carry ID? Will he/she show ID to someone if lost? Will he/she ask for assistance if lost?	**If a person doesn't carry/use an ID, then team needs to brainstorm about how to have identifying info available with person and/or a provider when in the community in case of emergency.** **This area also includes if a person tends to overshare information, doesn't want their disability made known, keeps certain information from employers or family members, etc.**
Stranger Awareness Record information about the person's ability to interact with strangers. In which way is the person vulnerable to victimization, such as opening doors to strangers? In public places, will the person wander off with a stranger? This information should include the level of supervision and assistance the person needs.	**Oversahring** **Internet capability/usage/awareness** **Sending money to strangers** **Virtual dating** **Online video game etiquette**
Sensory Concerns Describe any sensory concerns and how to support the person. Many people under or over respond to noise, touch, sights and other stimuli. For example, someone with a hearing impairment may not hear an alarm clock so one option would be to equip it with a flashing light or vibration. Or, the person may respond with anxiety to everyday sounds such as a plane flying in the sky.	**Don't forget to include not so obvious issues (TV volume, hearing aids, sensory seeking).** **This area may cross over with the communication section.**

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Meals/Eating Record information about the person's ability to eat. This information should include specialized diets such as pureed, low salt, low fat, feeding protocols, etc. Is there a choking risk? List any required positioning necessary during/after meals. Should any food with particular consistencies be avoided such as peanut butter? Include information from dietary and nutritional appraisals, as well as information regarding adaptive equipment. Include the level of supervision and assistance needed during meals both at home and at a restaurant. If a specific support plan exists related to eating or meals indicate where the hard copy is kept and who should be trained in its application prior to working with the person.	**SC: These also constitute 'specialized diet' when doing a monitoring. Be consistent when answering the question on the monitoring tool.** **MUST match physical and annual assessment if there is a special diet.** **If testing has been done, note when and the results.** **Include things such as diabetes, Prader Willi Syndrome, feeding tubes, etc.**

PLAN: HEALTH AND SAFETY: SUPERVISION CARE NEEDS

Supervision is the need to have a person present either within eyesight, the room, the building, in arm's length, or by a phone call or page system, etc. during the day, in their home, or in the community. All three areas should be described.

- Day supervision refers to normal day activities such as volunteering, working, attending a day program, etc.
- Home supervision refers to activities at the person's home, or the home of a family member.
- Community supervision refers to activities that take place outside of the person's home but not including places where the person typically or regularly spends his/her days (Monday-Friday). Community refers to places such as local shopping or recreational centers, the person's neighborhood, places of worship or business, public transportation, walking to the neighborhood grocery etc.

Describe the need for the service and its impact on the person's health and welfare in the "Description" field for the following services; Supplemental Habilitation, Additional Personized Staffing, Enhanced/Intensive Staffing (1:1 or higher staffing in a licensed home or day service), any day service except in-home services, Home and Community Habilitation services greater than 64 units per day.

Training supervision needs and staff ratio are available on MyODP.
When describing a person's supervision needs, describe what it takes to support the person and not necessarily how many people it might take.
The focus areas in this section can be done for all people with an ISP – not just for licensed settings or people receiving waiver funding.

***Supervision Care Need Type** (Indicate if Day Supervision, Home Supervision, or Community Supervision.)	
Number of hours of supervision If a person can have two hours of alone time while at home but requires supervision the remaining time, the number of hours for Home Supervision would be 22.	

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Description Indicate if and how long the person can be alone and any plans to increase time alone. Include the days and times the support will be provided as well as any additional supervision needs, such as…"person needs one on one when going to the bathroom." Describe any training needed beyond general staff orientation to support the person. Describe the need for the service and its impact on the person's health and welfare.	**Day program regs require amount of time a person can spend without supervision.** **Licensing requires the location of SEE Plan, restrictive BSP, etc. which should include a description of the support needed.**
***Is intensive supervision required in this setting?** (Yes or No) Intensive supervision is defined as one-to-one supervision or a higher staff to person ratio. If yes, the reason for intensive supervision must be detailed in the Reasons for Intensive Staffing area of the ISP.	

PLAN: HEALTH AND SAFETY: SUPERVISION CARE NEEDS: REASONS FOR INTENSIVE STAFFING

***Reason for Intensive Staffing**

__Requires assistance with medication administration
__Unable to evacuate independently
__Kitchen safety or require assistance with meal preparation
__Smoking safety
__Unable to recognize common household Dangers
__Elopement risk
__Behavioral issue(s)
__Roommate(s) require this staffing, this person does not
__Medical issue(s)
__Physical/Mobility issue(s)
__Other

Other Reason:	
Plan for Reducing Intensive Staffing Supports: The plan for reducing intensive staffing must include the specific role and purpose of the staff as well as when, where and how the enhanced support will occur (hours/days, location, etc.). Include what other measures have been tried in addition to intensive staffing. It must also include the plan for the eventual discontinuance or reduction of the intensive staffing. Update annually to validate the need for continued intensive staffing and include the date to maintain a history of the need for intensive staffing.	**REQUIRED any time person has 1:1 (or greater) ratio unless the reason is for retirement.** **This information needs included on a variance if a person requires one for supports outside of the service definitions.** **A fade plan would be required for supervision needs that are considered restrictive.**

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

INDICATE NEED, NOT STAFFING SHEDULE

Record information here for all people that participate in a service during the day (i.e. pre-vocational, community habilitation, etc.). The staffing ratio should reflect the provider's scheduled staffing ratio and should match the level of service in Service Details (i.e. if pre-vocational base level is attached, the staffing ratio should be 1:15). When a person needs additional support, this should be noted in "Supervision Care Needs."

This section should be completed for all providers when a person has multiple providers – a new entry for each provider.

***Provider**			
***Type**			
***Day** (day of week)			
***Start Time**		***End Time**	
Comments	**If a person needs 1:1 support when at a program with higher ratios, add information here.**		

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

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

This section should be completed for all providers when a person has multiple providers – a new entry for each provider.

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

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

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

This section should be completed for all people regardless of where they live.

Is there Awake/Overnight (A/O) staff in this person's home? (Yes or No)	
***Are the total number of full-time equivalent positions (FTEs), recommended in the staff ratio tables the same as the current approved staffing level?** (Yes or No)	
If not the same, is the difference more than the current approved staffing level? (Yes or No)	

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If the difference is more than the current approved staffing level, give a specific explanation and justification for the need.	**e.g.: housemate needs higher level of support to meet outcomes for personal time** **This could include information from a variance.**

PLAN: HEALTH AND SAFETY: BEHAVIORAL SUPPORT PLAN

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

This section must be completed if:

- The person receives a behavior support service
- The person has a restrictive BSP.
- A psychotropic medication is prescribed

***Is there a behavioral support plan in place?** (Yes, No) **yes also refers to a SEE Plan**	
Summary Provide a summary of the person's behavioral support plan. If a psychotropic medication is prescribed, document the plan to address the person's social, emotional and environmental support, as well as frequency and severity of psychiatric symptoms. Indicate who the behavioral support plan applies to, where the hard copy is kept for access, who should be trained in its application prior to working with the person, documentation requirements, and who is responsible for collecting the information. If a restrictive plan exists, it should address regulations separately. Include a review of data regarding the restrictive interventions, including patterns and trends, techniques for minimizing the use of restrictions, and the fade plan that is in place for each restriction.	**Behavior Specialist/Program Specialist does this section (with team assistance as needed).** **Include the details of the fade plan for the restrictions and/or the BSP.** **← See notes in Psychosocial Section: they apply here if restrictive plan exists. Review of restrictive intervention data needs to be completed at least once/year.**
If yes, is it restrictive? (Yes or No) Restrictive is defined as limiting a person's movement, activity, or function interfering with a person's ability to acquire positive reinforcement, resulting in the loss of objects or valued activities, or requiring a particular behavior that the person would not engage in if given freedom of choice.	Must have a fade plan for restrictions.

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PLAN: HEALTH AND SAFETY: CRISIS SUPPORT PLAN

A crisis support plan is a reactive, and/or a **proactive**, plan that is designed to protect the person, other persons, or valuable property. It is designed only for protection during a crisis and not as a means to limit future crises. It must address the person's needs in and out of the provider's service area.

Record information here for those people who receive funding through the Adult Community Autism Program (ACAP). This is optional for those who do not have a formal crisis support plan, however mandatory for those that do have a formal crisis support plan.

This is also the section where back up plans are entered. Each provider is required to have a back up plan as to how their service(s) will continue as authorized in the ISP in the event of an emergency or staffing issue. The back up plans need to be given in entirety to the SC. **Only the portions related to service continuity should be in the ISP.**

***Is there a crisis support plan in place?** (Yes or No)	
Summary Indicate who the crisis support plan applies to, where the hard copy is kept for access, who should be trained in its application prior to working with the person, documentation requirements, and who is responsible for collecting the information.	**Information on back up plans is listed in the 2025 ISP Manual on pages 18-19 and Communication 06-19 from SASMG.**

PLAN: HEALTH AND SAFETY: HEALTH CARE

***Name of Designated Health Support Person** This is the person who is designated to help assist the coordination of the person's health. This could be a family member, support coordinator, provider agency nurse, a specific staff person in the agency, etc. Include the role of the person who is designated. This may not be the health care decision maker (health care proxy). If agency personnel are listed here, please be sure to update if they leave the agency or the position allowing them to be a health support person.	**Indicate role with the highest level of authority if there are multiple roles; e.g. family member who is also guardian.**
***Address**	
***City, *State *Zip**	
***Phone** (123) 456-7890	
Pager Number	
Is the person able to make health care decisions? (Yes or No) This means the person is able to understand the options including the risks and benefits and make a decision.	

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Is there an advance directive in place? (Yes or No) Advance directives are legal documents that convey decisions about end-of-life care ahead of time. They provide a way for people who can make medical decisions to communicate wishes about their care to family, etc. in the event that they develop an end stage condition. Advance directives also can be used to document a chosen decision maker (health care proxy) for people who cannot make their own medical decisions but are able to choose someone to make decisions for and with them. Advance directives must be made by the person themselves not by their family or guardian. Not all people will be able to complete an advance directive or choose a health care proxy. If "Yes", it should be verified that the person themselves completed the advance directive.	**Contact SASMG or UPMC (ACEL) for resources on end of life care, advance directives, etc.**
If No, what steps will be taken to assist the person to complete an advance directive? If the person is not able to complete an advanced directive or choose a health care proxy, indicate not applicable.	**The team needs to seriously consider this and discuss as often as necessary so the information in the ISP is accurate.**
If the person cannot make health decisions, has a substitute decision maker been identified? (Yes, No, or NA)	
If substitute decision maker is identified, is it a (Facility Director, Family Member, Guardian, Other – specify) Include health care proxy under "Other."	
Name, Contact information of Decision Maker	
If substitute decision maker is not identified, then what steps will be taken to identify a substitute decision maker and by when? Enter the steps to be taken to identify a substitute decision maker, as well as when these steps need to be taken.	**The team needs to encourage this to happen and to be kept current each year.**

PLAN: HEALTH AND SAFETY: HEALTH PROMOTION

Document any health conditions or issues for which there is currently a recommendation or any health practices that the person currently engages in or would like to work on or engage in. These items may or may not lead to outcomes. Examples are weight reduction, toileting protocols, self-administration of medication, smoking cessation, increased exercise, recommendations from health professionals including those recommendations specific to particular diagnoses, refusals to accept routine exams or treatment (this includes either the person or guardian's refusal), etc.

This section can also be used for information regarding who's responsible for certain health and safety tasks on behalf of the person. Examples: family members responsible for sending medical info/appointment summaries to the team, what each provider is responsible for (one does dental visits and one does PCP visits, etc.), who in the agency is responsible for health and safety assurance as applicable, etc.

***Health Condition/Issue**	This section of ISP could be used more; be specific (don't just say take Rx)

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***Promotion/Strategy Support Required** Include information on what both the person and staff need to know, do, and needed training. **How to report to doctor, team, respond to crisis, diabetes training, side effects of medication, etc.**	DENTAL required for residential **unless** independent and so stated in Adaptive/Self Help section. AT A MINIMUM complete a Health Promotion for each of the following, if applicable: 1. Management for Active Seizures 2. Diabetes 3. Any physical exams or protocols the person struggles with.
***Desired Outcome**	
***Person/Agency Responsible**	**The person listed must be understand their responsibility and agree to be named in the ISP.**

PLAN: FUNCTIONAL INFORMATION: FUNCTIONAL LEVEL

In the functional areas of the plan, describe what the person is able to do on his or her own, where assistance is required or any other types of needs. In some situations, one area of a person's life can impact another. For example, communication skills or needs often can be observed in their learning/cognition abilities, their ability to express emotions under social/emotional information, etc. When this occurs, the details of support needed may be recorded in the related functional area. (For example: for a person who cannot express emotions verbally, the social/emotional area may have more detail of the support needed than the communication area.) In such situations, choose where the details fit best and refer to that in the related area. Include recommendations, where applicable, of what the person may be interested in learning or expanding their abilities.

Note progress or changes the person has made in the past 12 months.

Physical Development Describe current skills and needs that include gross and fine motor skills, vision and hearing, use of assistive technology, ability to perform simple exercises, mobility, stair travel, and ambulation and gait assessment information. Include developmental statements from family and information regarding positioning and transfer needs if applicable.	**Use service notes, progress reports, Learning or Daily Logs to gather info.** **Don't talk about what a person can't do; indicate the level of support needed instead; have information about what they can do and like as much as possible.**

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Adaptive/Self Help Document information pertaining to self-help or hygienic information. Include information about the person's ability to perform specific functions, assistance needs, and adaptations needed. Areas to consider are bathing/showering, dressing, drinking from a cup, eating, bathroom needs, being transported (seating, rails, supervision, etc.), walking, etc. Record self-administration of medications skills, needs, and an explanation if the person is not working toward self-administration. Include strengths and needs for completing household chores as well.	**When someone doesn't have needs in this area make a general statement that someone can do something on their own.** **You don't need to list everything.** **When people do not need assistance with dental hygiene, note that here. They don't need a dental health promotion.**
Learning/Cognition Describe skills and needs about how a person learns and processes information, thinks, remembers, reasons, problem solves, makes decisions, manages money, etc. Record the person's ability to manage their own finances and property.	**Note the person's ability to manage amounts of money with examples (a shopping trip, $30, at the Dollar Store but not at the mall, daily, weekly, etc.). This should be updated to their current abilities and skills. What a person could do in junior high or high school may be completely different as an adult today.** **Are social stories helpful?**

Communication

All people communicate. Supporters who are highly observant and/or spend a lot of time with a person should be strong contributors to this section. All behaviors are communication.

Primary Mode of Communication (select one)

___ Verbal – Person communicates their messages verbally.
___ PECS – Person communicates through the Picture Exchange Communication System.
___ Sign Language – Person uses manual communication, body language, and lip patterns instead of sound to convey messages.
___ Modified Sign Language – A mutual understanding is reached over hand and body motions.
___ Picture Board – A visual aide/tool commonly used to help persons comprehend verbal language. It generally consists of icons that represent specific words, actions, events or situations.
___ Vocal Output Device – Person uses an electronic device to communicate messages.
___ Gestures and Facial Expressions – Person uses gestures and facial expressions to communicate Messages.
___ None Identified – A means of communication has not yet been figured out for this person.
___ Other – Provide explanation in the details section.

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Communication Details Describe communication abilities and areas of need. It is important to consider both how the person understands others, as well as how the person expresses or communicates with others. Description of how assistive technology (e.g. speech generating devices, letter boards, etc.) is used should be included, if appropriate. This information should also capture whether the person speaks/understands English and/or another language.	**Receptive communication is very important to discuss and keep current. How a person understands others is crucial in positive support for him/her.** **Do the person's skills vary from environment to environment?** **Include any formal communication evals or assessments. Summarize the results.** **If the team does not know if any formal evals were done, note that.** **If the person's communication style is informal, list enough detail so others can understand/communicate effectively.**
Social Emotional Information Describe the skills and needs related to the process of learning to control emotions and having empathy and respect for others, and the ability to establish and maintain social interactions.	**This is NOT the place to reference the behavior plan, psych questionnaire, medications.**

PLAN: FUNCTIONAL INFORMATION: FUNCTIONAL LEVEL: EDUCATIONAL/VOCATIONAL INFORMATION

Educational/Vocational Information is used to record if the person is a student and/or an Office of Vocational Rehabilitation (OVR) Client. Include information on current educational enrollment or vocational abilities, and current areas in which the person needs assistance.

Transition plans for school students can be listed here. Keep in mind the differences between the education system and the ID/A system (language, philosophies, etc.).

This section should be completed for all people.

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

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***OVR Client** (Yes or No)	
OVR Counselor Name	
OVR Counselor Phone (123) 456-7890	
***Does this consumer have training goals** (Yes or No) If the person is not currently a student or OVR client, it is still possible that he or she may have training goals.	
List training goals	
Comments	

PLAN: FUNCTIONAL INFORMATION: FUNCTIONAL LEVEL: EMPLOYMENT/VOLUNTEER

This section should be completed for all people age 14 and over.

Employment/Volunteer Information is used to document if the person is competitively employed or volunteers, and related details such as full or part-time, employer, position, work address, work phone number, and employment/volunteer goals. Include all information related to the person's current abilities related to obtaining and/or maintaining a job or volunteer status. If currently employed or volunteering, indicate the type and amount of support they require. Include information related to any current goals for employment or volunteering, desire the person has to be or continue to be, employed, and relevant notes on information learned from previous jobs, work or volunteer experiences. **Attending the VTI is not considered employment. Employment is integrated and pays minimum wage or higher.**

Use of companion during competitive integrated employment should be detailed here.

Fade plans should be entered here for the appropriate services.

*Work Status (Employed, Volunteer, None) Only select "Employed" if the person has competitive community employment including self-employment where at least the minimum wage is earned. If the person participates in a vocational facility or adult training facility, answer "None".	
Frequency (Fulltime or Part-time)	
Position	
Employer	
Address	
City, State Zip	
Phone (123) 456-7890	
Does this person have employment/volunteer goals (Yes or No) Employment/Volunteer goals could be whether the person would like to: explore community employment or volunteer opportunities, increase or decrease hours of current employment/volunteer time, change jobs, increase responsibilities, etc. If a person is not currently working or is working in a vocational facility, it is still possible that he/she may have employment goals.	

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List employment/volunteer goals List employment/volunteer goals whether or not the person is currently working or volunteering. Pre-vocational goals can also be included here.	
Comments Provide further explanations for any of the information on the Employment/Volunteer area, such as important notes regarding the person's experiences in the work or volunteer place, supervisor name, or details of his/her employment/volunteer goals. Include information regarding the person's anticipated date of retirement and retirement plans, including activities that the person would like to do during his or her newly expanded free time.	**If a person wants employment, then there MUST be an employment OUTCOME that reflects this. It can be listed as an unmet outcome if needed.**

PLAN: FUNCTIONAL INFORMATION: UNDERSTANDING COMMUNICATION

Record information in Understanding Communication about the person's verbal or nonverbal, overt subtle behaviors that he/she uses to communicate needs, wants, likes/dislikes, what is important, when he/she is in pain, discomfort, or not feeling well, etc. All behavior is a form of communication. Communicative behaviors help others understand the person and respect and respond in a helpful way. The information is gathered from important knowledge that people who know the person will have from understanding and knowing the person over time. Information regarding facilitated communication, assistive technology use/skill etc. should be included if appropriate. If the person's primary language is not English, include documentation noting his or her need for language assistance and resources utilized.

Include all emotions expressed without words: happy, sad, lonely, depressed, homesick, etc.

- **When this is happening**…refers to the circumstances around the person, the setting, the environment, the time of day, etc. For example, loud noises or eating.
- **The person does**…refers to the observable actions in which the person engages, or sounds/words or phrases the person uses in those situations.
- **We think it means**…refers to the shared understanding and meaning of the action for the person.
- **We should**…refers to the response or actions expected or to be avoided from the people providing support.

***When this is happening…**	
***The person does…**	
***We think it means…**	
***We should…**	

PLAN: FUNCTIONAL INFORMATION: OTHER NON-MEDICAL EVALUATION

Use the Evaluation area to capture detailed information about completed evaluations, such as fine or gross motor skills that are not medically related.

The statewide standardized needs assessment (SIS) should be documented as Other.

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

If Type is "Other" Specify "Other" can include evaluations of mobility, functional vision, wheelchair evaluations, and purchases along with information on the purchase of other adaptive equipment, etc. Evaluations and purchases completed within the last year and those from which recommendations are still followed need only to be recorded.	**Be sure to review these options and add all that are applicable.**

***Name/Type of Evaluation**	
***Date of Evaluation** (mm/dd/yyyy)	
Evaluator Name (Last Name, First Name)	
Evaluator Agency	

PLAN: FINANCIAL: FINANCIAL INFORMATION

Include the source of the person's current income. If a representative payee exists, include his or her name and contact information. If more than two sources exist, note in Financial Issues how asset limits will be maintained.

***Source** Social Security Supplementary Security Income (SSI) Veteran's Benefits Railroad Retirement Fund Civil Service Annuity Other (Specify)	**All ISPs should have this included.**
***Claim #** If not the person's SSN, list the benefit tracking number. If the claim number is an SSN and the person does not wish to share it, please enter the person's name as the claim number. Example: Jane Nissley's SSN.	**You can alternately enter the SSN as all zeroes.**

***Payee**	

PLAN: FINANCIAL: FINANCIAL MANAGEMENT ISSUES

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

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

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

Can the person manage their finances (in any part) without help?
What kinds of assistance are needed?
Does the residential provider keep ledgers?
If no payee is in place, consider an outcome about money management.

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***Explanation of Issues**	e.g. Resources cannot exceed $.....
***How the provider proposes to address the issue(s)**	Develop budget and review income and expenses monthly
***Start Date**	Use ISP date
***Completion Date**	One year later
***Desired Outcome**	Remains eligible for waiver and has person expenses met
***Person/Agency Responsible**	Payee or designated person

PLAN: FINANCIAL: FINANCIAL RESOURCES

Governmental benefits should be indicated by selecting "Other Resources" and typing in "Governmental Benefits" and the actual name of the resource in "Resource Name." Include the location and person responsible for maintaining the original documentation.

***Resource Type** Life Insurance Trust/Guardianship Burial Reserve Burial Plot	Pre-paid Funeral Arrangements Bank Account Checking Bank Account Savings Other Resources	**People living in a licensed residential home MUST have a burial reserve or a plan to start one**

Resource Value	NOT needed
***Resource Name**	
Policy Number	**Keep private**
Address	
City, State Zip	
***Who has the original documentation?**	VERY important

PLAN: SERVICES AND SUPPORTS: OUTCOME SUMMARY

Contact the AE if Person Centered Outcome Training is needed for a team, provider, or SC.

Each service must have an outcome. Not every outcome must be attached to a paid service.
Natural supports/ resources can constitute an outcome.

***Outcome Phrase** *This is a description to easily identify the outcome; this phrase is intended to assist with easily navigating through the ISP to find all related information.*	**Keep it simple but be creative.** **Use something of interest to the person as much as possible.**
***Outcome Start Date** (mm/dd/yyyy) *The date activity will begin to work toward achieving the outcome.*	**Dates can be short term/less a full year depending on the outcome.**

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***Outcome End Date** (mm/dd/yyyy) *The estimated date of when the outcome should be achieved.*	**Must coincide with the ARUD.** Plan year dates, NOT fiscal year dates.
Outcome Actual End Date (mm/dd/yyyy) *The actual date the outcome was **completed**.*	**Added when the outcome is finished due to successful completion or changes in outcomes.**
***Has the outcome been successfully accomplished** (Yes or No) *Select "Yes" or "No" to indicate whether the outcome has been successfully accomplished.* *Note: When initially creating outcomes, this field should be "No." When this field is changed to "Yes," an Actual End Date should be entered for the outcome.*	Can be left blank for plan creations.
***Outcome Statement** Represents what is currently important to the person, what needs to be maintained for the person, or what needs to be changed. The outcome should describe how it will make a difference in the person's life. The outcome must build on information gathered during the ISP process and reflect a shared commitment to action. Remember that outcomes supported by ODP funding must be within the context of the health and safety of the person and/or assuring their continued life within the community. Outcomes that address other priorities of the person should be represented and supported with other community, family or non-traditional supports. Use the principles of Everyday Lives to develop outcomes with the person: choice, control, quality, community inclusion, stability, accountability, safety, personality, relationships, freedom, success, contributing to the community, collaboration, communication, and mentoring. Include health related outcomes only if there is a gap in the provision of support for the person's health needs.	**Outcomes must reflect one or more sections in the ISP. The priority being the Individual Preferences sections.** **The Statement should be:** Specific: make it clear Results oriented: describe the end/not the means Action oriented: use action verbs **Phrasing:** Begin with the person's name followed by an action verb/phrase, continue with how it will make a difference using 'so that/in order to' or something similar. **Remember:** Services are not outcome statements. Goals are not outcomes.
***Reason for Outcome** This provides contextual information beyond the Outcome Statement for the team to understand how/why the outcome is important to the person. Should be found in at least one of the preferences sections.	**How does it support his or her needs for personal health/safety? How does it reflect their assessment information? How does it balance needs vs. wants?**

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***Concerns Related to Outcome** Describe any barriers (including health and safety issues) the team will need to address to successfully work towards the outcome. This may include information on what has been tried in the past but has not worked, what the person's team has tried to figure out, or other concerns any team member may have. For therapy and nursing services, document here the denial from the State Plan and/or private insurance. Should be found in What Doesn't Make Sense.	**Barriers are related to health and safety (not bad weather or similar reasons), family dynamics, environmental factors, personal issues, etc.** **Reflect what the team needs to find out, be trained in, resolve, cultural issues, issues with service delivery, barriers to inclusion, etc.** **Rarely are there not any concerns, but it's possible.**
***Relevant Assessments Linked to Outcome** List any relevant formal or informal assessments that directly affect the outcome. Informal assessments may include: direct observations, interviews with family or direct care staff and/or review of previous records. Formal assessments may include: statewide standardized assessments in addition to person-centered assessments utilized by provider agencies that have previously been approved by licensing agents. (If a formal assessment has been completed, it should be noted in the "Other Non-Medical Evaluations" section of the ISP.) Assessments may be utilized to assess whether an outcome has made an impact.	**LEARNING LOGS are a good resource; encourage staff to use them.** **SIS, IM4Q, review of incidents, formal and informal assessments** **These will be based on what each service provider requires and/or how the team assesses the outcome and progress.**

PLAN: SERVICES AND SUPPORTS: OUTCOME ACTIONS

It is critical for the team to address any concerns related to health and safety issue or any other barriers. Persons need team support to attain outcomes because collective problem solving and resources will make the difference. Problem-solve to identify any needed actions. Each Outcome Summary should have an Outcome Action.

***Related Outcome Phrase** This is created in the Outcome Summary and selected here to link the Outcome Summary and Outcome Actions. It is a description to easily identify the outcome; this phrase is intended to assist with easily navigating through the ISP to find all related information.	
***What are current needs** Describe the current reality related to the outcome. This should be related specifically to the person – what they are able to do toward the outcome, including assistance that is necessary. This should crosswalk with previous sections of the ISP where needs are described.	**NEEDS not actions** **Needs of the person not needs of the provider or staff.** **e.g. transportation, assistance with medical appointments, level of support from staff**

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***What actions are needed** Identify steps and actions to achieve the outcome. Include those provided by paid and non-paid people such as family members or friends. Include actions that currently occur and need to continue; this should describe any actions, including those provided by natural supports, non-paid support, and paid support. What happens currently to meet the need; is it adequate? Are there parts of the person's specific outcome being met, and others not being met? If a specific service is required, it can be named here. Document steps to assure the person's health and safety while working toward desired changes.	**List staff instructions and clinical interventions.** **Provide the details for plan implementation as a 'blue print' for others to follow.** **Identify steps to address concerns listed above.** **Very important section for direct supports.** **← Keep general, e.g. staff trained in level of support needed**
***Who's responsible** Include the person and/or other team members (name and relationship to the person) involved who will assist with the implementation of the outcome and that will be responsible for seeing that the actions occur.	**The title of the position is okay. Be sure to update regularly if a name is added.** **List all providers/positions who will work on this outcome.** **This can include natural/unpaid support.**
***Frequency and Duration of the actions needed** Include the frequency (number of times) and the duration (length of time) for each of the needed actions. Include those provided by paid and non-paid people such as family members or friends. Specific information on total number of units is listed on Service Details.	**Frequency details the number of times per week, month, year, etc. the service occurs.** **Duration details how long the service will occur (days, weeks, months, etc.).** **F & D must match all other references to staffing, scheduling, licensed program attendance, etc. in the ISP.**
***By When** (mm/dd/yyyy) List the anticipated date (or end of plan date) that the actions will be accomplished; whichever is appropriate.	
***How will you know that progress is being made towards this outcome?** Progress links directly to the outcome. Describes what is expected as a result of the services and supports. Identify how and who will give input about progress made over time.	**Progress is observable. What do the person's supporters see that show progress, or lack of, regarding the outcome? What does the person do, say, communicate that shows progress? It can be measurable depending on the type of outcome/service.**

PLAN: PLAN ADMINISTRATION: MONITORING

Before submitting the ISP for approval, the Monitoring screen must be completed. Monitoring should meet the required standards of funding sources received by the person or in accordance with county policy. See Waivers and/or ISP Manual for further description of appropriate monitoring frequency.

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***Person requires the following Monitoring frequency**: **REQUIRES PRIOR ODP approval to check non-statutory frequency.** (Mark appropriate one) ___ Statutory Frequency (TSM and waivers) ___ Non Statutory Frequency (as per county policy)	
Reason for Non-statutory frequency	
PLAN: PLAN ADMINISTRATION: DRAFT PLAN	
***Consent to share plan:** (Yes or No)	
***Were lifesharing options considered for Residential Services:** (Yes, No or N/A)	
Has the ISP signature sheet been completed?: (Yes or No)	
Has the ISP Provider Choice information been shared with the person?: (Yes or No)	