

INDIVIDUAL SUPPORT PLAN

My legal name:		Date of Plan	
My preferred name:		Anniversary Date	

REVIEW OF PREVIOUS YEAR

A review of current supports and their progress towards previous outcomes should be conducted prior to the planning meeting in order to identify the ongoing support needs. Please provide a narrative addressing the following questions:

- Were supports provided in a manner and at a level that best supports the individual? If no, please explain changes needed in the coming year.
- Did the individual achieve and/or make progress in meeting his/her outcomes and goals? If no or more progress is needed, please describe why and what is needed?

BACKGROUND – PREPARATION FOR THE PLAN

Various assessments should be used to inform this plan, including Person Centered Planning. This ISP is not the Person-Centered Plan.

My Assessments Used to Inform this ISP	
NOTE: Assessments should be within the last 18 months except for the SIS, which is done every 5 years	
Method/Tool:	Date(s):

- Types of Assessments Include:**
- Person Centered Plan (MAPS, PATH, etc)
 - Vocational Assessment
 - Community Based Experiences
 - Discovery
 - Profiles
 - Risk Assessment
 - Support Intensity Scale / Level of Care
 - Behavioral Assessment
 - Review of information from case notes, including support services, health inventories, nursing reviews, etc.
 - Other applicable assessment / tools

My Preparatory Experiences		
Experience	Tool or Method	Date
Social Skills Training		
Career Exploration		
Soft Skill Development		
Job Skill Development		
Leadership Development		
Educational & Community Services		
Self-Advocacy/ Self-Determination		
Conflict Resolution		
Peer & Adult Mentorship		
Daily Living Skills		
Assistive Technology		
Other:		

Name: _____ Plan Effective Dates: _____

My Vocational & Related Services			
Experience	Date	Experience	Date
Job Fairs		Volunteering	
Business Tour		Work based Learning Experience	
Job Shadow		Work-study	
Informational Interviews		Resume Development- Traditional	
Mock Interview		Resume – Visual/Pictorial	
Service Learning		Job Development Traditional	
Internships		Job Development - Customized	
Short term Situational Assessment		Job Coaching -	
Long term Situational Assessment		Other:	
Other:		Other:	
Other:		Other:	

Name: _____ Plan Effective Dates: _____

What is Important to Me?

This ISP is not the Person-Centered Plan. Please draw from Person-Centered Plan, or insert one here. This section is here to inform the goals in the next section. Feel free to personalize it!

Who is important to me:

What is important to me: Hopes, Dreams & Wants, Needs, Likes & Dislikes, Special Interests

What I would like to try:

What do I need to work on:

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What people like and admire about me / What are my strengths:

WHAT DO WE NEED TO KNOW OR DO TO SUPPORT YOU?

What kind of supports work for me?
What doesn't work for me? What would I change?
Primary Language Used/Understood. (If sign language is used, state what type of sign.)
Method of Communication (e.g, verbal, communication boards, interpreter, etc.)
How do I learn best?

What type of environment do I like to be in?

Is there anything else you'd like to share?

Education						
	Yes	No	School/Program/Training Site	Start Date	End Date	
Diploma						
Certificate of Completion						
Post-Secondary Education						
Other: describe						
Training & Certifications						
Work History						
Employer/Work Site	Duties		Setting	Start Date	End Date	Wage

Name: _____ Plan Effective Dates: _____

GOALS

Desired Outcomes – *What do I want to do or accomplish this year? How do I do it?*

Note: Change, add, or delete template headings for outcomes as needed to make it more relevant to the individual.

Employment

New (N) or Continuing (C) Goal	Desired Goal/Outcome: What do I want?	What actions will you take to reach this goal? (Use as many lines as needed to describe each step)	Who is responsible to help me?	Timeline How often or by what date?	How will we record progress?

Health & Safety

New (N) or Continuing (C) Goal	Desired Goal/Outcome: What do I want?	What actions will you take to reach this goal? (Use as many lines as needed to describe each step)	Who is responsible to help me?	Timeline How often or by what date?	How will we record progress?

Independence

New (N) or Continuing (C) Goal	Desired Goal/Outcome: What do I want?	What actions will you take to reach this goal? (Use as many lines as needed to describe each step)	Who is responsible to help me?	Timeline How often or by what date?	How will we record progress?

Social Relationships & Community Integration

New (N) or Continuing (C) Goal	Desired Goal/Outcome: What do I want?	What actions will you take to reach this goal? (Use as many lines as needed to describe each step)	Who is responsible to help me?	Timeline How often or by what date?	How will we record progress?

Transportation

New (N) or Continuing (C) Goal	Desired Goal/Outcome: What do I want?	What actions will you take to reach this goal? (Use as many lines as needed to describe each step)	Who is responsible to help me?	Timeline How often or by what date?	How will we record progress?

Other

New (N) or Continuing (C) Goal	Desired Goal/Outcome: What do I want?	What actions will you take to reach this goal? (Use as many lines as needed to describe each step)	Who is responsible to help me?	Timeline How often or by what date?	How will we record progress?

RISK

It is imperative if an *Altered Level of Supervision* is needed to benefit the individual, then a clear description of the *altered level of supervision* must be addressed specifically in the ISP. Altered Levels of supervision may include “Alone Time,” “Line of Sight,” and “1:1” supports, etc. This needs to be a team decision (this includes the individual, guardian, provider agency, support coordinator and others identified by the team to participate).

Natural Supports, Community Resources and Other Voluntary Services and Supports:

Describe natural or community services/supports:

Provided by:

Differences:

Note any differences between the contents of this plan and what I want.

Note any differences between the contents of this plan and what my guardian has requested.

Review of My Plan

	Yes	No	Declined
1. Does this ISP reflect the services I choose and the outcomes/goals I want?	[]	[]	[]
2. Have I been provided information about the planning process and how to request changes and updates to my ISP?	[]	[]	
3. Did I choose the location of my ISP meeting?	[]	[]	[]
4. Did I choose who came to my ISP meeting?	[]	[]	[]
5. Did the case management agency review the services that are available to me?	[]	[]	[]
6. Was I informed of my rights?		[]	[]
	Yes	No	N/A
7. Does this ISP reflect what is needed for my family to effectively provide supports?	[]	[]	[]

If No to any of the above, please explain:

ISP Team – Does this ISP reflect person centered planning in the areas of:

Independence: Having control and choice over one’s own life.

Yes No

[] []

Integration: Living near and using the same community resources and participating in the same activities as, and together with, people without disabilities.

[] []

Productivity: Engaging in contributions to a household or community; or engaging in income-producing work that is measured through improvements in income level, employment status or job advancement.

[] []

Describe the reason for any question above remaining “no” and the plan to address it:

Agreement to this Plan

These people agree to this plan and associated documents as reflecting my strengths and preferences, support needs as identified by an assessment and the services and supports that will assist me to achieve identified desired outcomes.

- **Participant:** I agree with this plan and intend to participate in steps outlined to work toward my goals.
- **Support Coordinator/Case Manager:** Ensure the plan meets the person’s current service needs and complies with requirements for person centered planning and associated funding.
- **Providers:** Agree to implement and provide the supports that have been designated as their responsibility in this ISP.

Name	Relationship to me	Present at meeting?	Signature	Date	Comments
		[] Yes [] No			
		[] Yes [] No			
		[] Yes [] No			
		[] Yes [] No			
		[] Yes [] No			
		[] Yes [] No			
		[] Yes [] No			
		[] Yes [] No			
		[] Yes [] No			
		[] Yes [] No			
		[] Yes [] No			

Behavior Plan: Yes No If yes, please attach

Nursing Care Plan: Yes No If yes, please attach

Income Disregard Form: Yes No If yes, please attach

Name: _____ Plan Effective Dates: _____



BHDDH DIVISION OF DEVELOPMENTAL DISABILITIES ISP ATTACHMENT FORM FOR BENEFITS PLANNING AND EMPLOYMENT

What information on Social Security Work Incentives, have you received? This includes information a family member or rep payee received on your behalf. Check all that apply.

I received (*check all that apply*):

I attended (*check all that apply*):

- | | |
|---|---|
| <input type="checkbox"/> SSA Working While Disabled Pamphlet | <input type="checkbox"/> A group work incentive information session |
| <input type="checkbox"/> Myths & Facts: Social Security Benefits & Work | <input type="checkbox"/> An individual counseling session for a benefits plan |
| <input type="checkbox"/> Sherlock Plan information | |

I have secured employment and have a benefits plan written by a Certified Work Incentives Counselor (CWIC)?

If YES, date of plan: _____ If NO, I have declined a benefits plan _____

Working age adults (age 18+) must choose one of the following statements:

- I am employed and choose to:** *Check all that apply.*
 - Retain current integrated job.
 - Advance in current integrated job (more hours, raise, new skills, promotion, etc.)
 - Get a new integrated job.
 - Get an additional integrated job.
 - Maintain a job in a non-integrated employment setting.
 - *Complete separate Request for Variance for Segregated Employment and submit separately.*

- I am Retired – I am at least 62 or will be this ISP year.**
 - *Employment goals are not required, but plan must address retirement activities.*

- I am currently not working in integrated employment, but I'm interested and choose to:** *Check all that apply.*
 - I want to obtain integrated employment.
 - Explore interests in integrated employment or in community settings through an Employment Path, Discovery, or other time-limited service.
 - I'm enrolled in Post-Secondary Education or a Vocational Training Program.
 - Not pursue integrated employment at this time due to need to stabilize health (including behavioral health).
 - Other: please explain _____

- I am not interested in employment**
 - *Complete Request for Variance for Day Only Services and submit separately.*

Status with Office of Rehabilitation Services (ORS)

- | | |
|---|--|
| <input type="checkbox"/> I want ORS services
Application Date: _____ | <input type="checkbox"/> I went to ORS in the past, now closed |
| <input type="checkbox"/> I am currently receiving ORS Services | <input type="checkbox"/> Other/Not Applicable, please explain: |