Meeting Date:

About Me

Important People

My Dreams

My Choices & Supports

Where I choose to live:

How I choose to spend my day:

Supports I need:

My preferences:

My Support Needs

Medical/Physical Health support needs:

Dental needs:

Behavorial health support needs:

I/DD-Related needs:

TBI-Related needs:

Social needs:

Educational needs:

Vocational needs:

Other Service needs:

Strategies to improve self-management:

Strategies to improve planning skills:

My Community Integration Needs

Strategies to increase my social interaction:

Strategies to increase my employment integration:

Strategies to increase my community integration:

What is Working for Me / Whats’s Not Working

What works?

What is not working?

My Plans for the Next Year

When I may need Extra Help

Things that may create stress. Situations where I'll need extra help?

What you can do to help me prepare ahead?

What you can do to help me out of difficult situations?

Crisis Planning

What A Crisis Looks Like for Me?

Who to call?

How to Support Me Best?

Emergency/Natural Disaster/Crisis Plan:

Strategies to mitigate risks to health, well-being and safety for me and of others:

Life Transition/Future Planning

What changes are happening in my life?

What supports I need to help me with these changes?

What needs to happen before my next birthday?

What needs to happen after my next birthday?

My Action Plan

Long-range Goal 1

Who helps me:

How and how often (service/frequency):

Where am I now:

Where:

Target Date:

Long-range Goal 2

Who helps me:

How and how often (service/frequency):

Where am I now:

Where:

Target Date:

Long-range Goal 3

Who helps me:

How and how often (service/frequency):

Where am I now:

Where:

Target Date:

Long-range Goal 4

Who helps me:

How and how often (service/frequency):

Where am I now:

Where:

Target Date:

Long-range Goal 5

Who helps me:

How and how often (service/frequency):

Where am I now:

Where:

Target Date:

**Demographic Information**

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| Name |  | Medicaid County |  |
| Date of Birth |  | Medicare # |  |
| Address |  | Insurance Carrier |  |
| City, State, Zip |  | Insurance # |  |
| Home Phone: |  | Other Phone: |  |
| Cell Phone: |  | Email: |  |
| Current Living Situation | Private Residence with family or natural supports:  Owned  Rented/Leased  Private Home alone or with a roommate (Supported Living):  Owned  Rented/Leased  Alternative Family Living/AFL Home ( Unlicensed ,  Licensed for \_\_ beds)  Non-Private Residence (residence leased or owned by provider)  ( Unlicensed ,  Licensed for \_\_ beds)  Other (describe): | | |
| Age/Graduation Status | 22 or over  Under 22:  In School  Graduated with Diploma/GED – Date of Graduation:  Completed School with Certificate  Other: | | |
| Employment Status | Student  Unemployed  Employed at or above Minimum Wage   * Employer: * Average Hours worked per week: | | |

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| **Legally Responsible Person:**  Self  Parent (minor child)  Legal Guardian  Other (describe): | | | |
| Name: |  | | |
| Does the legally responsible person have advanced directives or estate planning documents regarding their wishes for a successor legally responsible person for the individual supported? YesNo  (if yes, provide information regarding the advance directive and instructions below) | | | |
| Advance Directive Information (including advance instructions for treatment as appropriate): | | | |
| Does the legally responsible person live in the home with person supported? YesNo  (If no, provide address and phone # of legally responsible person below) | | | |
| Address: |  | | |
| City, State, Zip: |  | | |
| Home Phone: |  | Other Phone: |  |
| Cell Phone: |  | Email: |  |
| **Emergency Contact(s) in the event that the legally responsible person cannot be reached:** | | | |
| Name: |  | Phone: |  |
| Name: |  | Phone: |  |

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| **Back-Up Guardianship Plan (if applicable, please describe):** |
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| **Participants in Plan Development** | |
| **Name/Relationship** | **Name/Relationship** |
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| **Contact Information of Key Providers, Family Members, Care Team Members and others chosen by the Member to be involved in Planning and Service Delivery** |

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| **Name/Relationship** | **Contact Phone Number** | **Email Address** |
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| **Assessments/Reports Utilized in Plan Development (mark all that apply and attach to ISP)** | |
| **Supports Intensity Scale™ (required)** | **Risk/Support Needs Assessment (required)** |
| **Person-Centered Planning Tool** | **Behavior Support Plan** |
| **Assessment of Outcomes and Supports** | **TBI Waiver: Ranchos Los Amigos Levels of Cognitive Functioning Scale** |
| **Comprehensive Assessment** | **Other (describe):** |

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| **Diagnostic Information** | |
| **ICD-10 Code** | **Description** |
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| **Back-Up Staffing Plan** | | |
| **Agency-Directed Services OR**  **Individual/Family Direction / Agency With Choice (AWC) Model** | **Who** | **Contact #** |
| **Agency Back-Up (mandatory)** |  |  |
| **Non-Paid Back-Up (in the event of an emergency)** |  |  |
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| **Individual/Family Direction / Employer of Record (EOR) Model\*** | **Who** | **Contact #** |
| **Back-Up Staffing Agency**  (Back-Up Staffing Agency must be included, even if EOR does not anticipate needing to use this agency) |  |  |

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| Behavioral Supports Needed | | |
| Behavior Support Plan is recommended if   * Rating is ≥ 13 for children (ages 21 and under) * Rating is ≥ 10 for adults (ages 22 and over) * Any individual identified as a Community Safety Risk   based on self -injury or dangerousness to others | Supports Intensity Scale / Behavioral Rating |  |
| Community Safety Risk based on self- injury or dangerousness to others? | Yes  No |

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| **Status of Individual and Family Direction** | |
| Yes  No  (If yes, skip next three questions) | Currently using Individual/Family Direction  Agency with Choice  Employer of Record  Services Self-Directed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Yes  No | Orientation to Individual/Family Direction Given |
| Yes  No | Individual/Family Chose Not To Receive Orientation |
| Yes  No | Interested in Individual/Family Direction |

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| **Care Coordination** |
| Your Care Coordinator can assist you in the following ways:   * Assisting you with assessment and documentation of your support needs. * Assistance with development of your plan and Individual Budget. * Monitoring services to ensure that you are receiving services to meet your needs and that you are happy with them. * Monitoring to ensure that you are healthy and safe. * Helping you receive information on directing your own services. * Help you with problems or complaints about services, if necessary. |

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| **Care Coordination Monitoring Plan (⌧ all that apply)** |
| Minimum of monthly contact  Minimum of monthly face-to-face contact required for the following (**Check All That Apply**):  Individuals living in residential placements, including alternative family living homes  Individuals new to the waiver for the first six months  Individuals who have service(s) provided by a guardian or relative living in the same home  Individuals participating in Individual and Family Directed Services  Minimum of quarterly face-to-face contact with individual  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Signature Pages**

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| **Innovations** **Waiver /** **Level of Care Re-Determination** |
| I certify that there has been no substantial change in the individual’s condition and that the individual continues to require an ICF/IID Level of Care.  There has been a change in the individual’s condition and the individual needs an ICF/IID assessment.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Care Coordinator Date |

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| **Innovations Waiver / Freedom of Choice** |
| I understand that enrollment in the NC Innovations Waiver is strictly voluntary. I also understand that if I am determined to be ICF-IID eligible, I will be receiving Waiver services instead of services in an ICF-IID (Intermediate Care Facility for Individuals with Intellectual Disabilities). I understand that in order to be determined to need waiver services, an individual must require the provision of at least one waiver service monthly and that failure to use a waiver service monthly will jeopardize my continued eligibility for the Innovations waiver.  I **have chosen** Innovations Waiver Services  I **have not chosen** Innovations Waiver Services  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Individual or Legally Responsible Person Date |

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| **Choice in Residential Supports Statement** |
| I live in a group home or AFL of my choice.  I live in a group home or AFL that I did not choose. Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I live on my own.  I live with family or other natural supports.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Individual or Legally Responsible Person Date |
| **Choice in Individual Support Plan Template Format Statement** | |
| My Care Coordinator informed me of my Individual Support Plan template options. I have chosen the option I prefer.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Individual or Legally Responsible Person Date | |

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| **Statement of Concern or Disagreement** |
| I, the individual/Legally Responsible Person signing this plan have concerns or disagree with the following issues related to my Individual Support Plan: |

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| **Individual and/or Legally Responsible Person Signatures** |
| By signing this plan, I am indicating agreement with the bulleted statements listed here unless crossed through. I understand that I can cross through any statement with which I disagree.   * My Care Coordinator helped me know what services are available. * I was informed of the range of providers in my community qualified to provide the service(s) included in my plan and freely chose the providers who will be providing services/supports. * This plan includes the services/supports I need. * I participated in the development of this plan. * I understand that Sandhills Center will be coordinating my care with the Sandhills Center network providers listed in this plan. * I understand that all services under the Innovations Waiver, including Residential Supports and Supported Living, should be requested to the full extent of the individual’s level of medical necessity; regardless of the individual’s budgeting category. * I understand that services may be authorized in excess of the Individualized Budget.   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Individual Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Legally Responsible Person Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Care Coordinator Date |
| I acknowledge that I have received and reviewed the plan and attachments:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Qualified Professional / Agency Name Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Other Plan Participant /Agency Name Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Other Plan Participant / Agency Name Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Other Plan Participant / Agency Name Date |