Meeting Date:

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| (Images here) | About Me: |

|  |  |
| --- | --- |
| Important People: | (Images Here) |

|  |  |
| --- | --- |
| (Images Here) | My Dreams: |

My Choices and Supports\*

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| --- | --- |
| Where I choose to live: | How I choose to spend my day: |
| Supports I need: | My preferences: |

My Needs\*

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| --- | --- |
| My Medical Needs: |  |

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| --- | --- |
| My Behavioral Health Needs: |  |

What’s Working/What’s Not?

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| What is Working? |  |

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| --- | --- |
| What is NOT Working? |  |

My Plans for the Next Year

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| --- | --- | --- |
| (Images Here) | (Images Here) | (Images Here) |
| [Text] | [Text] | [Text] |

My Action Plan\*

|  |  |
| --- | --- |
| (Images Here) | Goal 1:   * Who helps me: * How and How Often (service/frequency): * Where am I now? * Where: * Target Date: |

|  |  |
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| (Images Here) | Goal 2:   * Who helps me: * How and How Often (service/frequency): * Where am I now? * Where: * Target Date: |

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| (Images Here) | Goal 3:   * Who helps me: * How and How Often (service/frequency): * Where am I now? * Where: * Target Date: |

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| (Images Here) | Goal 4:   * Who helps me: * How and How Often (service/frequency): * Where am I now? * Where: * Target Date: |

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| (Images Here) | Goal 5:   * Who helps me: * How and How Often (service/frequency): * Where am I now? * Where: * Target Date: |

When I May Need Extra Help\*

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| Things that may create stress or situations where I’ll need extra help: |  |

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| What you can do to help me prepare ahead: |  |

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| What you can do to help me out of difficult situations: |  |

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| (Images Here) | What does a Crisis Look Like for Me? |
| (Images Here) | Who to Call when I'm in Crisis: |
| (Images Here) | Things to remember about communicating with me when I'm in crisis: |

Future Planning

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| --- | --- |
| Before my next birthday: |  |
| After my next birthday: |  |

**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 | | | |
| 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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| **Participants in Plan Development** | |
| **Name/Relationship** | **Name/Relationship** |
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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** | **Other (describe)** |

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| **Diagnostic Information** | |
| **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)** |  |  |
|  | | |
| **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 |

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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 Alliance Health will be coordinating my care with the Alliance Health 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 |

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| 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 |