Meeting Date:

|  |  |
| --- | --- |
| (Images here) | About Me:  |

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

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

My Choices and Supports\*

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

My Needs\*

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

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

What’s Working/What’s Not?

|  |  |
| --- | --- |
| What is Working? |  |

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

My Plans for the Next Year

|  |  |  |
| --- | --- | --- |
| (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: |  |

|  |  |
| --- | --- |
| (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

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

**Demographic Information**

|  |  |  |  |
| --- | --- | --- | --- |
| 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:
 |

|  |
| --- |
| **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? [ ] Yes[ ] No |
| Does the legally responsible person live in the home with person supported? [ ] Yes[ ] No(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 |

|  |
| --- |
| **Status of Individual and Family Direction** |
| Yes [ ]  No [ ]  (If yes, skip next three questions)  | Currently using Individual/Family Direction [ ]  Agency with Choice [ ]  Employer of RecordServices 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:  |

|  |
| --- |
| **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 |