

Annotated ISP Forms

an•no•tate *Verb.* to add notes to something



This ISP training resource contains an abridged version of the required ISP forms. Text boxes were added to tell you more about key points on each page.

Square text boxes provide specific requirements and logistical information.

Oval text boxes offer helpful tips.

Person Centered Thinking Tools are identified in these text boxes.

This packet includes an annotated version of the following **9.9.09** ISP forms:

- Personal Focus Worksheet (PFW)
- Risk Tracking Record Cover Sheet
- Risk Tracking Record (RTR)
- Constipation Protocol
- Financial Plan
- ISP Meeting Agenda
- Individual Support Plan (ISP)

You may download the ISP forms and other resources at www.otac.org/isp

Personal Focus Worksheet for _____

Section I

Describes what is **important** to this person from his/her perspective

1. Describe the relationships in this person’s life:

Person Centered Thinking Tool: Relationship Map



All numbered questions (1-20) **must** be answered.

“**Supporting Questions**” may be used for questions 1-20 to help you get at valuable details. It is not required to answer every PFW Supporting Question.. You can download a copy of the PFW supporting questions by going to www.otac.org/isp/isp-forms-021407/

Agenda question: *Are there any relationships that should be developed or changed?*

Any “Agenda Questions” answered in Sections I, II, and III, must be added to the ISP Agenda “Discussion Topics”.

Write “N/A” or “not at this time” for agenda questions that were reviewed but for which the team decides to take no action at this time.

2. Describe what this person enjoys and list his/her interests:

Person Centered Thinking Tool: Morning Ritual



The person’s perspective is honored and written down, no matter the content.

Information said by the person is in “quotations” and when additional information is needed from others for clarification use (parentheses).

Agenda question: *Which of these interests are not happening as much as the person would like? From the team’s perspective, which of these interests, if any, need to be limited?*

The PFW must be completed within 45 days prior to the ISP meeting date.

5. List and describe what is most important to this person from his/her perspective:

The answer to this question must be transferred directly to the ISP.

From the learning and information gathered in the above questions, list and describe what is most important to this person. New information may be added that is not in the information above.

All answers to question #5 must be transferred word for word to the first page (What's Most Important) of the ISP (usually done during the Pre-Meeting).

Answers recorded may be written out in a narrative style, like a story; in a bullet-point style, like a list; or it may be a combination of styles. Photos and pictures are also helpful.

Agenda question: *What is most important to this person that is not happening or needs to be strengthened?*

[Empty rectangular box for agenda question response]

Section II

Describes what is **happening** in this person's life from anyone's perspective

6. Describe what people like and admire about this person:

[Large rectangular box for question 6 response]

The CDDP Services Coordinator or Children's Residential/Development Specialist are **not required** to contribute, but they may if they have a historical perspective or information that they would like to share.

Some people may have valuable information to contribute but may not have time to write it directly on a PFW. Information may be gathered through discussion or review of past records, and then added to the PFW.

13. Describe any supports this person needs to participate in activities that are important to this person:

If using **hand written forms** and more space is needed for writing, you can use another sheet of paper and write the number and question, or the back of the PFW sheet can be used.

Person Centered Thinking Tool: Important To/Important For



Agenda question: Does anything about these supports needs to change or be enhanced?

Empty rectangular box for agenda question response.

Answers to questions in **Sections IV and V** must be added to the ISP Meeting Agenda "Discussion Topics".

Section IV

Describes what would **enhance** this person's life from anyone's perspective

All answers below must be transferred directly to the ISP Meeting Agenda.

14. What could improve this person's ability to be independent?

Questions 14-19 will help you explore "Independence, Integration, and Productivity" further.

Person Centered Thinking Tool: Working/Not Working



15. How could this person be more involved in activities or events in his/her community?

Empty rectangular box for question 15 response.

Person Centered Thinking Tool: 4 + 1




Don't forget to number your pages if using the handwritten form.

PFW Updates Page for _____

*Use this page to update any information in this PFW. Follow team agreements for communicating new information to other team members. **Sign and date each entry.** Incorporate any updates into dnext year’s PFW, as needed.*

If a PFW Updates Page is written throughout the ISP year; the original is maintained with the provider.

Person Centered Thinking Tool: Learning Log, Working/Not Working, 4+1



Each year a new (blank) PFW Updates Page is distributed with the new PFW and the previous PFW Updates Pages are archived after the information is transferred to the new updated PFW.

It is optional to update the PFW throughout the year using the “PFW Updates Page”.

When updating the PFW before a new ISP, it’s highly recommended that a copy of the previous completed PFW is sent out to team members to add, modify, or change sections they feel need updating.

Risk Tracking Record Cover Sheet

Signatures and Updates

Person Receiving Services: _____

Date	Name	Relationship to	Signature
<div style="border: 1px solid black; padding: 2px; width: fit-content;"> This is the Pre-Meeting Date. </div>			<div style="border: 1px solid black; padding: 5px;"> This page is completed annually by, at minimum, a representative from residential provider and <ul style="list-style-type: none"> Adults: Employment/ATE provider (if no second provider, best practice is to include a second person who knows the person's risks) Children: Residential Specialist </div>

RTR Updates:

Date of update:		Date of update:	
Updated with changes to question number(s):		Updated with changes to question number(s):	
Notes:	<div style="border: 1px solid black; padding: 5px;"> There is space to record two separate updates here. If more updates are needed during the ISP year, attach an Additional RTR Updates pages. </div>	Notes:	<div style="border: 1px solid black; padding: 5px;"> <ul style="list-style-type: none"> Complete a new RTR Cover Sheet every year at the Pre-Meeting Remove and archive previous cover sheet at the Pre-Meeting every year. </div>
Signatures of person(s) completing update:			

Complete this form when reviewing the RTR every year at the Pre-Meeting. Keep the RTR current at all times. Record any changes made throughout the year in the RTR Updates boxes. An additional RTR Updates page is available. Remember to also complete an ISP Change Form if any risks change mid-year. See ISP manual for more details.

Additional Risk Tracking Record Updates:

Date of update:		Date of update:	
Updated with changes to question number(s):		Updated with changes to question number(s):	
Notes:		Notes:	
Signatures of person(s) completing update:		Signatures of person(s) completing update:	

Date of update:		Date of update:	
Updated with changes to question number(s):		Updated with changes to question number(s):	
Notes:		Notes:	
Signatures of person(s) completing update:		Signatures of person(s) completing update:	

Only use this page if needed

Remove and file Additional RTR Updates pages every year at the Pre-Meeting.

RTR Updates pages are numbered independently. If one Additional RTR Updates page is used, it is page 1 of 1. If there are two Updates pages they are numbered 1 of 2 and 2 of 2 and so on.

Updates page ____ of ____

Tracking Record

This section of the RTR looks at indicators related to this person's risk of Aspiration/Choking .			
Questions		Yes	No
1. Does this person have a diagnosis of dysphagia, or has this person been identified to be at risk of aspiration by a Physician, Speech/Language Pathologist, or Occupational Therapist? If Yes , add risk of Aspiration to ISP.	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <i>Person Centered Thinking Tool: Important To/For</i> </div>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does someone else put anything into this person's mouth? If Yes , add risk of Aspiration to ISP.	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> All questions on the RTR must be answered Yes, No, or, where applicable, History. </div>	<input type="checkbox"/>	<input type="checkbox"/>
3. Does this person cough or choke during eating or drinking (more than once during a current evaluation)? If Yes , add risk of Aspiration to ISP. Requires a current evaluation to determine risk of aspiration (see the ISP manual).	<div style="border: 1px solid black; border-radius: 50%; padding: 10px; display: inline-block;"> When thinking about supports for risks identified, what's important TO the person should be considered to help improve their quality of life. </div>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has this person been diagnosed with gastroesophageal reflux (GERD) or reflux (see the ISP manual)? If Yes , add risk of Aspiration to ISP. Requires a current evaluation to determine risk of aspiration (see the ISP manual).		<input type="checkbox"/>	<input type="checkbox"/>
5. Does this person complain of chest pain, heartburn, or have small frequent vomiting (especially after meals) or unusual burping (happens frequently or sounds wet)? If Yes , add risk of Aspiration to ISP. Requires a current evaluation to determine risk of aspiration (see the ISP manual).		<input type="checkbox"/>	<input type="checkbox"/>
6. Does this person have a feeding tube? If Yes , add risk of Aspiration to ISP.		<input type="checkbox"/>	<input type="checkbox"/>
7. Does food or fluid regularly fall out of this person's mouth? If Yes , add risk of Aspiration to ISP. Requires a current evaluation to determine risk of aspiration (see the ISP manual).	<div style="border: 1px solid black; border-radius: 50%; padding: 10px; display: inline-block;"> The ISP Manual details specific tasks that must be completed when questions are marked "Yes." See ISP Manual starting on page 36 for more information about the Health/Medical section. </div>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does this person drool excessively? If Yes , add risk of Aspiration to ISP. Requires a current evaluation to determine risk of aspiration (see the ISP manual).		<input type="checkbox"/>	<input type="checkbox"/>
9. Does this person have chronic chest congestion, pneumonia in the last year, rattling when breathing, and persistent cough or frequent use of cough/asthma medication? If Yes , add risk of Aspiration to ISP. Requires a current evaluation to determine risk of aspiration (see the ISP manual).		<input type="checkbox"/>	<input type="checkbox"/>

This section of the RTR looks at indicators related to this person’s risk of Seizures .			
Questions	Yes	No	History
29. Does the person have a diagnosis of seizures or epilepsy? See ISP manual for an exception. If Yes , add risk of Seizures to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Does this person take medication for seizures? If Yes , add risk of Seizures to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Has this person’s seizure medication, type or dosage, or seizure precautions such as water, bicycle use, safety equipment, etc. changed? If Yes , add risk of Seizures to the ISP. The Seizure precautions should be updated.	<input type="checkbox"/>	<input type="checkbox"/>	
32. Has this person had a seizure in the past year? If Yes , add risk of Seizures to the ISP. The Seizure precautions should be updated.	<input type="checkbox"/>	<input type="checkbox"/>	
33. Has this person had a seizure in the past five years? If Yes , add risk of Seizures to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>	
Record any notes related to Seizure questions:			

Changes to the questions of the RTR may be either

- handwritten directly on the RTR page, or
- the existing page may be removed and replaced with a new electronically updated page.

Be sure to date the handwritten changes so it is clear to others which answer is current.

This section of the RTR looks at issues relating to this person’s Safety and Finances.		
Questions	Yes	No
40. Is this person able to remain at home or at work/community inclusion without support for any length of time? **If the person is under the age of 18, you must mark No. If Yes , add risk of At Home Without Support and/or At Work/ATE Without Support to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>
41. Is this person able to be away from home, without support, for any length of time? If Yes , add risk of Away From Home Without Support to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>
42. Does this person need <u>any</u> assistance to adjust water temperature? If Yes , add risk of Safety Issue: Water Temperature to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>
43. Does this person need <u>any</u> assistance to evacuate when a fire or smoke alarm sounds? If Yes , add risk of Safety Issue: Fire Evacuation to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>
44. Does this person need <u>any</u> assistance to remain safe around household chemicals? If Yes , add risk of Safety Issue: Household Chemicals to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>
45. Does this person need <u>any</u> assistance to remain safe around traffic, while getting in or out of vehicles or while riding in vehicles? If Yes , add risk of Safety Issue: Vehicle Safety to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>
46. Does this person have any court mandated conditions or restrictions that are <u>not</u> a result of this person’s behavior? If Yes , add risk of Safety Issue: Court Mandated Conditions to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>
47. Does this person have any other important, serious safety issues while at their inclusion workplace that are not otherwise addressed in these questions? If Yes , add risk of Workplace Safety Issue: (list specific issue) to the ISP and list it.	<input type="checkbox"/>	<input type="checkbox"/>
48. Does this person have any other important, serious safety issues not addressed through the previous questions in this section? If Yes , add risk of Safety Issue: (list specific issue) to the ISP and list issue(s):	<input type="checkbox"/>	<input type="checkbox"/>

The Safety section has specific risks.

Example: a Restraining Order against someone else in the person’s life that could pose a Safety risk to the person.

This section of the RTR looks at risks relating to this person’s behavior or the status of their mental health.			
Questions	Yes	No	History
50. Does this person ingest non-edible objects or have a diagnosis of pica? If Yes , add risk of <i>Ingesting Non-Edible Objects</i> and <i>Aspiration/Choking</i> to the ISP. See ISP Manual for specific Support Document requirements.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. Does this person place non-edible objects in his/her mouth that may cause poisoning, aspiration or choking? If Yes , add risk of <i>Non-Edible Objects in Mouth</i> and <i>Aspiration/Choking</i> to the ISP. See ISP Manual for specific Support Document requirements.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
52. Does this person engage in physical aggression? If Yes , add risk of <i>Physical Aggression</i> to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
53. Does this person engage in self-injurious behaviors? If Yes , add risk of <i>Self Injury</i> to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
54. Does this person engage in property destruction? If Yes , add risk of <i>Property Destruction</i> to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
55. Does this person leave or attempt to leave supervised settings and is unsafe to do so? If Yes , add risk of <i>Leaves Supervised Settings</i> to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
56. Does this person engage in the unsafe use of flammable materials? If Yes , add risk of <i>Unsafe Use of Flammable Materials</i> to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
57. Does this person use illegal drugs or abuse drugs? If Yes , add risk of <i>Drug Abuse</i> to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
58. Does this person abuse alcohol? If Yes , add risk of <i>Alcohol Abuse</i> to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
59. Does this person engage in unsafe social behavior? If Yes , add risk of <i>Unsafe Social Behavior</i> to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
60. Does this person engage in undesirable sexual behavior? If Yes , add risk of <i>Undesirable Sexual Behavior</i> to the ISP. Requires a current evaluation by a qualified professional to determine the current level of risk and support needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Mark “History” if it is **not a current issue** and does not currently require any supports, but it did happen or need supports within the last **five** years.

Behavior/Mental Health questions, continued	Yes	No	History
61. Does this person engage in behavior that is harmful to animals? If Yes , add risk of <i>Harm to Animals</i> to the ISP. Requires a current evaluation by a qualified professional to determine the current level of risk and support needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
62. Does this person use weapons or objects in an attempt to injure himself/herself or others? If Yes , add risk of <i>Use of Objects as Weapons</i> to the ISP. Requires a current evaluation by a qualified professional to determine the current level of risk and support needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
63. Does this person engage in illegal behavior? If Yes , add risk of <i>Illegal Behavior</i> to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
64. Does this person have any court mandated conditions or restrictions that are a result of this person's behavior? If Yes , add risk of <i>Court Mandated Conditions: (list court order and date)</i> to the ISP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
65. Does this person have a psychiatric diagnosis? See ISP Manual for details. If Yes , add risk of <i>Mental Health Diagnosis</i> to the ISP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
66. Does this person engage in suicidal attempts, gestures or threats? If Yes , add risk of <i>Suicide</i> to the ISP. Requires a current evaluation by a qualified professional to determine the current level of risk and support needs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Record any notes related to the Behavior/Mental Health questions: <div style="border: 1px solid black; padding: 10px; margin: 20px auto; width: fit-content;"> The original RTR is kept with the Services Coordinator/Residential Specialist </div>			
Record any evaluations that occurred for the Behavior/Mental Health section: Evaluation type: _____ Date of evaluation: _____ Document location: _____ Evaluation type: _____ Date of evaluation: _____ Document location: _____			

CONSTIPATION PROTOCOL

You do not need permission to call 911

Describe how you know this person is at risk for constipation (include diagnosis, history, and special considerations):

Protocols must indicate preventative measures.

SECTION 1: Description of Preventions

<input type="checkbox"/> Prunes _____ times daily <input type="checkbox"/> Prune juice _____ times daily <input type="checkbox"/> Bran _____ times daily <input type="checkbox"/> High fiber diet <input type="checkbox"/> Extra fluids:	<input type="checkbox"/> Instructional program for toilet use Instructions located: <input type="checkbox"/> Regularly scheduled bowel medications <input type="checkbox"/> Exercise/activity:
<input type="checkbox"/> Other dietary support to help minimize risk of constipation:	<input type="checkbox"/> Regular scheduled time in the bathroom:
<input type="checkbox"/> Other preventions (Privacy, reminders, etc):	
<input type="checkbox"/> Record bowel movements Where: <input type="checkbox"/> BM Chart <input type="checkbox"/> MAR/TAR <input type="checkbox"/> Other: _____ Bowel movements are <input type="checkbox"/> Self-reported <input type="checkbox"/> Observed <input type="checkbox"/> Other: _____ <input type="checkbox"/> BM data is shared with <input type="checkbox"/> School <input type="checkbox"/> Work <input type="checkbox"/> Home <input type="checkbox"/> Other: _____ How is BM data shared?	

Check all boxes that apply to the person.

SECTION 2: Signs and Symptoms of Constipation

<ul style="list-style-type: none"> ● Hard, small, dry stools ● Spending a lot of time sitting on toilet ● Bloating stomach ● Stomach pain and discomfort ● Has refused to eat for _____ meals <input type="checkbox"/> Refusing to eat or drink ● Unusual straining and grunting on the toilet <input type="checkbox"/> Has had no stool or only 'small' stool in _____ days 	<input type="checkbox"/> Person's own way of letting others know he/she is constipated: <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> If "Record bowel movements" box is <u>not</u> checked (above), this box must be checked and a description written in. </div>
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Support Documents are created for specific environments.

Person receiving services: _____ Date: _____

Protocol for: Work Home Other: _____

SECTION 3: What to do if any signs and symptoms are observed

- Administer PRN bowel medications as ordered, see MAR
 - Additional instructions for administering PRNs if not included in the order:
 - If there is no PRN bowel medication order
 - If PRN medication is not effective
 - If no bowel movement occurs within ____ day(s) after administering PRN medication
 - If vomiting occurs with other signs and symptoms of constipation
 - If signs of blood in stool are present except: _____
 - Other:
1. Contact and follow any instructions given:
 Supervisor Nurse Physician _____
2. Document incident in: Progress Notes Incident Report Other: _____
3. Notify: Work Home School Family/Guardian Other: _____

Information is required on bulleted items that are not optional.

SECTION 4: CALL 911 AND START EMERGENCY AND FIRST AID PROCEDURES AS TRAINED, IF ANY OCCUR

- Person appears gravely ill or you are concerned about their immediate health and safety
- If person vomits material that smells like BM, or looks like coffee grounds or dark jelly
- If the person has a very hard, protruding abdomen
- If the person has severe abdominal pain
- Other:

The original protocol is kept with the provider that developed it.

Always choose notification options with staff in mind: who do direct care staff need to notify?

After calling 911,

Contact and follow any instructions given:

- Supervisor Serv. Co./Res. Spec. Physician
- Nurse Family/Guardian Other: _____

If the protocol ever gets changed, update this date, update the ISP Risks page and complete an ISP Change Form.

After the person is stable, document incident in:

- Incident Report Progress notes Other: _____

Written by: _____

No signatures or review initials are required by the ISP process, only the author's name.

Person receiving services: _____ Date: _____

Protocol for: Work Home Other: _____

FINANCIAL PLAN

Describe this person’s ability to make financial decisions

This area must be completed on every Financial Plan.

The person has a Representative Payee. Name: _____

Person’s responsibility for spending money

The person accesses and/or receives cash, prepaid debit cards, or gift cards. Describe:

When boxes are checked, the information needs to be specific to the individual.

The person uses checks, ATM/debit cards, or credit cards. Describe:

This area must be completed on every Financial Plan.

Person can be independently responsible for up to: \$ _____
Are receipts required to be kept for purchases made by this person? Yes No

Program responsibility for money management

Residential provider manages cash, prepaid debit cards, or gift cards for the person. Describe:

Employment/ATE provider manages cash, prepaid debit cards, or gift cards for the person. Describe:

Generally, if there are any financial supports provided at work as well as at home, there should be one combined Financial Plan for Work and Home.

Person receiving services: _____ Date: _____

Financial Plan for: Work Home Other: _____

Residential provider manages account(s) for the person. Describe:

Residential provider manages ATM/debit/credit cards. Describe:

Employment/ATE provider manages ATM/debit/credit cards. Describe:

Other program money management considerations:

Describe the manner and frequency of reconciliation of program-managed financial records:

This area must be completed on every Financial Plan.

ISP Team responsibility for money management

Approval required for total individual expenditures over: \$_____ per month
Approval required for single purchases over: \$_____.
How approval will be obtained to exceed these limits and where approval will be documented:

These areas must be completed on every Financial Plan.

All personal property valued at or purchased over \$_____ and any items of value will be recorded on a Personal Property Record.

Who is responsible for reporting wages to Social Security?

Person receiving services: _____ Date: _____

Financial Plan for: Work Home Other: _____

Income	Approximate amount

These are only suggestions. On the template version, they may be deleted.

Expenses	Approximate amount
Room and Board	
Residential Offset	
Medications	

This may be monthly expenses or some other time frequency (example, Burial Plan: \$500 per year).

Budgeting

An individual spending budget is maintained for this person.
Describe or indicate where located:

Additional Information

The person routinely purchases money orders.

Other information:

Written by: _____

Person receiving services: _____ Date: _____

Financial Plan for: Work Home Other: _____

ISP Meeting Agenda

Person receiving services: _____ Meeting date: _____

1. ISP Review

Review successes and achievements of the previous year. Review the things that didn't work or didn't get completed. Is there anything from last year's ISP that needs to continue or be enhanced? If so, add as a discussion topic.

2. Review drafted ISP

If anything needs to continue, be sure to add it to the agenda discussion topic.

3. Team Discussion

Each topic must be addressed in a Discussion Record, Action Plan, or have other response from the team documented on the agenda:

- a. Anything the person wants to talk about at the meeting
- b. All responses to the PFW Agenda Questions
- c. Responses to all questions in Section IV & V of the agenda
- d. Any Items for Consideration marked "Yes"
- e. Any items from last year's agenda that need to be discussed
- f. Other items not yet addressed that the team needs to discuss

The original copy of the Agenda is kept by the Services Coordinator/Residential Specialist after the ISP meeting. Providers need a copy of the agenda.

<u>Yes</u>	<u>No</u>	<u>Items for Consideration</u>
<input type="checkbox"/>	<input type="checkbox"/>	Does the person want to self-administer medications? Consider any training needs the person will be monitored.
<input type="checkbox"/>	<input type="checkbox"/>	Does the person need a Health Care Representative?
<input type="checkbox"/>	<input type="checkbox"/>	Are there any unfinished tasks from the RTR or Support Documents that are not yet completed?
<input type="checkbox"/>	<input type="checkbox"/>	Are there any Support Documents that interfere with what's most important to the person?
<input type="checkbox"/>	<input type="checkbox"/>	Does any team member have an objection to any Support Document listed on the ISP Risks page?
<input type="checkbox"/>	<input type="checkbox"/>	Does the person need financial planning or benefits counseling in order to maximize resources?
<input type="checkbox"/>	<input type="checkbox"/>	Is the person at risk of exceeding financial resource limits?
<input type="checkbox"/>	<input type="checkbox"/>	Are there any variances requiring team approval?
<input type="checkbox"/>	<input type="checkbox"/>	Are the hours of Employment/ATE less than the standard unit of service?
<input type="checkbox"/>	<input type="checkbox"/>	Are the hours of school less than entitled?

Anything marked "Yes" must be added to the agenda discussion topics.

INDIVIDUAL SUPPORT PLAN

Person receiving services: _____

For people under 18 the answer is always 'Yes.'

Does this person have a Legal Representative/Guardian? No Yes, name: _____

Meeting Date: _____ ISP start date: _____ ISP end date: _____

What's most important to this person:

The entire answer to PFW question #5 must be transferred word for word to this page. Additional information may be added to this page by the team at the ISP meeting, if needed.

End date is either one year from date implemented or the last day if the ISP month.

The start date is the date the ISP will be implemented. The ISP must be implemented no later than the last day of the month that the previous ISP ended.

Staff that work with the person receiving services must be trained on their ISP and all Support Document no later than this date.

Providers must draft and distribute this page to team members before the ISP meeting.

If more than one meeting was held to complete the ISP, record the final meeting date on all pages.

Page numbers are written in at the end of the ISP Meeting.

Person Receiving Services: _____ Meeting Date: _____ Page _____ of _____

Risks

This person is at risk of, or has a risk related to, the following (as identified on the Risk Tracking Record)	List the title of each Support Document that will be used to support the risk	Support Document Information			
		Home		Work/ATE	
		Date	Where kept	Date	Where kept
<i>Seizures</i>	Tonic Clonic Seizure protocol Absence Seizure protocol	10-20-09 10-18-09	Med book Med book	10-15-09 10-5-09	Training file Training file
<i>Complications of Diabetes</i>	Hypoglycemia protocol Hyperglycemia protocol Diabetes protocol	10-14-08 10-29-08 n/a	Med book Med book n/a	n/a n/a 10-5-08	n/a n/a Training file
<i>Safety Issue: Water Temperature</i> <i>Safety Issue: Fire Evacuation</i>	Safety Plan	10-29-08	Chart Book	10-4-08	Training file
<i>Self Injurious Behavior</i> <i>Physical Aggression</i> <i>Property Destruction</i>	Behavior Support Plan	10-23-09	Chart Book	10-30-09	Training file
<i>Safety Issues: Vehicle Safety</i>	Safety Plan Behavior Support Plan	10-29-08 10-23-09	Chart Book Chart Book	10-4-08 n/a	Training file n/a

Multiple risks may be addressed by a single Support Document

One risk may be addressed by multiple Support Documents

Record only risks in ***bold-italics*** that are identified by the Risk Tracking Record.

List each risk only once, even if it was identified by more than one question on the RTR.

Providers must draft and distribute this page to team members before the ISP meeting.

Professional Services this Person Uses/Needs

* See Residential Individual Summary Sheet for current names of specialists

Type of specialist*	List the specific reasons why this person sees this specialist	How often or date due	Where to record	Notes
Primary Physician	<div data-bbox="373 289 865 418" style="border: 1px solid black; padding: 5px;"> Identify in this column specific services the specialist provides or describe what issue they monitor. </div>			<div data-bbox="1381 240 2011 565" style="border: 1px solid black; border-radius: 50%; padding: 10px;"> Teams do not have to fill in the notes section. It can be used to record anything that is useful such as the date the person was last seen by the professional. </div>
	<div data-bbox="247 500 531 602" style="border: 1px solid black; padding: 5px;"> List specialists by title, not by name. </div>			
				<div data-bbox="1234 695 1955 889" style="border: 1px solid black; border-radius: 50%; padding: 10px;"> Providers may draft and distribute this page to team members before the ISP meeting. </div>
				<div data-bbox="1255 976 1755 1089" style="border: 1px solid black; padding: 5px;"> "Health Care Representative" is always 'No' for people under 18. </div>

Does this person have a Nursing Care Plan at home? No Yes, where found: _____

Does this person have a Nursing Care Plan at work? No Yes, where found: _____

Does this person have a Health/Medical Problem List? No Yes, where found: Home: _____ Work: _____

Does this person have a Health Care Representative? No Yes, appointment date: _____

If yes, Self-appointed ISP Team appointed Where is the document located? _____

Person Receiving Services: _____ Meeting Date: _____ Page _____ of _____

Discussion Record

Issue:

More than one issue may be recorded on one Discussion Record.

- A Discussion Record is required for team disagreements & unresolved issues
- A Discussion Record may be used to document any discussion the team wishes

Discussion:

Every ISP must include at least one Discussion Record.

Document everyone's perspective in the discussion, including the person's perspective.

Bring blank copies of Discussion Records to the ISP meeting.

Decision:

A decision must be noted, even if the decision is that the team is still undecided or unresolved with next steps for continuing the discussion.

If the issue was an ISP team disagreement or unresolved issue and no Action Plan will be created, write the justification for not having an Action Plan in the decision box.

Is there an Action Plan associated with this issue? No Yes

Person Receiving Services: _____ Meeting Date: _____ Page _____ of _____

Service Supports

Employment/ATE/School <input type="checkbox"/> Alternative to Employment <input type="checkbox"/> Facility-based Employment <input type="checkbox"/> Supported Employment <input type="checkbox"/> School <input type="checkbox"/> Other: _____	Name and Address of Agency Responsible 	Typical Schedule <div style="border: 1px solid black; border-radius: 50%; padding: 10px; text-align: center;"> This page may be drafted prior to the ISP meeting. </div>
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Residential <input type="checkbox"/> 24-hour Residential Services <input type="checkbox"/> Supported Living Program <input type="checkbox"/> Proctor Care <input type="checkbox"/> Other: _____	Name and Address of Agency Responsible
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Transportation <input type="checkbox"/> Employment/ATE/School <input type="checkbox"/> Medical Appointments <input type="checkbox"/> Other	Responsible Provider 	Transportation method and contact information <div style="border: 1px solid black; padding: 5px;"> Note how transportation is actually provided and how to contact if a ride needs to be scheduled or canceled. </div>
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Team members must ensure that this plan is designed to enhance the person's independence, integration and productivity.

- Independence: Having control and choice over one's own life.
- Integration: Living near and using the same community resources as other people without disabilities.
- Productivity: Engaging in work that contributes to a household or community, as measured through improvements in income level, employment status or job advancement.

Before signing off on the ISP, team members must review the ISP and ensure the plan is designed to enhance these areas. There must be, at minimum, one instance of each in the person's ISP.
****Remember Employment/ATE OAR's.****

together with, _____ that is

ISP Signature Page

Next ISP Meeting: Tentative date Tentative time

The complete original ISP must be kept by the Services Coordinator/ Residential Specialist.
A copy must be kept by providers.

Team approval for changes to the ISP or Support Documents prior to the next ISP meeting
 Team members will be contacted to obtain verbal approval for all changes to the ISP or Support Documents

Exceptions:

Team Members	Relationship to this person	Present at meeting?	Signature (indicates approval of ISP and support documents listed on the Risks page)	Date	Objections to the plan or support documents, if any
	Person Receiving Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;"> The person must sign the ISP, or they may make a mark and someone else sign as a witness. </div>		
	Parent/Family Member	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	Legal Representative/Guardian	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	CDDP Services Coordinator	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	ODDS Residential Specialist	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	Residential Provider Representative	<input type="checkbox"/> Yes <input type="checkbox"/> No			
	Employment/ATE Provider Rep.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		<input type="checkbox"/> Yes <input type="checkbox"/> No			

If the person was not present for the meeting, you must also document why the person was not present: here, on a discussion record, or on the agenda.

If this person was not present for part or all of this meeting, see ISP manual for additional requirements. Note here who will explain this plan to this person: