



IP.1 - Information Profile

Name:	Date:	
Address:	Sex: Select	
City/Zip: ,	DOB:	
Phone: () -	DDS#:	
Email: @ .		
Type of Residence: Select	Primary language: English	Ethnicity: Select
Allergies:	Communication Style: Select	

Case Manager (CM):	CM Phone: () -	
Level of MR: Select	Diagnosis:	ICD 9 codes:
Legal Status: Select	Type of Waiver: Select	
Registered Voter: Select	Waiver Enrollment Date:	
Residential WL: <input type="checkbox"/> Priority Status:	Day WL: <input type="checkbox"/> Priority Status:	
WL Referral Date:	WL Referral Date:	

Guardian: Select		
Name:	Home: () -	Cell: () -
Address:	Email: @ .	
Primary Responsible Person		
Name:	Home: () -	Cell: () -
Relationship:	Email: @ .	
Address:		
Emergency Contact (stand by if PRP is not available)		
Name:	Home: () -	Cell: () -
Address:	Email: @ .	
Conservator		
Name:	Home: () -	Cell: () -
Address:	Email: @ .	

Medical Contacts:

Physician:	Phone: () -	Fax: () -
Dentist:	Phone: () -	Fax: () -
Other:	Phone: () -	Fax: () -
Other:	Phone: () -	Fax: () -
Other:	Phone: () -	Fax: () -
Other:	Phone: () -	Fax: () -

Provider Agency Contacts

Residential:	Phone: () -	Fax: () -
Contact/Title: ,	Email: @ .	
Day:	Phone: () -	Fax: () -
Contact/Title: ,	Email: @ .	
Fiscal Intermediary:	Phone: () -	Fax: () -
Contact/Title: ,	Email: @ .	
DSS:	Phone: () -	Fax: () -
Contact/Title: ,	Email: @ .	
SSI:	Phone: () -	Fax: () -



Contact/Title: ,	Phone: () -	Email: @ .
Other:	Phone: () -	Fax: () -
Contact/Title: ,	Phone: () -	Email: @ .
Other:	Phone: () -	Fax: () -
Contact/Title: ,	Phone: () -	Email: @ .

Resource and Benefit information (Check all that apply)

Medicaid Application/Redetermination Current <input type="checkbox"/> Yes Last Redetermination Date: / /		
<input type="checkbox"/> Earned Income – Monthly \$	<input type="checkbox"/> Prepaid Funeral Plan	<input type="checkbox"/> Health Insurance#
<input type="checkbox"/> Savings Balance \$	<input type="checkbox"/> Prepaid Burial Plan	<input type="checkbox"/> Railroad Insurance#
<input type="checkbox"/> SSI# - - Month \$	<input type="checkbox"/> Title XIX #	<input type="checkbox"/> Medicare A#
<input type="checkbox"/> SSDI# Monthly \$	<input type="checkbox"/> DSS Cash Assistance \$	<input type="checkbox"/> Medicare B#
<input type="checkbox"/> Checking Balance \$	<input type="checkbox"/> Food Stamps Monthly\$	<input type="checkbox"/> Medicare D#
<input type="checkbox"/> Trust Fund \$	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

DDS Support Information

<input type="checkbox"/> CM	<input type="checkbox"/> TCM				
<input type="checkbox"/> Residential	<input type="checkbox"/> Self Direct	<input type="checkbox"/> Vendor	<input type="checkbox"/> Master Contract	<input type="checkbox"/> Public	<input type="checkbox"/> Other
<input type="checkbox"/> Day/Employment	<input type="checkbox"/> Self Direct	<input type="checkbox"/> Vendor	<input type="checkbox"/> Master Contract	<input type="checkbox"/> Public	<input type="checkbox"/> Other
<input type="checkbox"/> Individual and Family Grant	Need Level:	<input type="checkbox"/> Low	<input type="checkbox"/> Med	<input type="checkbox"/> High	Amount
<input type="checkbox"/> Respite Center	<input type="checkbox"/> Rent Subsidy Monthly:				
<input type="checkbox"/> IFS Resource Support Team	<input type="checkbox"/> Other				

Notifications and Review (Check NA for any that do not apply)

PAR Notification (annually at IP)	Date:
Medicaid Due Process Rights Notification (annually at IP) <input type="checkbox"/> NA	Date:
Family/Guardian Notification of Incident Reporting Requirements (annually at IP)	Date:
Family/Guardian's Incident Reporting Request, Describe if beyond procedural requirements:	
Individual Informed of Human/Civil Rights (annually at IP)	Date:
Individual Informed of Abuse & Neglect Information (annually at IP)	Date:
Choice of Service Options Discussed (self-directed, vendor, agency with choice) (annually at IP)	Date:
Choice of Independent broker to provide FICS (prior to IP for those who self direct) <input type="checkbox"/> NA	Date:
Choice of Vendors/Providers discussed	Date:
Waiting list Priority Status Notification (annually at IP for those on WL) <input type="checkbox"/> NA	Date:
Transfer Hearing Notification <input type="checkbox"/> NA	Date:
Consent Form(s) (at initial visit or if not current) <input type="checkbox"/> NA	Date:
HIPAA Notification (at initial visit or if not current) <input type="checkbox"/> NA	Date:
Legal Liability Notification (at initial visit or change of Guardian) <input type="checkbox"/> NA	Date:
Voter Registration Notification (at initial visit, IP, after 17 th birthday or new address) <input type="checkbox"/> NA	Date:
PRC Review (Programmatic Review Committee) month/yr next review, Review exemption annually <input type="checkbox"/> NA	Date:
Emergency Fact Sheet and Relocation Form Updated, if applicable. <input type="checkbox"/> Residence <input type="checkbox"/> Day <input type="checkbox"/> NA	Date:
Other Notification:	Date:
Other Notification:	Date:



Name:	DDS#:
Case Manager:	Region: Select
Meeting Date:	Plan Effective Date: to

IP.2 - Personal Profile

For each profile domain, briefly describe the person’s current situation, experiences and issues that will be addressed in the development of the individual plan. Please refer to interview prompt questions for each domain. Include choices, preferences, likes and dislikes, as well as, assistance needed to make decisions in relevant domains.

Important To Know About You:

Accomplishments, Strengths and Things You Are Most Proud Of:



Name:	DDS#:
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Relationships:

Home Life:

Any Issues or concerns that need to be discussed:



Name:	DDS#:
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Work, Day, Retirement or School:

Leisure Interests and Community Life:

Health and Wellness:



Name:	DDS#:
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Medications:

List Current medications including Over the Counter (OTC) medications.

Type:	Reason for Medication/Comments:
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.
11.	11.
12.	12.
13.	13.

Adaptive Devices (if applicable):

Finances:



Name:

DDS#:

IP.3 - Future Vision

What are your hopes and dreams for the future (one to three years?)

What do you hope to accomplish in the coming year?



Name:	DDS#:
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IP.4 Assessments, Screenings, Evaluations and Reports

What current assessment, screenings, evaluations or reports information is available to help you plan for your future?
 Indicate if assessments, screenings, evaluations or reports are current, needed or not applicable.

Assessments, Screenings, Evaluation Report:	Current	Needed	N/A
▪ Physical Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Self-Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Dental Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Gynecological Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Mammogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Other Health/Medical:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Level of Need Assessment & Screening Tool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ My Health and Safety Screening (Optional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Speech & Language /Communications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Assistive Technology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Nutrition/Dietary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Psychological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Other Clinical:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ ADL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Aquatic Activity Screening (Required)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Bed & Safety Rail Audit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Vocational/Day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Guardianship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Resource/Financial (ex. Benefit Checkup)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Level of Support and Supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Waiting List Priority Checklist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Respite Profile Information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ IHS Nursing Health and Safety Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ IHS DDS Life Skills Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ IHS Self Medication Form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Aging Assessments (Falls, Dementia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
▪ Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:



Name:	DDS#
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IP.5 - Action Plan

Issues or Needs (Why is this Important? Current Status?)	Desired Outcome (What Do You Hope to Accomplish?)	Actions and Steps	Responsible Person(s)	<i>By When</i>
1.	1.	1A:		
		1B:		
		1C:		
		1D:		
		1E:		

Issues or Needs (Why is this Important? Current Status?)	Desired Outcome (What Do You Hope to Accomplish?)	Actions and Steps	Responsible Person(s)	<i>By When</i>
2.	2.	2A:		
		2B:		
		2C:		
		2D:		
		2E:		

Issues or Needs (Why is this Important? Current Status?)	Desired Outcome (What Do You Hope to Accomplish?)	Actions and Steps	Responsible Person(s)	<i>By When</i>
3.	3.	3A:		
		3B:		
		3C:		
		3D:		
		3E:		



Name:	DDS#
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Issues or Needs (Why is this Important? Current Status?)	Desired Outcome (What Do You Hope to Accomplish?)	Actions and Steps	Responsible Person(s)	By When
4.	4.	4A:		
		4B:		
		4C:		
		4D:		

Issues or Needs (Why is this Important? Current Status?)	Desired Outcome (What Do You Hope to Accomplish?)	Actions and Steps	Responsible Person(s)	By When
5.	5.	5A:		
		5B:		
		5C:		
		5D:		

Issues or Needs (Why is this Important? Current Status?)	Desired Outcome (What Do You Hope to Accomplish?)	Actions and Steps	Responsible Person(s)	By When
6.	6.	6A:		
		6B:		
		6C:		
		6D:		

Issues or Needs (Why is this Important? Current Status?)	Desired Outcome (What Do You Hope to Accomplish?)	Action and Steps	Responsible Person(s)	By When
7.	7.	7A:		
		7B:		
		7C:		
		7D:		

Strategies for working on Outcomes: List people involved:



Name:	DDS#
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IP.7 – Provider Qualifications & Training

DDS Waiver Services to be Provided (please check all that apply):

<input type="checkbox"/> Comp – Individualized Home Support	<input type="checkbox"/> Group Day Supports (includes DSO)
<input type="checkbox"/> Comp – Residential Habilitation (CLA & CTH)	<input type="checkbox"/> Individualized Day Supports
<input type="checkbox"/> Comp – Assisted Living	<input type="checkbox"/> Supported Employment - Individual
<input type="checkbox"/> IFS – Individualized Home Support	<input type="checkbox"/> Supported Employment - Group
<input type="checkbox"/> IFS – Residential Habilitation (CTH)	<input type="checkbox"/> Adult Day Health Services
<input type="checkbox"/> IFS – Family Training	<input type="checkbox"/> Respite
<input type="checkbox"/> Personal Support	<input type="checkbox"/> Nutrition
<input type="checkbox"/> Adult Companion Services	<input type="checkbox"/> Interpreter Services
<input type="checkbox"/> Health Care Coordination	<input type="checkbox"/> Transportation
<input type="checkbox"/> Clinical Behavioral Support Services	<input type="checkbox"/> Independent Support Broker

DDS Waiver Service: Select

- No, additional qualifications are required**
- Yes, the following additional qualifications are required**

Additional or Specific Qualification(s) (Specialized Expertise and or Training)	Timeframe in which the Qualification(s) Must be Met (X)	
	Prior to working Alone	Within 30 days
	<input type="checkbox"/>	<input type="checkbox"/>

DDS Waiver Service: Select

- No, additional qualifications are required**
- Yes, the following additional qualifications are required**

Additional or Specific Qualification(s) (Specialized Expertise and or Training)	Timeframe in which the Qualification(s) Must be Met (X)	
	Prior to working Alone	Within 30 days
	<input type="checkbox"/>	<input type="checkbox"/>



DDS Waiver Service: Select

- No, additional qualifications are required
- Yes, the following additional qualifications are required

Additional or Specific Qualification(s) (Specialized Expertise and or Training)	Timeframe in which the Qualification(s) Must be Met (X)	
	Prior to working Alone	Within 30 days
	<input type="checkbox"/>	<input type="checkbox"/>

DDS Waiver Service: Select

- No, additional qualifications are required
- Yes, the following additional qualifications are required

Additional or Specific Qualification(s) (Specialized Expertise and or Training)	Timeframe in which the Qualification(s) Must be Met (X)	
	Prior to working Alone	Within 30 days
	<input type="checkbox"/>	<input type="checkbox"/>

DDS Waiver Service: Select

- No, additional qualifications are required
- Yes, the following additional qualifications are required

Additional or Specific Qualification(s) (Specialized Expertise and or Training)	Timeframe in which the Qualification(s) Must be Met (X)	
	Prior to working Alone	Within 30 days
	<input type="checkbox"/>	<input type="checkbox"/>



Name:	DDS#
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IP.8 - Emergency Back-Up Plan

This form is to be completed for individuals who receive waiver services and live in their own home, family home or other settings where staff might not be continuously available, and who receive *personal care and/or supervision supports* and the failure of those supports to be available would lead to an immediate risk to the individual’s health and/or safety.

- No Emergency Back-up Support Plan is Required
- Yes, an Emergency Back-up Support Plan is Required and Described Below:

Type of Personal Care or Supervision Support Provided	Agency (A) or Self-Directed (SD) Supports		Name of Emergency Contact Person	Telephone Number of Emergency Contact Person	Specific Protocols
	A	SD			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			



Name:	DDS#:
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IP.9 - Summary of Representation, Participation & Plan Monitoring

Choice and Decision Making

Planning and Support Team review an assessment of a person’s understanding and capacity to make important decisions/choices, accept assistance from others and possible need for guardian/advocate/legal or personal representative.

Individual’s Participation in Planning Process

Summary of team’s efforts to involve the person in planning, the person’s actual participation in the planning process, and planned efforts to enhance the person’s future participation in planning.

Representative’s Participation in Planning Process

Summary of the team’s efforts to involve the person’s family/guardian/advocate/legal or personal representative in the planning process, the actual participation of these individuals in the process, and planned efforts to involve these individuals in planning in the future.

Summary of Monitoring and Evaluation of the Plan

Summary of the team’s efforts to ensure that the plan is being implemented and that progress is being made toward desired outcomes.



Name:	Region: Select	DDS#
Case Manager:	Plan Date:	

IP.10 – HCBS Re-determination

There is reasonable indication that the person, but for the provision of waiver services would in an ICF/MR.
 [42CFR441.302(c)]

The person requires assistance due to the following (check at least one):

- Has a physical or medical disability requiring substantial and/or routine assistance as well as habilitative training in performing self-care and daily activities
- Has a deficit in self-care and daily living skills requiring habilitative training
- Has a maladaptive social and/or interpersonal behavior patterns to the extent that he/she is incapable of conducting self-care or activities of daily living without habilitative training

This determination was made through a planning and support team process based on comprehensive professional assessments, evaluations, and/or reports that are on file in the:

- Case Record; or
- Other Location (identify)''

Signature: _____

Title (QMRP):



Name:	DDS#	Meeting Date:	<input type="checkbox"/> Plan Development
			<input type="checkbox"/> Periodic Review
			<input type="checkbox"/> Other

IP.11 - Individual Plan Signature Sheet

Name	Signature	Relationship To The Person	Attended Meeting (x)
		Individual	<input type="checkbox"/>
		Family Member/Guardian	<input type="checkbox"/>
		Advocate (as applicable)	<input type="checkbox"/>
		Case Manager	<input type="checkbox"/>
			<input type="checkbox"/>

As a consumer, family member, guardian or advocate, please contact your case manager within two weeks of receipt if you do not agree with this plan as written.

As a consumer, family member, guardian or advocate, you have the right to request a Programmatic Administrative Review pursuant to Policy DDS-7, if you disagree with any portion of the plan.

Comments: