Part II. Personal Profile

A Good Life: *What does a good life look like to me? include communication devices, (language)*

Talents, Strengths and Contributions: *What do people who know and care about me say about me? How do I contribute to friends, family and my community?*

This ISP belongs to:_____ ID# _____ ISP Start: _____ End: _____

What's working? Describe each area and include things I would like to stay the same	What's not working? (needs improvement) Things I would like to see changed.
Home	
Home:	
Routines:	
Independence:	
Privacy:	
Safety in my home:	
Community and Interests	
Inclusion in community:	
Safety in my community:	
Things I enjoy:	
Hobbies:	
Relationships	
Family and friends:	
Being understood by others:	
Qualities of those who support:	
Culture, traditions:	
Religion, spirituality:	
Work and Alternates to Work (Put into instructions: including age appropriate activities/volunteering)	
Days:	
Evenings:	
Weekends:	

This ISP belongs to:_____ ID# _____ ISP Start: _____ End: _____

What's working? Describe each area and include things I would like to stay the same	What's not working? (needs improvement) Things I would like to see changed.
Learning	
New accomplishments:	
Money	
Money, finances, accounts:	
Transportation and Travel	
Transportation:	
Travel:	
Health and Safety	
Foods, cooking, meals and supplements:	
Exercise and movement:	
Medications:	
Any Other Items or areas?	

Suggestion would be to put the medication history section from the long EI form here, or to say "Attach current Physician Order Sheet, at time of review".

This ISP belongs to:_____ ID# _____ ISP Start: _____ End: _____

Communication and Sensory Support

Preferred language:	Please *check one*) ☐ English ☐ Spanish ☐ Vietnamese ☐ Other (Please Specify):
Describe supports needed for communication (if any):	
Do I have any difficulty reading a magazine or newspaper?	☐ Yes ☐ No If *yes*, please describe.
Would a professional evaluation related to sensory or communication abilities be beneficial?	☐ Yes ☐ No

Adaptive Equipment, Assistive Technology and Modifications

Please describe any adaptive equipment and assistive technology supports (if any):	
Would a professional evaluation related to adaptive equipment, assistive technology or other modifications be beneficial?	☐ Yes ☐ No

Part III. Shared Planning**

Outcome #	What is important TO me for planning this year?	What does this look like when successful? (desired outcomes)	How often or by when?	Who's going to support me?

This ISP belongs to:_____ ID# _____ ISP Start: _____ End:

Outcome #	**What is important FOR me for planning this year?**	**What does this look like when successful? (desired outcomes)**	**How often or by when?**	**Who's going to support me?**

This ISP belongs to:_____ ID# _____ ISP Start: _____ End: _____

Part IV. Agreements

**Individual - Does my plan match…?			
what makes me happy?	☐ Yes ☐ No	what I need to be safe?	☐ Yes ☐ No
My dreams?	☐ Yes ☐ No	how I contribute?	☐ Yes ☐ No
being with people that I like?	☐ Yes ☐ No	new things I want to learn?	☐ Yes ☐ No
where & how I want to live?	☐ Yes ☐ No	my work dreams?	☐ Yes ☐ No
things I like to do?	☐ Yes ☐ No	the support that I need?	☐ Yes ☐ No
how I want to travel?	☐ Yes ☐ No	people who support me?	☐ Yes ☐ No
how I want to handle my money?	☐ Yes ☐ No	how I describe a good life?	☐ Yes ☐ No

If the answer is "no" to any of these questions, go back to that part of the profile and consider again. Please describe the reason for any questions above remaining "no" at the end of the meeting and any plan to resolve.

Team			
**Are there any unfinished tasks from my plan that are not yet completed?	☐ Yes ☐ No	** Does any team member have an objection to any outcomes in my plan?	☐ Yes ☐ No
**Are there any outcomes that are in conflict with what's most important to me?	☐ Yes ☐ No	** Do I need financial planning or benefits counseling in order to maintain or maximize resources?	☐ Yes ☐ No
Are there any conflicts in my plan that create a health and safety concern?	☐ Yes ☐ No	** Are there any items identified as IMPORTANT TO or IMPORTANT FOR in the SIS or PCT TOOLS that are not addressed in this plan?	☐ Yes ☐ No
*Scheduled at a time of my preference? If no, explain where relating note is found	☐ yes ☐ no	* Are there any items in my Assessments that are not addressed in this plan?	☐ Yes ☐ No

Please describe the reason for any questions above being marked "yes" and any plan to resolve.

This ISP belongs to:_____ ID# _____ ISP Start: _____ End: _____

Signatures of partners who help me with my plan:		
Individual		**Date**
Support Coordinator/QMRP:		**Date**
Guardian/ Authorized Representative W209		**Date**
Partner	**Relationship/service/support**	**Date**
Partner	**Relationship/service/support**	**Date**
Partner	**Relationship/service/support**	**Date**
Partner	**Relationship/service/support**	**Date**
Partner	**Relationship/service/support**	**Date**
Partner	**Relationship/service/support**	**Date**
Names of partners who contributed to my plan and were not here for planning: *ICFMR: For anyone not in attendance at the planning meeting, please include your signature, date and title. Your signature certifies you have read the plan and agree to assist the individual in the completion of his/her plan.		
****Quarterly review dates: 1- ,2- , 3- , 4-**		

This ISP belongs to:_____ ID# _____ ISP Start: _____ End:

Comments:

NOTE: Asterisks denote areas which are only required for the provider listed below:
* ICFMR providers only
** waiver programs only

This ISP belongs to:_____ ID# _____ ISP Start: _____ End: