|  |
| --- |
| **Part I. Personal Profile** |
| Legal Last Name |  |
| Legal Middle Name |  |
| Legal First Name |  |
| Preferred Name |  |
| How I am best supported to direct my planning process: |  |
| My preferences for annual planning: |  |
| My preferred date, time, and location for my meeting: |  |
| List great things about {PreferredName} |  |
| Describe what’s important TO {PreferredName} |  |
| Describe what’s important FOR {PreferredName} |  |
| Describe {PreferredName}’s vision of the life he or she wants |  |
| Describe what {PreferredName} doesn’t want in his/her life |  |
| **Part II. Essential Information** |
| Individual has a Supported Decision-Making Agreement? | [ ]  Yes[ ]  No  |
| If no, following a conversation about supported decision-making, is the individual interested in developing a supported decision-making agreement? | [ ]  Yes[ ]  No |
| If yes, enter the effective date of the Agreement. |  |
| If the individual has an SDMA, Is the individual satisfied with their Supporter(s)? | [ ]  Yes[ ]  No |
| If no, who will support the individual in making changes to their SDMA? |  |
| Decisions that are supported under the Agreement (check all that apply). | [ ] Health and Personal Care[ ] Friends and Partners[ ] Money[ ] Where I Live and Community Living[ ] School and Education[ ] Working[ ] My rights and Safety[ ] Meeting and Talking with My Supporters[ ] Other  |
| If other, please specify |   |
| Individual has the following | [ ] L : Legal Guardian[ ] A : Authorized Representative[ ] N : None |
| Are there any concerns with having or needing a substitute-decision maker? | [ ]  Yes[ ]  No |
| If yes, describe |  |
| Decisions that the representative is authorized to make (check all that apply). | [ ] Medical;[ ] Financial;[ ] Housing;[ ] Service Planning;[ ] Other |
| If other, please specify decision |  |
| Individual has a power of attorney? | [ ]  Yes[ ]  No |
| Is there an advanced directive? | [ ]  Yes[ ]  No |
| Comments (to include co-guardian, if applicable) |  |
| SSA Disability Determination Completed? | [ ]  Yes[ ]  No |
| Medications Required? | [ ]  Yes[ ]  No |
| Did the SC/CM ask all providers who are administering psychotropic medications if evidence of consent for use has been obtained (according to the providers’ own policies)? | [ ]  Yes[ ]  No[ ]  N/A |
| Medication name |  |
| Location where side effect information is stored and accessible |  |
| Are there currentmedical diagnoses (e.g., diabetes, asthma, flu, HIV, hepatitis B, COVID, measles, etc.)?  | [ ]  Yes[ ]  No |
| If yes, list  |  |
| Are there any supplemental protocols, plans, devices, or instructions (e.g., pureed meals, seizure protocol, communication device, crisis steps, etc.)?  | [ ]  Yes[ ]  No |
| If yes, list  |  |
| Is there a history of past medical conditions? | [ ]  Yes[ ]  No |
| If yes, list  |  |
| Is there a history of hospitalizations? | [ ]  Yes[ ]  No |
| If yes, list  |  |
| Is there a history of surgeries? | [ ]  Yes[ ]  No |
| If yes, list  |  |
| Is there a history of mental health conditions? | [ ]  Yes[ ]  No |
| If yes, list  |  |
| Is there a history of psychiatric hospitalizations? | [ ]  Yes[ ]  No |
| If yes, list  |  |
| Serious illnesses and/or chronic conditions of parents, siblings, and/or significant others in the same household? | [ ]  Yes[ ]  No |
| If yes, describe:  |  |
| Any of the following optional health screenings or vaccinations in the past 12 months? (Select all that apply) | [ ] Eye Exam[ ] Hearing Test [ ] Pap Test (women 21 and older)[ ] Mammogram (women 40 and older)[ ] Colorectal Cancer Screening (people 45 and over)[ ] Vaccines |
| Date of my last complete physical exam |  |
| Physical exam date is approximate. | [ ]  Yes[ ]  No |
| Examination Results (Physical Exam). |  |
| Date of my last complete dental exam. |  |
| Dental exam date is approximate. | [ ]  Yes[ ]  No |
| Examination Results (Dental Exam) |  |
| Diagnosed Allergies (describe seasonal, food, drug, other) |  |
| Adverse Reactions (describe seasonal, food, drug, other) |  |
| Describe my relevant social, developmental, behavioral, and family history. |  |
| History of abuse, neglect, sexual or domestic violence, or trauma including psychological trauma? | [ ]  Yes[ ]  No |
| If yes, describe |  |
| Provide a summary of my current and past living arrangements |  |
| Any concerns with accessing needed services or supports? | [ ]  Yes[ ]  No |
| If yes, describe:  |  |
| Highest level of education completed. | [ ] None[ ] Elementary[ ] Middle School[ ] Some High School[ ] High School[ ] Vocational[ ] Some College[ ] College Degree[ ] Some Graduate School[ ] Master’s Degree of Higher |
| Describe my educational history: |  |
| Employment status (select one). | [ ] currently employed;[ ] currently employed, looking;[ ] previously employed, looking;[ ] previously employed, not looking or retired;[ ] not previously employed, looking; [ ] not previously employed, not looking or child |
| Was there a conversation with the individual/substitute decision-maker about employment? | [ ]  Yes[ ]  No |
| [If No] Describe the reason the person does not want to discuss or pursue employment. |  |
| Did the employment conversation include employment interests? | [ ]  Yes[ ]  No |
| If yes, describe:  |  |
| Did the employment conversation include available employment options? | [ ]  Yes[ ]  No |
| If yes, describe:  |  |
| Did the employment conversation include satisfaction or dissatisfaction with current services? | [ ]  Yes[ ]  No |
| If yes, describe:  |  |
| Did the employment conversation include possible barriers to employment? | [ ]  Yes[ ]  No |
| Indicate all of the current barriers to employment. | [ ] None (if selected no other choices can be marked)[ ] Impact to benefits[ ] Transportation[ ] Safety[ ] Lack of awareness[ ] Other - describe |
| If other, please specify |  |
| Did the employment conversation include ways to resolve barriers to employment? | [ ]  Yes[ ]  No |
| Ways to resolve barriers discussed (select all that apply) | [ ] Benefits Planning;[ ] Employment and Community Transportation;[ ] Workplace Assistance;[ ] Therapeutic Consultation[ ] Community; Engagement/Coaching for education;[ ] Other |
| If other, please specify  |  |
| Did the employment conversation include a timeline for reviewing options in the future? | [ ]  Yes[ ]  No |
| If yes, describe |  |
| Did the employment conversation include any related actions that will be taken? | [ ]  Yes[ ]  No |
| If yes, describe |  |
| Is the individual between 14 and 17 years old at the time of this discussion? | [ ]  Yes[ ]  NoIf yes, the next **4 elements** are needed.  |
| Did the employment conversation include what the person is working on at home or school that leads to employment? | [ ]  Yes[ ]  No |
| If yes, describe |  |
| Did the employment conversation include how alternate sources of funding can support employment? | [ ]  Yes[ ]  No |
| If yes, describe |  |
| Volunteer status (select one). | [ ] currently volunteering;[ ] currently volunteering, looking;[ ] previously volunteered, looking;[ ] previously volunteered, not looking; [ ] no previous volunteering, looking; [ ] no previous volunteering, not looking |
| Community involvement occurring in the following ways (select all that apply). | [ ] Natural Supports;[ ] Community Engagement;[ ] Community Coaching;[ ] Group Day;[ ] Residentially-based services;[ ] Other |
| If other, please specify  |  |
| Was there a conversation with the individual/substitute decision-maker about integrated community involvement? | [ ]  Yes[ ]  No |
| [If No] Describe the reason the person does not want to discuss or pursue integrated community involvement. |  |
| Did the integrated community involvement conversation include community interests? | [ ]  Yes[ ]  No |
| If yes, describe |  |
| Did the integrated community involvement conversation include available community options? | [ ]  Yes[ ]  No |
| If yes, describe |  |
| Did the integrated community involvement. conversation include satisfaction or dissatisfaction with current services? | [ ]  Yes[ ]  No |
| If yes, describe |  |
| Did the integrated community involvement conversation include possible barriers to integrated community involvement? | [ ]  Yes[ ]  No |
| Indicate all of the current barriers to community involvement. | [ ] None; (if selected no other choices can be marked)[ ] Lack of awareness;[ ] Medical;[ ] Behavior;[ ] Other – describe |
| If other, please specify  |  |
| Did the integrated community involvement conversation include ways to resolve barriers to integrated community involvement? | [ ]  Yes[ ]  No |
| Ways to resolve barriers discussed (select all that apply) | [ ] Community Engagement;[ ] Community Coaching;[ ] Nursing;[ ] Employment and Community Transportation;[ ] Residentially-based services;[ ] Therapeutic Consultation;[ ] Workplace Assistance;[ ] Other - describe |
| If other, please specify  |  |
| Did the integrated community involvement conversation include a timeline for reviewing options in the future? | [ ]  Yes[ ]  No |
| If yes, describe |  |
| Did the integrated community involvement conversation include any related actions that will be taken? | [ ]  Yes[ ]  No |
| If yes, describe |  |
| Was there a conversation with the individual/substitute decision-maker about unpaid relationships? | [ ]  Yes[ ]  No |
| Summarize conversation about opportunities for relationships with people not paid to support the person and how barriers will be addressed as applicable. |  |
| Confirm topics included in the relationship conversation (select all that apply)\*\*at least one option must be selected | [ ] people to spend time with[ ] people who share interests and where they meet[ ] satisfaction or dissatisfaction with current services[ ] barriers related to developing relationships [ ] addressing barriers, as applicable [ ] a timeline for reviewing options in the future, at least annually[ ] any related actions that will be taken [ ] what the person is working on at home and school that will lead to more unpaid relationships[ ] alternate sources for funding (such as parks & recreation, social clubs, and faith-based services) |
| Describe plan for future living arrangements |  |
| Describe supports needed to transition to more inclusive settings |  |
| Current primary living situation | *System Populated in WaMS* |
| Current primary employment or day setting(Check all that apply). | [ ]  Community Coaching[ ] Community Engagement[ ] Employment Group[ ] Employment Individual[ ] Group Day Services[ ] Residential[ ] Self-Employed[ ] Unemployed[ ] Other |
| If other, describe |  |
| Has the individual and/or substitute decision maker identified an interest in pursuing one or more of these integrated housing options? (Check all that apply). | [ ] No interest expressed after a discussion of these integrated housing options (if selected no other choices can be marked)[ ] Local tenant-based rent assistance[ ] Low Income Housing Tax Credit properties[ ] Project-based rental assistance[ ] Other options |
| If Other, describe |  |
| Has the individual and/or substitute decision maker identified an interest in pursuing one or more of these integrated waiver service options? | [ ] No interest expressed after discussion of these integrated waiver service options; (if selected no other choices can be marked)[ ] Supported Employment[ ] Community Coaching;[ ] Community Engagement;[ ] Consumer-Directed Supports;[ ] Electronic Home-Based services;[ ] Other options |
| If Other, describe |  |
| Has the individual and/or substitute decision maker identified an interest in pursuing one or more of these integrated residential waiver service options?(Check all that apply). | [ ] No interest expressed after discussion of these integrated residential waiver service options (if selected no other choices can be marked)[ ] Independent Living Supports[ ] In-home Support Services[ ] Shared Living[ ] Sponsored Residential[ ] Supported Living[ ] Other options |
| If Other, describe |  |
| Additional Comments |  |
| **Part III. Shared Planning** |
| **Planning** |
| **Outcome #1** |
| Life Area | [ ] Employment[ ] Integrated Community Involvement [ ] Community Living[ ] Safety & Security[ ] Healthy Living[ ] Social & Spirituality[ ] Citizenship & Advocacy |
| Desired Outcome |  |
| Key steps and services to get there |  |
| Support Type | Select at least one:[ ] Relationship-based;[ ] Community-based;[ ] Eligibility-based |
| Support Provider Name |  |
| Other supporters |  |
| Start Date |  |
| End Date (End Date cannot be before the start date) |  |
| **Outcome #2** |
| Life Area | [ ] Employment[ ] Integrated Community Involvement [ ] Community Living[ ] Safety & Security[ ] Healthy Living[ ] Social & Spirituality[ ] Citizenship & Advocacy |
| Desired Outcome |  |
| Key steps and services to get there |  |
| Support Type | Select at least one:[ ] Relationship-based;[ ] Community-based;[ ] Eligibility-based |
| Support Provider Name |  |
| Other supporters |  |
| Start Date |  |
| End Date (End Date cannot be before the start date) |  |
| **Outcome #3** |
| Life Area | [ ] Employment[ ] Integrated Community Involvement [ ] Community Living[ ] Safety & Security[ ] Healthy Living[ ] Social & Spirituality[ ] Citizenship & Advocacy |
| Desired Outcome |  |
| Key steps and services to get there |  |
| Support Type | Select at least one:[ ] Relationship-based;[ ] Community-based;[ ] Eligibility-based |
| Support Provider Name |  |
| Other supporters |  |
| Start Date |  |
| End Date (End Date cannot be before the start date) |  |
| **Outcome #4** |
| Life Area | [ ] Employment[ ] Integrated Community Involvement [ ] Community Living[ ] Safety & Security[x] Healthy Living[ ] Social & Spirituality[ ] Citizenship & Advocacy |
| Desired Outcome |  |
| Key steps and services to get there |  |
| Support Type | Select at least one:[ ] Relationship-based;[ ] Community-based;[ ] Eligibility-based |
| Support Provider Name |  |
| Other supporters |  |
| Start Date |  |
| End Date (End Date cannot be before the start date) |  |
| **Outcome #5** |
| Life Area | [ ] Employment[ ] Integrated Community Involvement [ ] Community Living[ ] Safety & Security[ ] Healthy Living[ ] Social & Spirituality[ ] Citizenship & Advocacy |
| Desired Outcome |  |
| Key steps and services to get there |  |
| Support Type | Select at least one:[ ] Relationship-based;[ ] Community-based;[ ] Eligibility-based |
| Support Provider Name |  |
| Other supporters |  |
| Start Date |  |
| End Date (End Date cannot be before the start date) |  |
| **Outcome #6** |
| Life Area | [ ] Employment[ ] Integrated Community Involvement [ ] Community Living[ ] Safety & Security[ ] Healthy Living[ ] Social & Spirituality[ ] Citizenship & Advocacy |
| Desired Outcome |  |
| Key steps and services to get there |  |
| Support Type | Select at least one:[ ] Relationship-based;[ ] Community-based;[ ] Eligibility-based |
| Support Provider Name |  |
| Other supporters |  |
| Start Date |  |
| End Date (End Date cannot be before the start date) |  |
| Essential Supports |
| Identified Risk |
| Identified Risks (Select all that apply): | [ ] Pressure Injury[ ] Aspiration Pneumonia[ ] Fall with Injury[ ] Dehydration[ ] Bowel Obstruction[ ] Sepsis[ ] Seizure[ ] Community Safety Risks[ ] Self-Harm[ ] Elopement[ ] Lack of Safety Awareness[ ] Substance use[ ] Suicidal ideations[ ] None of these apply (If selected, then other options cannot be selected) |
| Potential Risk |
| Potential risk- pressure injury | Only complete if **Pressure Injury** is not selected on above Identified Risk Section.[ ]  Has been diagnosed with a PI in the past.[ ]  Has diagnosis of diabetes or congestive heart failure.[ ]  History or is currently experiencing paralysis or neurological damage.[ ]  Regularly spends much of each day in a bed, chair, or wheelchair. [ ]  Is unable to change body position independently.[ ]  Is incontinent of bowel and bladder.[ ]  Has experienced any wound or skin breakdown.[ ]  Has presence of swelling of ankles or feet.[ ]  None of these apply. |
| Potential risk- aspiration pneumonia | Only complete if **Aspiration Pneumonia** is not selected on above Identified Risk Section.[ ]  Has been diagnosed with aspiration pneumonia in the past.[ ]  Has a diagnosis of dysphagia, GERD and/or PICA.[ ]  Has a diagnosis of any neurologic disorder (e.g., Cerebral Palsy, Stroke, Dementia, Alzheimer’s Disease, Seizure disorder etc.)[ ]  Has been diagnosed with an upper respiratory infection.[ ]  Difficulty controlling head/neck muscles.[ ]  Requires assistance to be fed (food or liquid).[ ]  Regularly coughs while eating or has experienced a choking episode.[ ]  Has a feeding tube (G Tube, J Tube, NG Tube).[ ]  Is missing the majority or all of their teeth.[ ]  Has experienced impaired consciousness or awareness.[ ]  Has a tracheostomy and/or is suctioned routinely (including oral suctioning).[ ]  Has eating habits that could lead to choking (e.g., stuffing mouth, eating too quickly, jumping in seat etc.)[ ]  Has an altered textured diet or drink modifications (e.g., bite size, pureed, thickened liquids).[ ]  None of these apply |
| Potential risk – fall with injury(Select all that apply) | Only complete if **Fall with Injury** is not selected on above Identified Risk Section.[ ]  Has experienced a fall or fall with injury in the past.[ ]  Has been diagnosed with a seizure disorder, Meniere’s disease (vestibular syncope), or arthritis.[ ]  Takes more than 4 medications daily (polypharmacy)[ ]  Uses walking aids and/or other Durable Medical Equipment (DME)[ ]  Has experienced syncope (fainting).[ ]  Has experienced risk taking behaviors or impulsive behaviors such as darting or changing directions quickly with little to no indication.[ ]  Experiences urinary/bowel urgency.[ ]  Experiences fatigue and weakness with activity.[ ]  Is 65 or older.[ ]  None of these apply (If selected, then other options cannot be selected) |
| Potential risk – dehydration(Select all that apply) | Only complete if **Dehydration** is not selected on above Identified Risk Section.[ ]  Has been diagnosed with dehydration in the past.[ ]  Diagnosis of dysphagia, irritable bowel syndrome (IBS), hyperhidrosis and/or thermoregulation disorder.[ ]  Requires assistance to be fed (food or liquid).[ ]  Refuses to drink beverages.[ ]  Has experienced chronic/repetitive diarrhea.[ ]  Has experienced chronic/repetitive vomiting.[ ]  Is prescribed routine diuretic medication.[ ]  None of these apply (If selected, then other options cannot be selected) |
| Potential risk – bowel obstruction(Select all that apply) | Only complete if **Bowel Obstruction** is not selected on above Identified Risk Section.[ ]  Has been diagnosed with a bowel obstruction in the past.[ ]  Has been diagnosed with constipation, gastroparesis, Crohn’s disease, diverticulitis, PICA or an ileus.[ ]  Has diagnosis of any neurological disorder (e.g., Cerebral Palsy, Spina Bifida, Muscular Dystrophy, paralysis etc.)[ ]  Is prescribed laxatives or enemas (routine or PRN).[ ]  Refuses to drink beverages.[ ]  Requires assistance to be fed (food or liquid).[ ]  Is prescribed psychiatric and/or narcotic medications (routine or PRN).[ ]  Has limited mobility.[ ]  None of these apply (If selected, then other options cannot be selected) |
| Potential risk – sepsis(Select all that apply) | Only complete if **Sepsis** is not selected on above Identified Risk Section.[ ]  Has been diagnosed with Sepsis in the past.[ ]  Has been diagnosed with Diabetes, Chronic Obstructive Pulmonary Disease (COPD),Cirrhosis, Chronic kidney disease, Congestive Heart Failure (CHF), Pneumonia, UTI and/or lowered immune response (lupus, HIV, genetic disorders etc.)[ ]  Diagnosis of PI, skin breakdown or cellulitis[ ]  Recently experienced a severe hospitalization that includes an intensive care unit (ICU) admission.[ ]  Has been diagnosed with a urinary tract infection (UTI) and/or uses a urinary catheter (indwelling or requires in and out catheterization)[ ]  None of these apply (If selected, then other options cannot be selected) |
| Potential risk – seizure(Select all that apply) | Only complete if **Seizure** is not selected on above Identified Risk Section.[ ]  Has been diagnosed with seizure disorder in the past.[ ]  Has been diagnosed any neurological disorder, genetic disorder, (e.g., Autism Spectrum Disorder, Cerebral Palsy, Dementia, Alzheimer’s, Muscular Dystrophy, Obstructive Sleep Apnea, and Traumatic Brain Injury etc.) or thermoregulation disorder.[ ]  Has experienced a change in routine anti-epileptic medications (AEM).[ ]  Has missed or refused routine anti-epileptic medications (AEM).[ ]  Has been diagnosed with dehydration.[ ]  None of these apply (If selected, then other options cannot be selected) |
| Potential risk – community safety risks(Select all that apply) | Only complete if **Community Safety** is not selected on above Identified Risk Section.[ ]  Attempted to assault and/or injuring others[ ]  Property destruction due to fire setting and/or arson [ ]  Sexual aggression[ ]  None of these apply (If selected, then other options cannot be selected) |
| Potential risk – self-harm(Select all that apply) | Only complete if **Self-Harm** is not selected on above Identified Risk Section.[ ]  displays self-injury[ ] pica[ ] physical self-harm[ ] suicide attempts[ ] None of these apply (If selected, then other options cannot be selected) |
| Potential risk – elopement(Select all that apply) | Only complete if **Elopement** is not selected on above Identified Risk Section.[ ]  Leaves the setting unexpectedly, with a demonstrated history of lack of safety awareness, or ignoring common safety norms when leaving (i.e., walking into traffic)[ ]  Leaves the setting without support, despite current individualized safety restriction to include having support when leaving [ ]  None of these apply (If selected, then other options cannot be selected) |
| Potential risk – lack of safety awareness(Select all that apply) | Only complete if **Lack of Safety Awareness** is not selected on above Identified Risk Section.[ ]  displays a pervasive lack of safety awareness throughout their daily living due to communication deficits combined with cognitive deficits and/or brain injury that leaves them open to victimization (financial, daily living, socio-sexual)[ ]  None of these apply (If selected, then other options cannot be selected) |
| Potential risk – substance use(Select all that apply) | Only complete if **Substance Use** is not selected on above Identified Risk Section.[ ]  Expresses an intense desire for a substance. [ ]  Fails to fulfill obligations due to use of a substance. [ ]  Has quit or reduced participation in important activities in order to use the substance. [ ]  Spends excessive time obtaining, using, and/or recovering from the effects of a substance. [ ]  Uses larger amounts of a substance or for longer than intended. [ ]  Continues substance use despite having a physical or mental problem that could have been caused or exacerbated by the substance. [ ]  Expresses desire to cut down or regulate substance use and/or reports unsuccessful efforts. [ ]  None of these apply (If selected, then other options cannot be selected) |
| Potential risk – suicidal ideations(Select all that apply) | Only complete if **Suicidal Ideations** is not selected on above Identified Risk Section.[ ]  Talking, drawing, or writing about dying, death, or suicide[ ]  Making plans for suicide[ ]  Seeking means for suicide[ ]  Expressing hopelessness[ ]  Withdrawing from others[ ]  None of these apply (If selected, then other options cannot be selected) |
| Routine Supports |
| Routine Supports(Select all that apply): | [ ]  Adaptive equipment/DME[ ]  Bathing[ ]  Communication support[ ]  Dressing[ ]  Restroom support[ ]  Positioning/transferring[ ]  Personal appearance[ ]  Medication use[ ]  Housekeeping[ ]  Laundry[ ]  Shopping[ ]  Meal planning/preparation/intake[ ]  Banking/money management[ ]  Medical appointments[ ]  Transportation[ ]  Crisis plan[ ]  Other routine support #1 (e.g., dialysis, catheter care, ostomy care)[ ]  Other routine support #2 [ ]  Other routine support #3 [ ]  Other medical #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(e.g., high/low blood pressure, dementia/neurological impairment, respiratory care, G-Tube, etc.)[ ]  Other medical #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Other medical #3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Other behavioral #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(e.g. Self-neglect, trichotillomania, severe stereotypy, etc.)[ ]  Other behavioral #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Other behavioral #3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  None of these apply (If selected, then other options cannot be selected) |
| **Part IV. Agreements** |
| **Potential Risks Referral** |
| Will an appointment with a Qualified Health Professional be scheduled?Select one response: | Reference Potential Risks Identified in Part III:[ ] Pressure Injury[ ] Aspiration Pneumonia[ ] Fall with Injury[ ] Dehydration[ ] Bowel Obstruction[ ] Sepsis[ ] Seizure[ ] Community Safety Risks[ ] Self-Harm[ ] Elopement[ ] Lack of Safety Awareness[ ] Substance use[ ] Suicidal ideations[ ] None of these apply (If selected, then other options cannot be selected) |
| [ ]  If appointment is planned, who will schedule the appointment? [ ] If the appointment is not planned, described how needs are/will be met.  |  |
| **Individual Questions** |
| Does this plan move me closer to the life I want? | [ ]  Yes[ ]  No |
| Have I had the opportunity to plan for personal topics apart from the full team? | [ ]  Yes[ ]  No |
| I was supported to direct and participate in my planning process as described in Part II: Personal Profile? | [ ]  Yes[ ]  No |
| Do I choose or have input into my daily schedule? | [ ]  Yes[ ]  No |
| If the answer is “no” to any question above, go back and consider again. Describe the reason for any questions about remaining “no” at the end of the meeting and any plan to resolve. |  |
| **Team Questions** |
| Does any team member have an objection to any outcomes in my plan? | [ ]  Yes[ ]  No |
| Are there any restrictions that require review or agreement? | [ ]  Yes[ ]  No |
| Do I need financial planning or benefits counseling in order to maintain or maximize resources? | [ ]  Yes[ ]  No |
| Is there any IMPORTANT TO or IMPORTANT FOR information elsewhere that is not addressed in my plan? | [ ]  Yes[ ]  No |
| Describe the reason for any questions above being marked "yes" and any plan to resolve |  |
| Does any team member have an objection to any essential supports in my plan? | [ ]  Yes[ ]  No |
| If yes, describe the objection to any essential supports in my plan. |  |
| Are Therapeutic Behavioral Consultation waiver services needed? **Please review selections carefully and respond.****Select only 1** | [ ] Yes, referral to be completed within 30 days of ISP[ ] Yes, referral(s) already completed and waiting to start services[ ] Yes, and the person is connected to this service already[ ] Yes, there are needs but individual/SDM declined referral[ ] No, needs are addressed by other supports (e.g. ABA, psychology)[ ] No, needs do not require these services |
| If yes within 30 days, who will complete referral for behavioral services? **A service authorization should be submitted to DBHDS within 30 days of an identified need.** |  |
| Are Nursing waiver services needed? **Please review selections carefully and respond.****Select only 1** | [ ] Yes, referral to be completed within 30 days of ISP[ ] Yes, referral(s) already completed and waiting to start services[ ] Yes, and the person is connected to this service already[ ] Yes, there are needs but individual/SDM declined referral[ ] No, needs are addressed by other supports (e.g. ABA, psychology)[ ] No, needs do not require these services |
| If yes within 30 days, who will complete referral for nursing services? **A service authorization should be submitted to DBHDS within 30 days of an identified need** |  |
| Are supports or services needed that are not available? | [ ]  Yes[ ]  No |
| If yes, speak with your supervisor and you may contact your assigned Community Resource Consultant to discuss. |  |