SUPPORTS WAIVER INDIVIDUAL SERVICE PLAN (ISP)

Version 2 effective date: 03/11/2023

IDENTIFYING INFORMATION	
INDIVIDUAL'S FULL NAME:	DOB:
ADDRESS:	
CITY AND ZIP:	PHONE:
DIRECTIONS TO HOME:	
REGION: ☐ METRO ☐ NW ☐ NE ☐ SE ☐ SW	
NATIVE LANGUAGE:	INTERPRETER NEEDED: ☐ YES ☐ NO

DATE OF ISP MEETING:	DATE OF NEXT ISP MEETING:
EFFECTIVE DATES OF ISP: FROM	TO
TERM OF SW LEVEL OF CARE: FROM	TO
SUPPORTS WAIVER LEVEL OF CARE: ☐ I ☐ II ☐ III	
MEDICARE #:	
☐ INITIAL ☐ ANNUAL ☐ REVISION DATE:	REVISION VERSION:
TRANSFER FROM: ☐ PARTICIPANT DIRECTED ☐ AGENCY BASED (FOR PD DIRECTED VERSION ONLY)	
MANAGED CARE ORGANIZATION(MCO):	
MCO CARE COORDINATOR:	PHONE: E-MAIL:
LAST CARE NEEDS ASSESMENT (CAN):	CARE COORDINATION LEVEL:

SERVICE MODEL	
☒ **Agency Based**	☐ **Participant Directed**

PARTICIPANT PROGRAM SUPPORT	
Do you need support accessing:	Enter Y/N
Supports Waiver Program Information	
Participant Tool Kit	
Employer of Record Tool Kit	
Provider Selection Guide	
Identifying Resources	
Finding Providers and goods	
Interviewing and hiring employees	
Developing Interview Questions	
Checking References	
Additional Support	

EXTERNAL DOCUMENTS
What documents have been used to develop this ISP? Information from the Centennial Care Comprehensive Needs Assessment (CNA) or any other applicable assessments should be used when developing this ISP.

SERVICE BACK-UP PLAN

IF THERE IS AN EMERGENCY PLEASE CALL 911

Please print this and keep it easily available for your employees and other people who help you.
Each service requested and approved must have a back-up to provide necessary services for unplanned cancellations. A back-up can be an unpaid natural support or an employee.
If an agency is being accessed for a service, then the agency must be listed as a back-up provider for that service. If the service is self-directed the EOR should be contacted.

If regularly scheduled employees or service providers are unable to report to work I will contact the following:

SERVICE	NAME	ADDRESS (INLUDE E-MAIL)	PHONE	TIMES AVAILABLE

EMERGENCY BACK-UP PLAN

IF THERE IS AN EMERGENCY PLEASE CALL 911

Please print this and keep it easily available for yourself, employees and other people who help you.

CONTACT	NAME	ADDRESS (INCLUDE E-MAIL)	PHONE	ADDITIONAL
IN CASE OF EMERGENCY				
IN CASE OF EMERGENCY				
PHYSICIAN				
DENTIST				
FIRE				
POLICE				
UTILITY COMPANY				
CRISIS HOTLINE				
HOSPITAL				
URGENT CARE				

NARRATIVE SECTION

LIFE EXPERIENCES:
Who am I? Provide background information about your successful life experiences and major life events. Describe what life is like now and important relationships including who is a part of your circle of support. Include your important values and beliefs. Include information about your talents, hobbies and interests.

STRENGTHS:
What are my strengths? What are my preferences?

IMPORTANT THINGS:
What is important in my life now and in the future?

WORKING WELL:
What is working well in my life?

PROGRAM PARTICIPATION:
What do I want to have happen as a result of my participation in the Supports Waiver Program. Please include what your preferences in each area are.
at ***home*** related to my health, friends and relationships?
at ***work*** related to my health, friends and relationships?
in the ***community*** related to my health, friends and relationships?

COMMUNITY PARTICIPATION
How do you want to be involved in your community? Include interest in volunteering in areas such as community projects, charitable organizations or other special events in the community.

Are you interested in exploring what your interests or opportunities might be in the community?
☐ YES ☐ NO If yes, please explain.

Do you know how or where to access community activities or volunteer opportunities you are interested in?
☐ YES ☐ NO If no, please include plan to get information with assistance from the CSC.

EMPLOYMENT

If you are currently employed, please answer the following questions:

Where do you work?	
How many hours do you work?	

How long have you been employed?	
Do you enjoy your employment?	
What would make your employment better?	
Do you feel included in your work?	
Are there other employment opportunities (ie: advancement or a promotion at your current job, another job or career) you would like to pursue?	
If you are not employed, are you interested in exploring new experiences that could lead to work? If yes, please include plan to get information with assistance from the CSC.	

HEALTH AND WELLNESS
Provide summary information about significant health/medical/dental/behavioral-mental health/environmental concerns (past and present) and diagnosis(es) that have implications for planning or impact on the individual's health and safety, including what has been done to address these concerns.
Do you have any health concerns that have not been addressed? *Consider medical/health issues, eating and nutrition concerns, and behavioral/mental health concerns that might not be safe or helpful to your life. If yes, please explain and include what the plan is to address concerns.*

INDIVIDUAL HEALTH AND SAFETY INFORMATION

Please include all history and current information related to each area. List any identified health and safety issues in the column below. Each area with a history or that is currently present must include what the current intervention is and specific instructions to the service provider. Any additional areas that are relevant must be identified and included under (Additional).

Health and Safety Area	History	Current Intervention	Service Provider Instructions
Allergies – Food Specific			
Allergies			
Ambulation – including fall risk			
Aspiration			
Bowel Obstruction			
Dehydration			
GERD			
Seizures			
Special Diet/Meal Plan from a health professional.			
Respiratory (history of influenza or COVID 19 positive diagnosis)			

Additional (Oral care)			

HEALTH AND SAFETY INFORMATION
What information about you do you want to share related to health and safety?

ADDITIONAL TRAINING
What additional training would you like to identify for your service providers in addition to the required training with regards to your health and safety?

SUPPORTS WAIVER DIRECT SERVICES

Personal Care Services, Respite, Non-Medical Transportation and Community Membership Supports (Customized Community Supports Individual, Customized Community Supports Group and Employment Supports)

Individually determined supports that help you live as independently as possible in your home and community These supports can provide needed assistance with activities of daily living (ADLs), home management supports for health and safety or help you participate in community life in order to enhance relationships with others, work, or to participate in activities that are meaningful to you. Supports Waiver services add to but do not replace other paid and natural supports. The use of restraints, restrictive intervention and seclusion is not permitted in the delivery of Supports Waiver services.

Activity / Service	**Paid Supports (other than Supports Waiver) Ex: EPSDT Hours Per WK**	**Unpaid Supports Hours Per WK**	**Requested Supports Waiver Supports Hours Per WK**	**Total Hours Hours Per WK**	**Service Instructions**
ADLS					

Eating					
Dressing					
Transfers					
Toileting Maintenance Continence					
iADLS					
Personal Hygiene					
Light Housework					
Meal Preparation					
Grocery Shopping					
Laundry					
Routine Communications					
Money Management					
Banking					
Miscellaneous Finance					
Working with Vendors/Employees					
Scheduling Appointments					
Total Hours Per WK					

PERSONAL CARE SERVICES
If you are under 21, are you receiving Personal Care Services through EPSDT? ☐YES ☐No
If no do you need assistance with accessing EPSDT? ☐YES ☐NO
Do any of your Personal Care Services providers live in the same home with you? ☐YES ☐NO

SUPPORTS WAIVER DIRECT SERVICE	
PERSONAL CARE SERVICES	
Assessed Needs and Preferences	
Projected Amount, Requested Hours per month and per year	
Expected Outcome	

COMMUNITY MEMBERSHIP TABLE					
Activity / Service	**Paid Supports (other than Supports Waiver) Ex: EPSTD Hours Per WK**	**Unpaid Supports Hours Per WK**	**Requested Supports Waiver Supports Hours Per WK**	**Total Hours Hours Per WK**	**Service Instructions**
Community Supports Membership					
Employment					
Volunteering					
Educational					
Leisure / Recreational					
Building Relationships					
Translator / Interpreter					
ADL Support Needed in the Community					
Total Hours Per WK					

COMMUNITY MEMBERSHIP
Community Membership services Customized Community Support Individual and Group and Supported Employment that identify ADL support as a need must complete Personal Care Services Training. The use of restraints, restrictive intervention and seclusion is not permitted in the delivery of Supports Waiver services.

EMPLOYMENT SUPPORTS
Do you need assistance accessing DVR prior to utilizing Supports Waiver Employment Supports ? ☐YES ☐No
Do you need assistance coordinating a transition from DVR Employment Supports to Supports Waiver Employment Supports? ☐YES ☐NO

SUPPORTS WAIVER DIRECT SERVICE	
CUSTOMIZED COMMUNITY SUPPORT INDIVIDUAL	
Assessed Needs and Preferences	

Projected Amount, Requested Hours per month and per year	
Expected Outcome	
CUSTOMIZED COMMUNITY SUPPORT GROUP	
Assessed Needs and Preferences	
Projected Amount, Requested Hours per month and per year	
Expected Outcome	
SUPPORTED EMPLOYMENT	
Assessed Needs and Preferences	
Projected Amount, Requested Hours per month and per year	
Expected Outcome	

RESPITE SERVICES
ADL/iADL Table and Community Membership Table should be used to develop Respite Services. Respite services that identify ADL support as a need must complete Personal Care Services Training. The use of restraints, restrictive intervention and seclusion is not permitted in the delivery of Supports Waiver services.

Respite is provided to give the unpaid, primary caregiver time away from their duties. If requesting Respite, please provide the name of the unpaid primary caregiver utilizing the Respite and their relationship to you.

SUPPORTS WAIVER DIRECT SERVICE	
RESPITE SERVICES	
Assessed Needs and Preferences	
Projected Amount,	

Requested Hours per month and per year	
Expected Outcome	

NON-MEDICAL TRANSPORTATION
Non-Medical transportation services are offered in order to enable participants to gain access to waiver and other community services, activities and resources. The Community Membership Table should be used to develop this service. ADL Supports are not a part of this service.

Do you have information about medical transportation through your Managed Care Organization (MCO) in the event that medical transportation is needed? ☐ YES ☐ NO

SUPPORTS WAIVER DIRECT SERVICE	
NON-MEDICAL TRANSPORTATION	
Assessed Needs and Preferences	
Requested Mile Per Month and total per year	
Requested Hours by hourly driver per month and total per year	
Transportation through passes or ride share per month and total per year	
Expected Outcome	

Do you need any of your Direct Support Personnel to have training on wheelchair tie downs, lifting, and transferring, meal preparations or housekeeping skills? Please specify the trainings needed.
What else do you need your Direct Support Personnel To know about you?

RELATIVE AND LEGAL GUARDIAN APPROVAL
Do any of your paid Supports Waiver service providers live in the same home with you? ☐ YES ☐ NO

Are any of your paid Supports Waiver Personal Care, Respite, Customized Community Support Individual (CCS-I) or Non-Medical Transportation a relative or legal guardian? ☐ YES ☐ NO If yes, they need approval to provide services.
If yes, or currently requesting: please provide the relative or legal guardian's planned work schedule Monday through Sunday. If more than one employee is requesting to provide services please enter all employees.
Name of Relative or Guardian:
Relationship to Supports Waiver Participant: (Cannot be EOR)
Service Requesting to Provide:
Reason for Request:
Planned Work Schedule:

SUPPORTS WAIVER DIRECT SERVICE MEASUREMENTS AND MONITORING
How will I know if my services are working well for me and meet my identified needs? Please list an individual measurement to be monitored during monthly visits for each service.
Personal Care: **Respite:** **Customized Community Supports Individual:** **Customized Community Supports Group:** **Supported Employment:** **Non-Medical Transportation:**

BEHAVIOR SUPPORT CONSULTATION

BEHAVIOR SUPPORT CONSULTATION	
Assessed Needs and Preferences	
Projected Amount, Requested Hours per month and per year	
Expected Outcome	

What else do you need your Behavior Support Consultant to know about you?

BEHAVIOR SUPPORT CONSULTATION SERVICE MEASUREMENTS AND MONITORING
How will I know if my Behavior Support Services are working well for me and meet my identified needs? Please list an individual measurement to be monitored during monthly visits for each service.

COMMUNITY SUPPORT COORDINATOR (CSC)
Your Community Support Coordinator (CSC) will be contacting you by phone monthly and will conduct at least four (4) in person visits with you per year. Do you want more contact? ☐ YES ☐ NO **If yes, please give specifics below.**
How will I know if my Community Support Coordinator (CSC) services are working well for me and meet my identified needs?

SUPPORTS WAIVER OTHER SUPPORTS
SUPPORTS WAIVER OTHER SUPPORTS **Assistive Technology, Environmental Modification, Vehicle Modification**
Have you had any Assistive Technology, Environmental Modification or Vehicle Modifications funded by the Supports Waiver Program in the past five (5) years? *If you have utilized Assistive Technology, Environmental Modification or Vehicle Modifications in the last five (5) years, please contact your Community Support Coordinator (CSC) to see if funds are still available.* All Supports Waiver Other Supports Require an AT, EMOD or VMOD packet to be completed.

SUPPORTS WAIVER OTHER SUPPORTS	
ASSISTIVE TECHNOLOGY	
Projected Amount	
Expected Outcome	
How does this support your clinical, medical, functional, or habilitative needs related to your qualifying condition?	
ENVIRONMENTAL MODIFICATION	
Projected Amount	
Expected Outcome	
How does this support your clinical, medical, functional, or habilitative	

needs related to your qualifying condition?	
Expected Outcome	
VEHICLE MODIFICATION	
Projected Amount	
Expected Outcome	
How does this support your clinical, medical, functional, or habilitative needs related to your qualifying condition?	

Do you need any training for the requested assistive technology, environmental modification or vehicle modification? Please specify the trainings needed.
What else do you need individuals providing AT, EMOD or VMOD to know?

SERVICE MEASUREMENTS AND MONITORING

How will I know if my services are working well for me and meet my identified needs?
Please list an individual measurement to be monitored during monthly visits for each service.
Assistive Technology:
Environmental Modification:
Vehicle Modification:

Individual's who participated in the development of the ISP		
Developed By:	Title/Relationship to the Participant	Date of Entry
	Supports Waiver Participant	

COMMUNITY SUPPORT COORDINATOR MUST ACKNOWLEDGE: I have provided the Participant with a copy of the ISP, Emergency Back-Up Plan Acknowledgement Form, and I have reviewed the form with them. I confirm that the participant has completed the form in its entirety. A copy of the completed form will be kept by the Participant and in the Community Support Coordinator (CSC) file.