IP.1 - Information Profile

Name:	**Date:**	
Address:	**Sex:** Select	
City/Zip: ,	**DOB:**	
Phone: ( ) -	**DDS#:**	
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:	**Type of Waiver:** Select	
Registered Voter: Select	**Waiver Enrollment Date:**	
Residential WL: ☐ **Priority Status:**	**Day WL:** ☐ **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: ( ) -**
Address:	**City Zip: ,**	
Dentist:	**Phone: ( ) -**	**Fax: ( ) -**
Address:	**City/Zip: ,**	
Other:	**Phone: ( ) -**	**Fax: ( ) -**
Address:	**City/Zip: ,**	
Other:	**Phone: ( ) -**	**Fax: ( ) -**
Address:	**City/Zip: ,**	
Other:	**Phone: ( ) -**	**Fax: ( ) -**
Address:	**City/Zip: ,**	
Other:	**Phone: ( )**	**Fax: ( )**
Address:	**City/Zip: ,**	

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

Resource and Benefit information (*Check all that apply*)

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

DDS Support Information

☐ **CM**			☐ **TCM**		
☐ **Residential**	☐ **Self Direct**	☐ **Vendor**	☐ **Master Contract**	☐ **Public**	☐ **Other**
☐ **Day/Employment**	☐ **Self Direct**	☐ **Vendor**	☐ **Master Contract**	☐ **Public**	☐ **Other**
☐ **Individual and Family Grant**		**Need Level:**	☐ **Low** ☐ **Med**	☐ **High**	**Amount**
☐ **Respite Center**			☐ **Rent Subsidy Monthly:**		
☐ **IFS Resource Support Team**			☐ **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)	**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) ☐ **NA**	**Date:**
Choice of Vendors/Providers discussed	**Date:**
Waiting list Priority Status Notification (annually at IP for those on WL) ☐ **NA**	**Date:**
Transfer Hearing Notification ☐ **NA**	**Date:**
Consent Form(s) (at initial visit or if not current) ☐ **NA**	**Date:**
HIPAA Notification (at initial visit or if not current) ☐ **NA**	**Date:**
Legal Liability Notification (at initial visit or change of Guardian) ☐ **NA**	**Date:**
Voter Registration Notification (at initial visit, IP, 17th birthday or new address) ☐ **NA**	**Date:**
PRC Review (Programmatic Review Committee) month/yr next review, Review exemption annually ☐ **NA**	**Date:**
Emergency Fact Sheet and Relocation Form Updated, if applicable. ☐ **Residence** ☐ **Day** ☐ **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#:

Relationships:

Home Life:

Name:	DDS#:

Work, Day, Retirement or School:

Leisure Interests and Community Life:

Health and Wellness:

Name:	DDS#:

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#:

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	☐	☐	☐
▪ Self-Medication	☐	☐	☐
▪ Dental Exam	☐	☐	☐
▪ Gynecological Exam	☐	☐	☐
▪ Mammogram	☐	☐	☐
▪ Other Health/Medical:	☐	☐	☐
▪ Level of Need Assessment & Screening Tool	☐	☐	☐
▪ My Health and Safety Screening	☐	☐	☐
▪ Speech & Language /Communications	☐	☐	☐
▪ Physical Therapy	☐	☐	☐
▪ Occupational Therapy	☐	☐	☐
▪ Assistive Technology	☐	☐	☐
▪ Nutrition/Dietary	☐	☐	☐
▪ Behavior	☐	☐	☐
▪ Psychological	☐	☐	☐
▪ Psychiatric	☐	☐	☐
▪ Neurological	☐	☐	☐
▪ Other Clinical:	☐	☐	☐
▪ ADL	☐	☐	☐
▪ Water Safety	☐	☐	☐
▪ Bed & Safety Rail Audit	☐	☐	☐
▪ Vocational/Day	☐	☐	☐
▪ Guardianship	☐	☐	☐
▪ Resource/Financial	☐	☐	☐
▪ Level of Support and Supervision	☐	☐	☐
▪ Waiting List Priority Checklist	☐	☐	☐
▪ Respite Profile Information	☐	☐	☐
▪ SL Community Health and Safety Assessment	☐	☐	☐
▪ SL Skills Assessment	☐	☐	☐
▪ Other:	☐	☐	☐
▪ Other:	☐	☐	☐

Comments:

Name:	**DDS#**

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)**	***By When***
1.	1.	**1A:**		
		1B:		
		1C:		
		1D:		

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***
2.	2.	**2A:**		
		2B:		
		2C:		
		2D:		

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***
3.	3.	**3A:**		
		3B:		
		3C:		
		3D:		

Name:	**DDS#**

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:		

Name:	**DDS#**

IP.6 - Summary of Supports and Services

Agency/individual/Vendor	***Type of Support/Service*** *(specify type of HCBS Waiver Services and include non-waiver supports and services)*	***Amount of Support/Service*** *Hours per Week/Month/Year*
Case Manager/Support Broker		

Name:	DDS#

IP.7 – Provider Qualifications & Training

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

☐	**Comp – Supported Living**	☐	**Group Day Services (includes DSO)**
☐	**Comp – Residential Habilitation (CLA & CTH)**	☐	**Individualized Day Support**
☐	**Comp – Assisted Living**	☐	**Supported Employment Services**
☐	**Adult Companion Services**	☐	**Consultative Services**
☐	**Personal Support**	☐	**Respite**
☐	**IFS – Individual Support (IS) & Habilitation**	☐	**Interpreter Services**
☐	**IFS – Residential Habilitation (Supported Living)**	☐	**Transportation**
☐	**IFS – Family Training**	☐	**Family and Individual Consultation & Support**

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**
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

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**
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

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
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

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
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

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
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Name:	DDS#

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			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			

Name:	DDS#:

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 or NF. [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:	☐ Plan Development ☐ Periodic Review ☐ Other

IP.11 - Individual Plan Signature Sheet

Name	Signature	Relationship To The Person	Attended Meeting (x)
		Individual	☐
		Family Member/Guardian	☐
		Advocate (as applicable)	☐
		Case Manager	☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐
			☐

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: