



**Information Profile**

<b>Name:</b>	<b>Date:</b> /     /
<b>Address:</b>	<b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F
<b>City/Zip:</b>	<b>DOB:</b> /     /
<b>Phone:</b> (     )	<b>DMR#:</b>
<b>Type Residence:</b>	<b>Primary Language:</b>
<b>Allergies:</b>	<b>Communication Style:</b>

<b>Case Manager:</b>	<b>Case Manager phone#:</b>
<b>Level of MR:</b>	<b>Diagnosis: (ICD9 code)</b>
<b>Admission Status:</b>	<b>Type of Waiver:</b> <input type="checkbox"/> IFS <input type="checkbox"/> Comprehensive
<b>Registered Voter:</b> <input type="checkbox"/> Y <input type="checkbox"/> N	<b>Waiver Enrollment Date:</b>
<b>Legal Status:</b> (Plenary, Limited, Na)	<b>Fiscal Intermediary</b> <input type="checkbox"/> SS <input type="checkbox"/> Allied <input type="checkbox"/> Public Partnership
<b>Residential WL</b> <input type="checkbox"/> <b>Priority Status:</b>	<b>Day WL</b> <input type="checkbox"/> <b>Priority Status:</b>
<b>Date WL Referral:</b> /     /	<b>Date WL Referral:</b> /     /

<b>Guardian:</b>	<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>
<b>Address:</b>			
<b>Primary Responsible Person:</b>	<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>
<b>Address:</b>	<b>SS: (Optional)</b> /     /	<b>DOB:</b> /     /	
<b>Emergency Contact</b> (If PRP not available):	<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>
<b>Conservator:</b>	<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>

<b>Medical/Clinical Contacts:</b>			
	<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>
<b>Physician:</b>			
<b>Dentist:</b>			
<b>Psychologist:</b>			
<b>Psychiatrist:</b>			
<b>Other Med/Clinical:</b>			
:			
:			
:			
:			
:			
:			



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<b>Provider Agency Contacts:</b>	<b>Phone:</b>	<b>Fax:</b>	<b>Email:</b>
<b>Residential:</b>			
<b>Day/School:</b>			
<b>Fiscal Intermediary:</b>			
<b>*BRS Contact:</b>			
<b>*BESB Contact:</b>			
<b>*DSS Contact:</b>			
<b>*DCF Contact:</b>			
<b>*Other Contact:</b>			

**\*Optional**

<b>Resource and Benefit Information:</b>	
Medicaid Application/Redetermination Current <input type="checkbox"/> Yes	Last Redetermination Date: / /
<input type="checkbox"/> Earned Income – Monthly \$	<input type="checkbox"/> Checking Balance \$
<input type="checkbox"/> Savings Balance \$	<input type="checkbox"/> Trust Fund \$
<input type="checkbox"/> SSI # Monthly \$	<input type="checkbox"/> SSDI # Monthly \$
<input type="checkbox"/> Title XIX#:	<input type="checkbox"/> Railroad Insurance #:
<input type="checkbox"/> State Supplement	<input type="checkbox"/> Medicare A #:
<input type="checkbox"/> Health Insurance #:	<input type="checkbox"/> Medicare B #:
<input type="checkbox"/> Prepaid Funeral Plan	<input type="checkbox"/> Medicare D #:
<input type="checkbox"/> Prepaid Burial Plan	<input type="checkbox"/> Food Stamps: Monthly \$
<input type="checkbox"/> Other	<input type="checkbox"/> Other

<b>DMR Support Information:</b>	
<input type="checkbox"/> Residential	<input type="checkbox"/> Self-Direct
<input type="checkbox"/> Day/Employment	<input type="checkbox"/> Self-Direct
<input type="checkbox"/> Individual and Family Grant	<b>Need level:</b> Low <input type="checkbox"/> Mod <input type="checkbox"/> High <input type="checkbox"/>
<input type="checkbox"/> Respite Center	Amount: <input type="checkbox"/> Rent Subsidy Monthly: <input type="checkbox"/>
<input type="checkbox"/> IFS Resource Team Support	<input type="checkbox"/> Other

<b>Notifications &amp; Reviews:</b>	
<input type="checkbox"/> PAR Notification (annually at IP) Date: / /	
<input type="checkbox"/> Medicaid Due Process Rights Notification (annually at IP) Date: / /	<input type="checkbox"/> N/A
<input type="checkbox"/> Family/Guardian Notification of Incident Reporting Requirements (annually at IP) Date: / /	
<input type="checkbox"/> Family/Guardian's Incident Reporting Request (describe if beyond procedural requirements):	<input type="checkbox"/> N/A
<input type="checkbox"/> Individual Informed of Human/Civil Rights (annually at IP) Date: / /	
<input type="checkbox"/> Choice of Service Options discussed: (Self-direct, Vendor, Agency with Choice) Date: / /	
<input type="checkbox"/> Choice of Independent Support Broker to provide FICS: (prior to IP for those who choose to self direct) Date: / /	<input type="checkbox"/> N/A
<input type="checkbox"/> Choice of Vendors/Providers discussed Date: / /	
<input type="checkbox"/> Waiting List Priority Status Notification (annually at IP for those on WL) Date: / /	<input type="checkbox"/> N/A
<input type="checkbox"/> Transfer Hearing Notification Date: / /	<input type="checkbox"/> N/A
<input type="checkbox"/> Consent Form(s) are Current	
<input type="checkbox"/> HIPAA Notification (at initial visit) Date: / /	
<input type="checkbox"/> Legally Liable Relative Notification (at initial visit, change of guardian) Date: / /	<input type="checkbox"/> N/A
<input type="checkbox"/> Voter Registration Notification (initial visit, IP, 17 <sup>th</sup> Birthday, New Address) Date: / /	<input type="checkbox"/> N/A
<input type="checkbox"/> Other Notification: Date: / /	<input type="checkbox"/> N/A
<input type="checkbox"/> PRC Review (Programmatic Review Committee) (Next review date: month/year) /	<input type="checkbox"/> N/A
<input type="checkbox"/> Other Date: / /	



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<b>Name:</b>	<b>DMR#</b>
<b>Case Manager:</b>	<b>Region:</b>
<b>Meeting Date:</b>	<b>Plan Effective Dates:</b> From:    /    /                      To:    /    /

**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.

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**Important To Know About You:**

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**Accomplishments, Strengths and Things You Are Most Proud Of:**



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**Relationships:**

---

**Home Life:**



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**Work, Day, Retirement, or School:**

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**Leisure Interests and Community Life:**

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**Health and Wellness:**



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**Medications:**

<b>List current medications including Over the Counter (OTC) medications.</b>	
<b>Type:</b>	<b>Comments:</b>

**Adaptive Devices (if applicable):**

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**Finances:**

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Name:

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**Future Vision**

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

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What do you hope to accomplish in the coming year?



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**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.

Assessment, Screening, Evaluation, Report:	Current	Needed	NA
• Physical Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Other Health/Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Self-Medication	<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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Speech & Language/Communication	<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"/>
• Other Clinical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• ADL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Assessment, Screening, Evaluation, Report:	Current	Needed	NA
• Water Safety	<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	<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"/>
• SL Community Health and Safety Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• SL Skills Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• SL Quality of Life Assessment	<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:



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**Action Plan**

<b><i>Issues or Needs</i></b> (Why Is This Important? Current Status?)	<b><i>Desired Outcome</i></b> (What Do You Hope to Accomplish?)	<b><i>Actions and Steps</i></b> (What Will You and Your Support Team Do To Achieve This Outcome?)	<b><i>Responsible Person(s)</i></b>	<b><i>By When</i></b>
1.		1A:		
		1B:		
		1C:		
		1D:		

<b><i>Issues or Needs</i></b> (Why Is This Important? Current Status?)	<b><i>Desired Outcome</i></b> (What Do You Hope to Accomplish?)	<b><i>Actions and Steps</i></b> (What Will You and Your Support Team Do To Achieve This Outcome?)	<b><i>Responsible Person(s)</i></b>	<b><i>By When</i></b>
2.		2A:		
		2B:		
		2C:		
		2D:		



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<b>Issues or Needs</b> (Why Is This Important? Current Status?)	<b>Desired Outcome</b> (What Do You Hope to Accomplish?)	<b>Actions and Steps</b> (What Will You and Your Support Team Do To Achieve This Outcome?)	<b>Responsible Person(s)</b>	<b>By When</b>
3.		3A:		
		3B:		
		3C:		
		3D:		

<b>Issues or Needs</b> (Why Is This Important? Current Status?)	<b>Desired Outcome</b> (What Do You Hope to Accomplish?)	<b>Actions and Steps</b> (What Will You and Your Support Team Do To Achieve This Outcome?)	<b>Responsible Person(s)</b>	<b>By When</b>
4.		4A:		
		4B:		
		4C:		
		4D:		



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<b>Issues or Needs</b> (Why Is This Important? Current Status?)	<b>Desired Outcome</b> (What Do You Hope to Accomplish?)	<b>Actions and Steps</b> (What Will You and Your Support Team Do To Achieve This Outcome?)	<b>Responsible Person(s)</b>	<b>By When</b>
5.		5A:		
		5B:		
		5C:		
		5D:		

<b>Issues or Needs</b> (Why Is This Important? Current Status?)	<b>Desired Outcome</b> (What Do You Hope to Accomplish?)	<b>Actions and Steps</b> (What Will You and Your Support Team Do To Achieve This Outcome?)	<b>Responsible Person(s)</b>	<b>By When</b>
6.		6A:		
		6B:		
		6C:		
		6D:		

Use additional pages for action plan as needed.



Name:

DMR #

**Summary of Supports and Services**

<i>Agency/Individual/Vendor</i>	<i>Type of Support/Service ( specify type of HCBS Waiver services and include non-waiver supports and services)</i>	<i>Amount of Support/Service Hours Per Week/Month/Year</i>
<input type="checkbox"/> <b>Case Manager/Support Broker</b>		

Approved by the Case Management Supervisor (new or enhanced resources only): \_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date

Approved by the Case Manager (renewed plans only): \_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date



Name:

DMR #

**Provider Qualifications & Training**

**DMR Waiver Services To Be Provided (please check all that apply:)**

<input type="checkbox"/> Adult Companion Services	<input type="checkbox"/> IFS - Residential Habilitation (Supported Living)
<input type="checkbox"/> Consultative Services	<input type="checkbox"/> IFS - Family Training
<input type="checkbox"/> Comp - Supported Living	<input type="checkbox"/> Individualized Day Support
<input type="checkbox"/> Comp - Residential Habilitation (CLA & CTH)	<input type="checkbox"/> Interpreter Services
<input type="checkbox"/> Comp - Assisted Living	<input type="checkbox"/> Personal Support
<input type="checkbox"/> Family and Individual Consultation & Support	<input type="checkbox"/> Respite
<input type="checkbox"/> Group Day Services (includes DSO)	<input type="checkbox"/> Supported Employment Services
<input type="checkbox"/> IFS - Individual Support (IS) & Habilitation	<input type="checkbox"/> Transportation

Each DMR Waiver Service identifies the qualifications that the employee(s) must meet prior to employment and prior to being alone with the individual for whom the service is being provided. Please refer to the DMR HCBS Consolidated Waiver Manual where each service definition includes minimum training requirements.

It is also necessary for the planning and support team to identify the **additional or specific qualifications** (expertise, competence, and or training) required to effectively support the individual to *achieve the personal outcomes* identified in his or her plan and to maintain a *healthy and safe lifestyle*.

Based on the preferences and support needs of the individual, document the following:

- the **additional or specific qualifications** (expertise, competence, and or training) required to effectively support the individual to *achieve personal outcomes* and maintain a *healthy and safe lifestyle*
- the timeframe in which the specific qualification(s) must be met
- complete for each HCBS Wavier service provided

**DMR Waiver Service:**

- 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 (√)	
	Prior to Working Alone	Within 30 days



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**DMR Waiver Service:**

- 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 (√)	
	Prior to Working Alone	Within 30 days

**DMR Waiver Service:**

- 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 (√)	
	Prior to Working Alone	Within 30 days

*Continued Next Page*



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**DMR Waiver Service:**

- 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 (√)	
	Prior to Working Alone	Within 30 days

**DMR Waiver Service:**

- 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 (√)	
	Prior to Working Alone	Within 30 days

Use Additional Pages As Needed



Name:

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### Emergency Back-Up Support 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"/>			



Name:

DMR #

## Summary of Representation, Participation & Plan Monitoring

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### Choice and Decision Making

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

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### Individual's Participation in Planning Process

Summary of the 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.

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### 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.

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### 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 achieving desired outcomes?

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## HCBS Re-determination

<b>Name:</b>	<b>Region:</b>	<b>DMR #:</b>
<b>Case Manager:</b>	<b>Plan Date:</b>	

There is a reasonable indication that the person, but for the provision of waiver services would need services 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 deficits 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):



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<b>Name:</b>	<b>DMR #:</b>	<b>Meeting Date:</b>	<input type="checkbox"/> <b>Plan Development</b> <input type="checkbox"/> <b>Periodic Review</b>
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**Individual Plan Signature Sheet**

Name	Relationship To The Person	Attended Meeting √	Agreement with Individual Plan (Please Initial and Date)		
			YES	NO	DATE:
	<i>Individual</i>				
	<i>Family Member/Guardian</i>				
	<i>Advocate (as applicable)</i>				
	<i>Case Manager</i>				

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

**Comments:**



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<b>Name:</b>	<b>Review Date:</b>	<b>DMR #:</b>
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**Periodic Review of Plan**

**Type Of Review**

- Quarterly
- Semi-Annual
- Annual
- Other:

Period Reviewed:    From:                      To:                      Date of Next Meeting:

Please attach the Individual Plan Signature Sheet to indicate team members who participated in the review.

AREA REVIEWED	REVIEW SUMMARY	PLAN MODIFICATIONS (As applicable)
<b>All areas must be reviewed.</b>	<b>After discussion please check “yes” or “no” as appropriate. For any issues, updates or changes provide an explanation.</b>	
<b>Information Profile, IP.1</b>	Changes, Issues or Updates: No <input type="checkbox"/> Yes <input type="checkbox"/> If “yes” Explain and update the profile:	
<b>Personal Profile IP.2</b>	<p><b>Important to Know About You:</b> Changes, Issues or Updates: No <input type="checkbox"/>    Yes <input type="checkbox"/>    If “yes” explain</p> <p><b>Accomplishments, Strengths and Things You Are Most Proud Of:</b> Changes, Issues or Updates: No <input type="checkbox"/>    Yes <input type="checkbox"/>    If “yes” Explain:</p> <p><b>Relationships:</b> Changes, Issues or Updates: No <input type="checkbox"/>    Yes <input type="checkbox"/>    If “yes” Explain:</p>	



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AREA REVIEWED	REVIEW SUMMARY	PLAN MODIFICATIONS (As applicable)
	<p><b>Home Life:</b>            Changes, Issues or Updates: No <input type="checkbox"/> Yes <input type="checkbox"/> If “yes” Explain:  <i>Review residential or in home support goals in the Action Plan Section</i></p> <p><b>Work, Day, Retirement, or School:</b>            Changes, Issues or Updates: No <input type="checkbox"/> Yes <input type="checkbox"/> If “yes” Explain:  <i>Review work, school or day program goals in the Action Plan Section.</i></p> <p><b>Leisure Interests and Community Life:</b>            Changes, Issues or Updates: No <input type="checkbox"/> Yes <input type="checkbox"/> If “yes” Explain:  <i>Discuss any significant leisure activities that occurred during past quarter.</i></p>	
	<p><b>Health and Wellness:</b>            Changes, Issues or Updates: No <input type="checkbox"/> Yes <input type="checkbox"/> If “yes” explain</p> <p><b>Medications:</b>            Changes, Issues or Updates: No <input type="checkbox"/> Yes <input type="checkbox"/> If “yes” Explain:</p> <p>PRC:            Status Update (include dates):            Medication Informed Consent form is present in the home? Yes <input type="checkbox"/> No <input type="checkbox"/> If “No” Explain:</p> <p>HRC:</p> <p><b>Adaptive Equipment: Changes, if applicable:</b></p>	
	<p><b>Finances:</b>            Financial Changes, Issues or Updates: No <input type="checkbox"/> Yes <input type="checkbox"/> If “yes” explain</p>	



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AREA REVIEWED	REVIEW SUMMARY		PLAN MODIFICATIONS (As applicable)
<b>Future Vision IP.3</b>	What are your hopes and dreams for the future (one to three years?) Changes, Issues or Updates: No <input type="checkbox"/> Yes <input type="checkbox"/> If "yes" explain  What do you hope to accomplish in the coming year? Changes, Issues or Updates: No <input type="checkbox"/> Yes <input type="checkbox"/> If "yes" explain		
<b>Assessments, Screenings, Evaluations and Reports IP.4</b>	Did today's review indicate the need for any additional assessments? No <input type="checkbox"/> Yes <input type="checkbox"/> If "yes" explain  <i>Any new assessment needed to address potential risk areas including health and safety needs must be reflected in an 'Action Plan'</i>		
<b>At this point review any changes in any of the preceding areas and modify the Action Plans as needed to reflect these changes. Any risks identified on the Level of Need Summary Report must be reflected in Action Plans.</b>			
<b>Action Plan IP.5</b>	<b>SUMMARY OF PROGRESS</b>		
<b>Issue/Need</b>  1.  2.  3.  4.  5.  6.	<b>Review all action plans and steps and describe progress and/or modification. Indicate whether supports and services have been delivered and the individual's satisfaction with supports and services.</b>  1.  2.  3.  4.  5.  6.	<b>Responsible Persons:</b>  1.  2.  3.  4.  5.  6.	<b>By When:</b>  1.  2.  3.  4.  5.  6.



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AREA REVIEWED	REVIEW SUMMARY			PLAN MODIFICATIONS (As applicable)
<b>NEW OUTCOMES AND ACTION STEPS</b> Document below when new outcomes and action steps are developed for the individual as a result of the periodic review.				
Issue/Need	Desired Outcomes	Action & Steps	Responsible Persons:	By When:
1.	1.	1.	1.	1.
2.	2.	2.	2.	2.
<b>Summary of Supports and Services IP.6</b>	<b>Attach a new Summary of Supports and Services form, IP.6, when there are changes of types of supports or providers.</b>  Changes, Issues or Updates: No <input type="checkbox"/> Yes <input type="checkbox"/> If "yes" explain:			
<b>Provider Qualifications &amp; Training Form IP.7</b>	Changes, Issues or Updates: No <input type="checkbox"/> Yes <input type="checkbox"/> If "yes" explain:			
<b>Emergency Back-up Support Plan IP.8</b>	Changes, Issues or Updates: No <input type="checkbox"/> Yes <input type="checkbox"/> If "yes" explain:			
<b>Summary of Representation, Participation &amp; Plan Monitoring IP.9</b>	<b><u>Choice and Decision Making:</u></b> Changes, Issues or Updates: No <input type="checkbox"/> Yes <input type="checkbox"/> If "yes" explain:  <b><u>Individual's Participation in Planning process:</u></b> Changes, Issues or Updates: No <input type="checkbox"/> Yes <input type="checkbox"/> If "yes" explain:  <b><u>Representative's Participation in the planning Process:</u></b> Changes, Issues or Updates: No <input type="checkbox"/> Yes <input type="checkbox"/> If "yes" explain:			



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AREA REVIEWED	REVIEW SUMMARY	PLAN MODIFICATIONS (As applicable)
	<p><b><u>Summary of Monitoring And Evaluation Of The Plan:</u></b> Changes, Issues or Updates: No <input type="checkbox"/> Yes <input type="checkbox"/> If “yes” explain:</p>	
<b>Other:</b>		
<b>Other:</b>		

**Attachments:**

**Signature Sheet, IP.11; Summary of Supports and Services, IP.6 (when there are changes in the type of support or support providers/vendors); Progress Reports; New Assessments**