The Commonwealth of Massachusetts

Executive Office of Health & Human Services
Department of Developmental Services

Individual Support Plan

NAME:	DATE SEMI ANNUAL REPORTS DUE FROM PROVIDERS [1]
DATE OF MEETING:	
DATE OF NEXT ANNUAL REVIEW: ☐AM ☐ PM	PREPARED BY:

I INDIVIDUAL VISION FOR:		
	[2]	
1.		What does he/she identify as important activities and relationships to continue to be involved in? What other things would he/she like to explore?
	[3]	
2.		What does he/she think someone needs to know in order to provide effective supports?
	[4]	
3.		What does he/she think are his/her strengths and abilities?
	[5]	

4.		What would he/she like to see happen in his/her life over the next two years?
	6	

II. CURRENT SUPPORTS (Services, Settings, and People):

Home/Community:	7	
Employment/Day:	8	
Health and Dental:	9	
Medication(s):	10	

Adaptive Equipment/ Assistive Technology:	11	
Clinical:	12	

III. SAFETY AND RISK

Safety:	13
Home Alone Authorization:	
Risk:	14

IV. LEGAL/FINANCIAL/BENEFIT STATUS

LEGAL	☐ Competent	☐ Adjudicated Not Competent	☐ Clinical Team Review Recommended
☐ Guardian(s) 15	Name(s):		

Conservator	Name:		
☐ Rogers' Monitor(s)	Name(s):		
☐ Health Care Agent[16]	Name:		
☐ Alt Health Care Agent	Name:		
☐ Power of Attorney	Name:		
☐ Ricci Class Member			

BENEFITS		
☐ SSI	☐ Mass Health	☐ Other
☐ SSA	☐ Medicare	
☐ SSDI	☐ VA	
☐ Mass Health Eligibility Representative	Name:	
☐ Representative Payee	Name:	

FINANCIAL		
☐ Trust Fund	☐ Burial Plan	☐ Other

COMMENT

[17]	
[18]	Has the ISP Team recommended that the individual would benefit from a financial training plan? Yes ☐ No ☐

V. SUCCESSES / POSITIVE EVENTS, CHALLENGES, EMERGING ISSUES, AND UNMET NEEDS

Positive Events:	[19]	
Challenging Issues:	[20]	
Emerging Issues:	[21]	

Unmet Needs:	22	

VI. GOALS

23	

VII. OBJECTIVES

24	

[1] SEMI-ANNUAL REPORTS: **Are due from Service Providers 6 months after the ISP Meeting Date. This date will calculate automatically from the ISP Date.**

[2] INDIVIDUAL VISION – **The Individual's Vision Statement is an exploration of what is important to the person in his/her life. It should describe individual's preferences on how he/she wishes to live, work and spend his/her leisure time as well as interests, relationships, and activities he/she would like to continue and/or explore. If the individual is not able to fully express him/herself, please note the people and sources of information that contributed to the answers to the 4 Vision questions. This statement should be inserted before the first question so that readers understand how the Vision Statement was developed.**

[3] VISION QUESTION 1 – **These activities and relationships can be a springboard that will support the individual and his/her team, to create and pursue goals in the areas of employment, community connections, learning new skills, and building relationships, in support of his/her Vision.**

[4] VISION QUESTION 2 – **Describe the information the individual believes people need to know to support him/her to achieve what is important to him/her and to stay safe and healthy. Include how the person chooses to communicate and if there is any need for assistive technologies specific to communication.**

[5] VISION QUESTION 3 – **Include positive traits, characteristics, ways of interacting, accomplishments and strengths and the individual identifies.**

[6] VISION QUESTION 4 – **Describe the life circumstances the individual wants to achieve over the next 2 years.**

[7] HOME/COMMUNITY – **Describe where and with whom the person lives. List what supports are in place (natural, generic, DDS funded, or Mass Health services), the service model (i.e. 24 hour residential with or without PSS supports, Placement Services, Adult Foster Care with or without supplements, PCAs, or independent living). For individuals who receive limited supports, include the frequency and intensity of support that DDS has contracted for with the Service Provider. Describe the assessed needs of the individual and the support the individual needs to assure health and safety and to promote independence (i.e. support with ADLs, money management, housekeeping, meal planning and preparation, access and involvement with the person's community and relationships, etc.).**

[8] EMPLOYMENT/DAY – **Describe what the person does during the day. List what services are in place and how the support is provided (natural, generic, DDS funded or Mass Health services). Describe the setting(s) (competitive employment, supported employment, group supported employment, center based work, center based day, day habilitation, adult day health, etc.) and the way transportation is managed to promote success in this area. List the average number of hours the individual works. For individuals enrolled in Day Habilitation services, note "refer to Day Habilitation Plan" and attach it to the ISP.**

[9] HEALTH AND DENTAL – **Briefly summarize the individual's health and dental status and support needs. List the individual's health care providers and the dates of the annual physical and dental examinations. List any health care protocols, dietary needs, and whether or not the individual is capable of self-medicating. If the individual has significant health risks (PICA, ingesting inedible objects, obesity, etc.) please list the risk(s) and the supports provided to address and minimize these risk(s) to the greatest degree possible. Please note that HIV status is highly confidential and should not be discussed or recorded in the Health and Dental section of the ISP or the Health and Dental Assessment.**

[10] MEDICATION(S): **List the medications prescribed for the individual and their purposes. List any history of atypical or allergic reactions to medications. Do not include any reference to medications used to treat HIV.**

[11] ADAPTIVE EQUIPMENT / ASSISTIVE TECHNOLOGY – **List the types of adaptive equipment and/or assistive technology the person needs at work or home, including health related supports and protective devices. Adaptive equipment and assistive technology includes mobility devices (wheel chairs, walkers, braces, etc.), ADL aides, bed shakers, strobe lights, adaptive telephones, jigs, mealtime devices (mats, adaptive cutlery), etc.**

[12] CLINICAL – **List the clinical supports the individual receives including physical therapy, occupational therapy, speech and language, psychotherapy, and/or psychiatric care. Note if the individual has or needs a psychotropic medication treatment plan. For individuals taking anti-psychotic medication that is overseen by a Rogers Monitor, note, "refer to Rogers Order for details." For individuals with behavior plans, note the behaviors being addressed and the level of the plan consistent with DDS regulations.**

The reason for and effectiveness of the clinical supports provided over the past year should be included in the assessments developed by Service Providers and reviewed at the ISP meeting.

[13] SAFETY – **Briefly describe the person's safety skills and abilities at home and in the community, his/her supervision needs, and under what circumstances, if any, (s)he can be alone including if transportation providers can leave people unattended. For individuals in 24 hour residential programs, indicate his/her ability to evacuate in case of emergency within 2.5 minutes. If a wavier related to evacuation has been authorized, please note it here.**

[14] RISK – **Briefly describe the circumstances, if any, where the individual poses a significant risk to him/herself and/or the community. Describe supports provided to minimize risks to the individual and others, including specific supervision needs related to the identified risks. Also indicate specific staffing requirements in each program setting required to mitigate risk to the individual and or community (i.e. line of sight, 1:1, and arm's length). For individual involved in the criminal justice system, note any special requirements (probation, restraining order, etc.) and the frequency and duration of the requirement. Where relevant, note, "The individual is followed by the area's Risk Management process."**

[15] GUARDIAN – For extent of guardianship authority refer to guardianship decree

[16] HEALTH CARE AGENT – **The individual must have the capacity to understand and select a Health Care Agent. People under guardianship cannot execute a HCP; however, previously executed HCPs remain valid even if a Guardian is subsequently appointed.**

[17] COMMENT – **note if there are any financial issues that put the individual's Mass Health in jeopardy.**

[18] FINANCIAL TRAINING PLAN: **Answer Yes or No.**

[19] POSITIVE EVENTS – **List the successes the individual has had over the past year at home, at work, and other areas important to the person.**

[20] CHALLENGING ISSUES – **Indicate issues that are continuing to be difficult for the individual and any obstacles that interfere with his/her ability to engage in activities.**

[21] EMERGING ISSUES – **Briefly note <u>newly identified</u> changes in the individual's abilities or life circumstances that require specific attention, including requests for a change in services.**

[22] UNMET NEEDS – **Refer to the ISP Policy and Procedure Manual for the definition of Unmet Needs.**

[23] GOALS – **List the goals the ISP team has agreed to address over the next 2 years that relate to the Individual's Vision and or assessed needs.**

[24] OBJECTIVES – **List the objectives the ISP team has agreed to address over the next year that relate to the Individual's Goals, including the Service Provider Agency responsible for implementation (i.e. day, residential, etc).**