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| --- | --- | --- | --- |
| **Plan of Services and Supports** Status: Program Type: ID/DD | | | |
| **Overview** | | | |
| **Active:** |  | **Created Date:** |  |
| **PSS Type:** | Initial/Recertification/Change | **Effective Date:** |  |
| **Service Type** |  | **End Date:** |  |
| **Comments:** | | | |

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| **Part I - Essential Information** |

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| **Contact Information** | | | | |
| **Legal First Name:** |  | **Medicaid #** | |  |
| **Legal Last Name:** |  | **Initial Certification Date:** | |  |
| **Legal Middle Name:** |  | **Home Phone:** | |  |
| **Preferred Name:** |  | **Cell Phone:** | |  |
| **Date of Birth:** |  | **Email:** | |  |
| **Address:** |  | **Support Coordinator/TCM** | |  |
| **Family Contact** | | | | |
| **First Name:** |  | **Phone:** |  | |
| **Last Name:** |  | **Fax:** |  | |
| **Middle Name:** |  | **Email:** |  | |
| **Contact Type:** |  | **Address:** |  | |
|  |  |  |  | |
| **First Name:** |  | **Phone:** |  | |
| **Last Name:** |  | **Fax:** |  | |
| **Middle Name:** |  | **Email:** |  | |
| **Contact Type:** |  | **Address:** |  | |
|  |  |  |  | |
| **First Name:** |  | **Phone:** |  | |
| **Last Name:** |  | **Fax:** |  | |
| **Middle Name:** |  | **Email:** |  | |
| **Contact Type:** |  | **Address:** |  | |

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| **ID/DD Waiver Supports** | | | | | | | |
| **Service Information** | | | | | | | |
| **Service Type:** | |  | | **PSS Service:** | |  | |
| **Frequency Type:** | |  | | **Units per month:** | |  | |
| **Hours per Month:** | |  | | **Rate:** | |  | |
| **Minutes:** | |  | | **Costs:** | |  | |
| **How/When Support is Used:** | | | | | | | |
|  | | | | | | | |
| **Provider Information** | | | | | | | |
| **Provider Name:** |  | | | | **Provider Number:** | |  |
| **Contact Name:** |  | | | | **Phone:** | |  |
| **Address:** |  | | | | **Email address** | |  |
| **Service Information** | | | | | | | |
| **Service Type:** | |  | | **PSS Service:** | |  | |
| **Frequency Type:** | |  | | **Units per month:** | |  | |
| **Hours per Month:** | |  | | **Rate:** | |  | |
| **Minutes:** | |  | | **Costs:** | |  | |
| **How/When Support is Used:** | | | | | | | |
|  | | | | | | | |
| **Provider Information** | | | | | | | |
| **Provider Name:** |  | | | | **Provider Number:** | |  |
| **Contact Name:** |  | | | | **Phone:** | |  |
| **Address:** |  | | | | **Email address** | |  |
| **PSS Costs** | | | | | | | |
| **Annual Waiver Plan Services Total:** | | |  | | |  |  |
| **Annual 1915(i) Services Total:** | | |  | | |  |  |
| **Total PSS Budget:** | | |  | | |  |  |

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| **Non – Waiver Agency Supports** | | | | |
| **Agency** | **Contact Name** | **Phone Number:** | **Non-Waiver Agency Support** | **How/When Support Provided** |
|  |  |  |  |  |

| **Natural Supports** | | | |
| --- | --- | --- | --- |
| **Are there natural supports?** Yes/No | | | |
| **Support Person** | **Relationship** | **Support Role** | **Phone Number** |
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| **Medical Information** | | | | | | | | | | | | | | | | |
| **Physician** | | **Specialty** | | | | | **Address** | | | | | | | | **Phone** | |
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| **Medications** | | | | | | | | | | | | | | | | |
| **Medications required?** | | |  |  | | | | | | |  |  |  | | | |
| **Medication:** | **Physician:** | | | | **Dosage** | | | | **Frequency** | | | | | **Reason(s) Prescribed** | | **Psychotropic**  **Y/N** |
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| **Recent Physical and Health Conditions** | | | | | | | | | | | | | | | | |
| **Recent Physical Complaints and/or Health Conditions** | | | | | | | | | | | | | | | | |
| **Chronic health conditions?** | | | | | | **Yes** | **No** | **Description:** | | | |  | | | | |
| **History of health problems/issues?** | | | | | | **Yes** | **No** | **Description:** | | | |  | | | | |
| **Current limitations or restrictions on physical activities?** | | | | | | **Yes** | **No** | **Description:** | | | |  | | | | |
| **Any serious illnesses and/or hospitalizations in the past year including ER visits?** | | | | | | **Yes** | **No** | **Description:** | | | |  | | | | |
| **Admissions to ICF/IID, Mental Health Facilities, Rehabilitation Facilities or other inpatient care?** | | | | | | **Yes** | **No** | **Description:**  ***(when, where, why)*** | | | |  | | | | |
| **Latest Exam Dates** | | | | | | | | | | | | | | | | |
| **Date of my last physical exam:** | | | | | | | | | | **Date of my last dental exam:** | | | | | | |
| **Estimated/approximate date?** | | | | | | | | | | **Estimated/Approximate date?** | | | | | | |
| **Examination Results** | | | | | | | | | | **Examination Results** | | | | | | |

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| **Allergies:** |  |
| **Reactions:** |  |

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| **Medical Support Needs and Mental Health Support Needs** | |
| **Medical Support Needs** | **Mental Health Support Needs** |
|  | . |

| **Communication, Adaptive Equipment, Assistive Technology and/or Modifications** | | | |
| --- | --- | --- | --- |
| **Method(s) of communication:** | |  | |
| **Describe supports needed for communication (if any):** | |  | |
| **Describe any adaptive equipment or assistive technology supports used:** | |  | |
| **How is equipment maintained? Who is responsible?** | |  | |
| **What is the back-up plan for power outages if medical equipment is used?** | |  | |
| **Describe any environmental modifications necessary:** | |  | |
| **Risk Assessment** | | | |
| **Date Created**: | **Risk:** | | **Resolution** |
| **Back-up and Emergency Plans** | | | |
| **Steps to take if the provider does not show up:** | |  | |
| **Steps to take if the day program/work or other activity is canceled, closes or you have to**  **leave for some other reason:** | |  | |
| **Steps to take when a natural disaster occurs:** | |  | |
| **Plan for future living arrangements if something were to happen to the primary caregiver:** | |  | |

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| **Family and Current Living Arrangements** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Education** | | | | | | | | | | | | | | |
| **Current School** |  | | | | | | | | | **Year** | |  | | |
| **Last School Attended:** |  | | | | | | | | | **Year** | |  | | |
| **Type of Diploma/Certificate:** |  | | | | | | | | | **Year:** | |  | | |
| **Employment History** | | | | | | | | | | | | | | |
| **Was {name} ever employed?** | Yes | |  | | No |  |  | | | | | | | |
| **Reason why {name} isn’t working:** |  | | | | | | | | | | | | | |
| **Volunteer Activities** | | | | | | | | | | | | | | |
| **Did {name} ever volunteer?** | Yes | |  | | No |  |  | | | | | | | |
| **Behavior Supports** | | | | | | | | | | | | | | |
| **Previous and Current Behavior Supports:** | | | | | | | | | | | | | | |
| **Serious Incidents During the Past Year** | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Evaluation Information** | | | | | | | | | | | | | | |
| **Current ICAP Date:** | |  | | | | | | | **Current ICAP Score** | | | | |  |
| **Who Completed the ICAP** | |  | | | | | | | **Current ICAP Service Level** | | | | |  |
| **Previous ICAP Date** | |  | | | | | | | **Previous ICAP Score** | | | | |  |
| **Who Completed the ICAP?** | |  | | | | | | | **Previous ICAP Service Level** | | | | |  |
| **Psychological** | | | | | | | | | | | | | | |
| **Date:** | | | | | | | | | | | | | | |
| **Examiner Name:** | |  | | | | | | | **Examiner Agency:** | | | |  | |
| **Primary DSM Code** | |  | | | | | | | | | | | | |
| **Secondary DSM Code(s)** | |  | | | | | | | | | | | | |
| **Essential Information completed by:** | | | | | | | | | | | | | | |
| **Person:** | | | |  | | | | **Legal Guardian:** | | |  | | | |
| **Support Coordinator/Credentials:** | | | |  | | | | **Additional Contributors:** | | |  | | | |
| **Date Reviewed:** | | | |  | | | | | | | | | | |

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| **Part II – Personal Profile** |

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| **Great Things About {name}** | |
|  | |
| **Hopes and Dreams** | |
|  | |
| **Important To/For** | |
| **Important TO** | **Important FOR** |
|  |  |
| **Working/Not Working** | |
| **Perspectives** | |
| **Things that work** | **Things That Do Not work** |
| **\_\_\_\_\_\_\_\_\_\_’s Perspective:** | **\_\_\_\_\_\_\_\_\_\_\_’s Perspective:** |
| **Family’s Perspective** | **Family’s Perspective** |
| **Family’s Perspective** | **Family’s Perspective** |
| **Provider’s Perspective** | **Provider’s Perspective** |
| **Provider’s Perspective** | **Provider’s Perspective** |

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| Need to Know & Strengths |
| Things People Need to Know to Support {name} and Keep Him/Her Healthy and Safe |
|  |

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| --- |
| {Name} ‘s Strengths |
|  |

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| Questions/Things to Figure Out |

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| **Question** | **Person Responsible** |
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| Are any referrals needed? | | | | | |
| Yes |  | No |  | Explain: |  |

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| **Part III – Person Centeredness** | | | | |
| **Choice, Control, Restrictions/Limitations** | | | | |
| **Were you given a choice of service(s)?** | **Yes** | **No** | **Please describe:** |  |
| **Were you given a choice of provider(s)?** | **Yes** | **No** | **Please describe:** |  |
| **Were you given a choice of living setting(s)?** | **Yes** | **No** | **Please describe:** |  |
| **Were you given a choice of roommate(s)?** | **Yes** | **No** | **Please describe:** |  |
| **Do you have control of your personal resources?** | **Yes** | **No** | **Please describe:** |  |
| **Are you given a choice of activities in your living setting?** *(including where you want to go in the community)* | **Yes** | **No** | **Please describe:** |  |
| **Are you given a choice of activities in your day program setting?** *(including where you want to go in the community)* | **Yes** | **No** | **Please describe:** |  |
| **Do you have any restrictions or limitations set by staff?** *(including visitors and food)* | **Yes** | **No** | **Please describe:** |  |

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| **Contributors Not at Meeting** | | | |
| **Support Person** | **Relationship** | **Date contributed** |
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| **Signatures** | | | | | |
| **Type** | **Name** | **Services** | **Signature Name** | **Signature Date** |
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| **Part IV - Shared Planning** |

| **Desired Outcome** | **Supports** | **How Often** | **Start Date** | **End Date** |
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