|  |  |  |
| --- | --- | --- |
| **Part I. Personal Profile** | | |
| Legal Last Name | |  |
| Legal Middle Name | |  |
| Legal First Name | |  |
| Preferred Name | |  |
| How I am best supported to direct my planning process: | |  |
| My preferences for annual planning: | |  |
| My preferred date, time, and location for my meeting: | |  |
| List great things about {PreferredName} | |  |
| Describe what’s important TO {PreferredName} | |  |
| Describe what’s important FOR {PreferredName} | |  |
| Describe {PreferredName}’s vision of the life he or she wants | |  |
| Describe what {PreferredName} doesn’t want in his/her life | |  |
| **Part II. Essential Information** | | |
| Individual has a Supported Decision-Making Agreement? | | Yes  No |
| If no, following a conversation about supported decision-making, is the individual interested in developing a supported decision-making agreement? | | Yes  No |
| If yes, enter the effective date of the Agreement. | |  |
| If the individual has an SDMA, Is the individual satisfied with their Supporter(s)? | | Yes  No |
| If no, who will support the individual in making changes to their SDMA? | |  |
| Decisions that are supported under the Agreement (check all that apply). | | Health and Personal Care  Friends and Partners  Money  Where I Live and Community Living  School and Education  Working  My rights and Safety  Meeting and Talking with My Supporters  Other |
| If other, please specify | |  |
| Individual has the following | | L : Legal Guardian  A : Authorized Representative  N : None |
| Are there any concerns with having or needing a substitute-decision maker? | | Yes  No |
| If yes, describe | |  |
| Decisions that the representative is authorized to make (check all that apply). | | Medical;  Financial;  Housing;  Service Planning;  Other |
| If other, please specify decision | |  |
| Individual has a power of attorney? | | Yes  No |
| Is there an advanced directive? | | Yes  No |
| Comments (to include co-guardian, if applicable) | |  |
| SSA Disability Determination Completed? | | Yes  No |
| Medications Required? | | Yes  No |
| Did the SC/CM ask all providers who are administering psychotropic medications if evidence of consent for use has been obtained (according to the providers’ own policies)? | | Yes  No  N/A |
| Medication name | |  |
| Location where side effect information is stored and accessible | |  |
| Are there currentmedical diagnoses (e.g., diabetes, asthma, flu, HIV, hepatitis B, COVID, measles, etc.)? | | Yes  No |
| If yes, list | |  |
| Are there any supplemental protocols, plans, devices, or instructions (e.g., pureed meals, seizure protocol, communication device, crisis steps, etc.)? | | Yes  No |
| If yes, list | |  |
| Is there a history of past medical conditions? | | Yes  No |
| If yes, list | |  |
| Is there a history of hospitalizations? | | Yes  No |
| If yes, list | |  |
| Is there a history of surgeries? | | Yes  No |
| If yes, list | |  |
| Is there a history of mental health conditions? | | Yes  No |
| If yes, list | |  |
| Is there a history of psychiatric hospitalizations? | | Yes  No |
| If yes, list | |  |
| Serious illnesses and/or chronic conditions of parents, siblings, and/or significant others in the same household? | | Yes  No |
| If yes, describe: | |  |
| Any of the following optional health screenings or vaccinations in the past 12 months?  (Select all that apply) | | Eye Exam  Hearing Test  Pap Test (women 21 and older)  Mammogram (women 40 and older)  Colorectal Cancer Screening (people 45 and over)  Vaccines |
| Date of my last complete physical exam | |  |
| Physical exam date is approximate. | | Yes  No |
| Examination Results (Physical Exam). | |  |
| Date of my last complete dental exam. | |  |
| Dental exam date is approximate. | | Yes  No |
| Examination Results (Dental Exam) | |  |
| Diagnosed Allergies (describe seasonal, food, drug, other) | |  |
| Adverse Reactions (describe seasonal, food, drug, other) | |  |
| Describe my relevant social, developmental, behavioral, and family history. | |  |
| History of abuse, neglect, sexual or domestic violence, or trauma including psychological trauma? | | Yes  No |
| If yes, describe | |  |
| Provide a summary of my current and past living arrangements | |  |
| Any concerns with accessing needed services or supports? | | Yes  No |
| If yes, describe: | |  |
| Highest level of education completed. | | None  Elementary  Middle School  Some High School  High School  Vocational  Some College  College Degree  Some Graduate School  Master’s Degree of Higher |
| Describe my educational history: | |  |
| Employment status (select one). | | currently employed;  currently employed, looking;  previously employed, looking;  previously employed, not looking or retired;  not previously employed, looking;  not previously employed, not looking or child |
| Was there a conversation with the individual/substitute decision-maker about employment? | | Yes  No |
| [If No] Describe the reason the person does not want to discuss or pursue employment. | |  |
| Did the employment conversation include employment interests? | | Yes  No |
| If yes, describe: | |  |
| Did the employment conversation include available employment options? | | Yes  No |
| If yes, describe: | |  |
| Did the employment conversation include satisfaction or dissatisfaction with current services? | | Yes  No |
| If yes, describe: | |  |
| Did the employment conversation include possible barriers to employment? | | Yes  No |
| Indicate all of the current barriers to employment. | | None (if selected no other choices can be marked)  Impact to benefits  Transportation  Safety  Lack of awareness  Other - describe |
| If other, please specify | |  |
| Did the employment conversation include ways to resolve barriers to employment? | | Yes  No |
| Ways to resolve barriers discussed (select all that apply) | | Benefits Planning;  Employment and Community Transportation;  Workplace Assistance;  Therapeutic Consultation  Community; Engagement/Coaching for education;  Other |
| If other, please specify | |  |
| Did the employment conversation include a timeline for reviewing options in the future? | | Yes  No |
| If yes, describe | |  |
| Did the employment conversation include any related actions that will be taken? | | Yes  No |
| If yes, describe | |  |
| Is the individual between 14 and 17 years old at the time of this discussion? | | Yes  No  If yes, the next **4 elements** are needed. |
| Did the employment conversation include what the person is working on at home or school that leads to employment? | | Yes  No |
| If yes, describe | |  |
| Did the employment conversation include how alternate sources of funding can support employment? | | Yes  No |
| If yes, describe | |  |
| Volunteer status (select one). | | currently volunteering;  currently volunteering, looking;  previously volunteered, looking;  previously volunteered, not looking;  no previous volunteering, looking;  no previous volunteering, not looking |
| Community involvement occurring in the following ways (select all that apply). | | Natural Supports;  Community Engagement;  Community Coaching;  Group Day;  Residentially-based services;  Other |
| If other, please specify | |  |
| Was there a conversation with the individual/substitute decision-maker about integrated community involvement? | | Yes  No |
| [If No] Describe the reason the person does not want to discuss or pursue integrated community involvement. | |  |
| Did the integrated community involvement conversation include community interests? | | Yes  No |
| If yes, describe | |  |
| Did the integrated community involvement conversation include available community options? | | Yes  No |
| If yes, describe | |  |
| Did the integrated community involvement. conversation include satisfaction or dissatisfaction with current services? | | Yes  No |
| If yes, describe | |  |
| Did the integrated community involvement conversation include possible barriers to integrated community involvement? | | Yes  No |
| Indicate all of the current barriers to community involvement. | | None; (if selected no other choices can be marked)  Lack of awareness;  Medical;  Behavior;  Other – describe |
| If other, please specify | |  |
| Did the integrated community involvement conversation include ways to resolve barriers to integrated community involvement? | | Yes  No |
| Ways to resolve barriers discussed (select all that apply) | | Community Engagement;  Community Coaching;  Nursing;  Employment and Community Transportation;  Residentially-based services;  Therapeutic Consultation;  Workplace Assistance; Other - describe |
| If other, please specify | |  |
| Did the integrated community involvement conversation include a timeline for reviewing options in the future? | | Yes  No |
| If yes, describe | |  |
| Did the integrated community involvement conversation include any related actions that will be taken? | | Yes  No |
| If yes, describe | |  |
| Was there a conversation with the individual/substitute decision-maker about unpaid relationships? | | Yes  No |
| Summarize conversation about opportunities for relationships with people not paid to support the person and how barriers will be addressed as applicable. | |  |
| Confirm topics included in the relationship conversation (select all that apply)\*  \*at least one option must be selected | | people to spend time with  people who share interests and where they meet  satisfaction or dissatisfaction with current services  barriers related to developing relationships  addressing barriers, as applicable  a timeline for reviewing options in the future, at least annually  any related actions that will be taken  what the person is working on at home and school that will lead to more unpaid relationships  alternate sources for funding (such as parks & recreation, social clubs, and faith-based services) |
| Describe plan for future living arrangements | |  |
| Describe supports needed to transition to more inclusive settings | |  |
| Current primary living situation | | *System Populated in WaMS* |
| Current primary employment or day setting  (Check all that apply). | | Community Coaching  Community Engagement  Employment Group  Employment Individual  Group Day Services  Residential  Self-Employed  Unemployed  Other |
| If other, describe | |  |
| Has the individual and/or substitute decision maker identified an interest in pursuing one or more of these integrated housing options? (Check all that apply). | | No interest expressed after a discussion of these integrated housing options (if selected no other choices can be marked)  Local tenant-based rent assistance  Low Income Housing Tax Credit properties  Project-based rental assistance  Other options |
| If Other, describe | |  |
| Has the individual and/or substitute decision maker identified an interest in pursuing one or more of these integrated waiver service options? | | No interest expressed after discussion of these integrated waiver service options; (if selected no other choices can be marked)  Supported Employment  Community Coaching;  Community Engagement;  Consumer-Directed Supports;  Electronic Home-Based services;  Other options |
| If Other, describe | |  |
| Has the individual and/or substitute decision maker identified an interest in pursuing one or more of these integrated residential waiver service options?  (Check all that apply). | | No interest expressed after discussion of these integrated residential waiver service options (if selected no other choices can be marked)  Independent Living Supports  In-home Support Services  Shared Living  Sponsored Residential  Supported Living  Other options |
| If Other, describe | |  |
| Additional Comments | |  |
| **Part III. Shared Planning** | | |
| **Planning** | | |
| **Outcome #1** | | |
| Life Area | | Employment  Integrated Community Involvement  Community Living  Safety & Security  Healthy Living  Social & Spirituality  Citizenship & Advocacy |
| Desired Outcome | |  |
| Key steps and services to get there | |  |
| Support Type | | Select at least one:  Relationship-based;  Community-based;  Eligibility-based |
| Support Provider Name | |  |
| Other supporters | |  |
| Start Date | |  |
| End Date (End Date cannot be before the start date) | |  |
| **Outcome #2** | | |
| Life Area | | Employment  Integrated Community Involvement  Community Living  Safety & Security  Healthy Living  Social & Spirituality  Citizenship & Advocacy |
| Desired Outcome | |  |
| Key steps and services to get there | |  |
| Support Type | | Select at least one:  Relationship-based;  Community-based;  Eligibility-based |
| Support Provider Name | |  |
| Other supporters | |  |
| Start Date | |  |
| End Date (End Date cannot be before the start date) | |  |
| **Outcome #3** | | |
| Life Area | | Employment  Integrated Community Involvement  Community Living  Safety & Security  Healthy Living  Social & Spirituality  Citizenship & Advocacy |
| Desired Outcome | |  |
| Key steps and services to get there | |  |
| Support Type | | Select at least one:  Relationship-based;  Community-based;  Eligibility-based |
| Support Provider Name | |  |
| Other supporters | |  |
| Start Date | |  |
| End Date (End Date cannot be before the start date) | |  |
| **Outcome #4** | | |
| Life Area | Employment  Integrated Community Involvement  Community Living  Safety & Security  Healthy Living  Social & Spirituality  Citizenship & Advocacy | |
| Desired Outcome |  | |
| Key steps and services to get there |  | |
| Support Type | Select at least one:  Relationship-based;  Community-based;  Eligibility-based | |
| Support Provider Name |  | |
| Other supporters |  | |
| Start Date |  | |
| End Date (End Date cannot be before the start date) | |  |
| **Outcome #5** | | |
| Life Area | Employment  Integrated Community Involvement  Community Living  Safety & Security  Healthy Living  Social & Spirituality  Citizenship & Advocacy | |
| Desired Outcome |  | |
| Key steps and services to get there |  | |
| Support Type | Select at least one:  Relationship-based;  Community-based;  Eligibility-based | |
| Support Provider Name |  | |
| Other supporters |  | |
| Start Date |  | |
| End Date (End Date cannot be before the start date) |  | |
| **Outcome #6** | | |
| Life Area | Employment  Integrated Community Involvement  Community Living  Safety & Security  Healthy Living  Social & Spirituality  Citizenship & Advocacy | |
| Desired Outcome |  | |
| Key steps and services to get there |  | |
| Support Type | Select at least one:  Relationship-based;  Community-based;  Eligibility-based | |
| Support Provider Name |  | |
| Other supporters |  | |
| Start Date |  | |
| End Date (End Date cannot be before the start date) |  | |
| Essential Supports | | |
| Identified Risk | | |
| Identified Risks  (Select all that apply): | Pressure Injury  Aspiration Pneumonia  Fall with Injury  Dehydration  Bowel Obstruction  Sepsis  Seizure  Community Safety Risks  Self-Harm  Elopement  Lack of Safety Awareness  Substance use  Suicidal ideations None of these apply (If selected, then other options cannot be selected) | |
| Potential Risk | | |
| Potential risk – fall with injury  (Select all that apply) | Only complete if **Fall with Injury** is not selected on above Identified Risk Section.  Has experienced a fall or fall with injury in the past.  Has been diagnosed with a seizure disorder, Meniere’s disease (vestibular syncope), or arthritis.  Takes more than 4 medications daily (polypharmacy)  Uses walking aids and/or other Durable Medical Equipment (DME)  Has experienced syncope (fainting).  Has experienced risk taking behaviors or impulsive behaviors such as darting or changing directions quickly with little to no indication.  Experiences urinary/bowel urgency.  Experiences fatigue and weakness with activity.  Is 65 or older.  None of these apply (If selected, then other options cannot be selected) | |
| Potential risk – dehydration  (Select all that apply) | Only complete if **Dehydration** is not selected on above Identified Risk Section.  Has been diagnosed with dehydration in the past.  Diagnosis of dysphagia, irritable bowel syndrome (IBS), hyperhidrosis and/or thermoregulation disorder.  Requires assistance to be fed (food or liquid).  Refuses to drink beverages.  Has experienced chronic/repetitive diarrhea.  Has experienced chronic/repetitive vomiting.  Is prescribed routine diuretic medication.  None of these apply (If selected, then other options cannot be selected) | |
| Potential risk – bowel obstruction  (Select all that apply) | Only complete if **Bowel Obstruction** is not selected on above Identified Risk Section.  Has been diagnosed with a bowel obstruction in the past.  Has been diagnosed with constipation, gastroparesis, Crohn’s disease, diverticulitis, PICA or an ileus.  Has diagnosis of any neurological disorder (e.g., Cerebral Palsy, Spina Bifida, Muscular Dystrophy, paralysis etc.)  Is prescribed laxatives or enemas (routine or PRN).  Refuses to drink beverages.  Requires assistance to be fed (food or liquid).  Is prescribed psychiatric and/or narcotic medications (routine or PRN).  Has limited mobility.  None of these apply (If selected, then other options cannot be selected) | |
| Potential risk – sepsis  (Select all that apply) | Only complete if **Sepsis** is not selected on above Identified Risk Section.  Has been diagnosed with Sepsis in the past.  Has been diagnosed with Diabetes, Chronic Obstructive Pulmonary Disease (COPD),  Cirrhosis, Chronic kidney disease, Congestive Heart Failure (CHF), Pneumonia, UTI and/or lowered immune response (lupus, HIV, genetic disorders etc.)  Diagnosis of PI, skin breakdown or cellulitis  Recently experienced a severe hospitalization that includes an intensive care unit (ICU) admission.  Has been diagnosed with a urinary tract infection (UTI) and/or uses a urinary catheter (indwelling or requires in and out catheterization)  None of these apply (If selected, then other options cannot be selected) | |
| Potential risk – seizure  (Select all that apply) | Only complete if **Seizure** is not selected on above Identified Risk Section.  Has been diagnosed with seizure disorder in the past.  Has been diagnosed any neurological disorder, genetic disorder, (e.g., Autism Spectrum Disorder, Cerebral Palsy, Dementia, Alzheimer’s, Muscular Dystrophy, Obstructive Sleep Apnea, and Traumatic Brain Injury etc.) or thermoregulation disorder.  Has experienced a change in routine anti-epileptic medications (AEM).  Has missed or refused routine anti-epileptic medications (AEM).  Has been diagnosed with dehydration.  None of these apply (If selected, then other options cannot be selected) | |
| Potential risk – community safety risks  (Select all that apply) | Only complete if **Community Safety** is not selected on above Identified Risk Section.  Attempted to assault and/or injuring others  Property destruction due to fire setting and/or arson  Sexual aggression  None of these apply (If selected, then other options cannot be selected) | |
| Potential risk – self-harm  (Select all that apply) | Only complete if **Self-Harm** is not selected on above Identified Risk Section.  displays self-injury  pica  physical self-harm  suicide attempts  None of these apply (If selected, then other options cannot be selected) | |
| Potential risk – elopement (Select all that apply) | Only complete if **Elopement** is not selected on above Identified Risk Section.  Leaves the setting unexpectedly, with a demonstrated history of lack of safety awareness, or ignoring common safety norms when leaving (i.e., walking into traffic)  Leaves the setting without support, despite current individualized safety restriction to include having support when leaving  None of these apply (If selected, then other options cannot be selected) | |
| Potential risk – lack of safety awareness  (Select all that apply) | Only complete if **Lack of Safety Awareness** is not selected on above Identified Risk Section.  displays a pervasive lack of safety awareness throughout their daily living due to communication deficits combined with cognitive deficits and/or brain injury that leaves them open to victimization (financial, daily living, socio-sexual)  None of these apply (If selected, then other options cannot be selected) | |
| Potential risk – substance use  (Select all that apply) | Only complete if **Substance Use** is not selected on above Identified Risk Section.  Expresses an intense desire for a substance.  Fails to fulfill obligations due to use of a substance.  Has quit or reduced participation in important activities in order to use the substance.  Spends excessive time obtaining, using, and/or recovering from the effects of a substance.  Uses larger amounts of a substance or for longer than intended.  Continues substance use despite having a physical or mental problem that could have been caused or exacerbated by the substance.  Expresses desire to cut down or regulate substance use and/or reports unsuccessful efforts.  None of these apply (If selected, then other options cannot be selected) | |
| Potential risk – suicidal ideations  (Select all that apply) | Only complete if **Suicidal Ideations** is not selected on above Identified Risk Section.  Talking, drawing, or writing about dying, death, or suicide  Making plans for suicide  Seeking means for suicide  Expressing hopelessness  Withdrawing from others  None of these apply (If selected, then other options cannot be selected) | |
| Routine Supports | | |
| Routine Supports  (Select all that apply): | Adaptive equipment/DME  Bathing  Communication support  Dressing  Restroom support  Positioning/transferring  Personal appearance  Medication use  Housekeeping  Laundry  Shopping  Meal planning/preparation/intake  Banking/money management  Medical appointments  Transportation  Crisis plan  Other routine support #1 (e.g., dialysis, catheter care, ostomy care)  Other routine support #2  Other routine support #3  Other medical #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (e.g., high/low blood pressure, dementia/neurological impairment, respiratory care, G-Tube, etc.)  Other medical #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other medical #3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other behavioral #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (e.g. Self-neglect, trichotillomania, severe stereotypy, etc.)  Other behavioral #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other behavioral #3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  None of these apply (If selected, then other options cannot be selected) | |
| **Part IV. Agreements** | | |
| **Potential Risks Referral** | | |
| Will an appointment with a Qualified Health Professional be scheduled?  Select one response: | | Reference Potential Risks Identified in Part III:  Pressure Injury  Aspiration Pneumonia  Fall with Injury  Dehydration  Bowel Obstruction  Sepsis  Seizure  Community Safety Risks  Self-Harm  Elopement  Lack of Safety Awareness  Substance use  Suicidal ideations None of these apply (If selected, then other options cannot be selected) |
| If appointment is planned, who will schedule the appointment?  If the appointment is not planned, described how needs are/will be met. | |  |
| **Individual Questions** | | |
| Does this plan move me closer to the life I want? | | Yes  No |
| Have I had the opportunity to plan for personal topics apart from the full team? | | Yes  No |
| I was supported to direct and participate in my planning process as described in Part II: Personal Profile? | | Yes  No |
| Have I chosen all of the providers and services I receive having been informed about the benefits and risks? | | Yes  No |
| Have I chosen or has input into where I live? | | Yes  No |
| Have I chosen or has input into who lives with me? | | Yes  No |
| Do I choose or have input into my daily schedule? | | Yes  No |
| If the answer is “no” to any question above, go back and consider again. Describe the reason for any questions about remaining “no” at the end of the meeting and any plan to resolve. | |  |
| **Team Questions** | | |
| Does any team member have an objection to any outcomes in my plan? | | Yes  No |
| Are there any restrictions that require review or agreement? | | Yes  No |
| Do I need financial planning or benefits counseling in order to maintain or maximize resources? | | Yes  No |
| Is there any IMPORTANT TO or IMPORTANT FOR information elsewhere that is not addressed in my plan? | | Yes  No |
| Describe the reason for any questions above being marked "yes" and any plan to resolve | |  |
| Does any team member have an objection to any essential supports in my plan? | | Yes  No |
| If yes, describe the objection to any essential supports in my plan. | |  |
| Are Therapeutic Behavioral Consultation waiver services needed? **Please review selections carefully and respond.**  **Select only 1** | | Yes, referral to be completed within 30 days of ISP  Yes, referral(s) already completed and waiting to start services  Yes, and the person is connected to this service already  Yes, there are needs but individual/SDM declined referral  No, needs are addressed by other supports (e.g. ABA, psychology)  No, needs do not require these services |
| If yes within 30 days, who will complete referral for behavioral services?  **A service authorization should be submitted to DBHDS within 30 days of an identified need.** | |  |
| Are Nursing waiver services needed?  **Please review selections carefully and respond.**  **Select only 1** | | Yes, referral to be completed within 30 days of ISP  Yes, referral(s) already completed and waiting to start services  Yes, and the person is connected to this service already  Yes, there are needs but individual/SDM declined referral  No, needs are addressed by other supports (e.g. ABA, psychology)  No, needs do not require these services |
| If yes within 30 days, who will complete referral for nursing services?  **A service authorization should be submitted to DBHDS within 30 days of an identified need** | |  |
| Are supports or services needed that are not available? | | Yes  No |
| If yes, speak with your supervisor and you may contact your assigned Community Resource Consultant to discuss. | |  |