|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Individual Support Plan** | **ISP Effective Date:** |       |
| **(Edition Type)** |  |       |  |
|  | **(Person’s Full Name)** | **Date ISP Amended:** |       |
| **face sheet** |

|  |  |  |
| --- | --- | --- |
| **Person’s Information:** |  | **Planning Meeting:** |
| **Street Address:**  |       |  | **Date:** |       | **Time:** |       |  |
| **City, State, Zip:**  |       |  | **Location:** |       |
| **Phone:** |       |  |  |
| **Email:** |       |  | **For an amendment, amended sections are marked below:** |
| **I.D. Number:** |       | **Date of Birth:** |       | **Region:** |  |  | **[ ]  A. Personal Focus****[ ]  B. Action Plan** | **[ ]  C. Services and Supports****[ ]  D. Behavior Support Plan** |
| **HCBS Waiver:** |  | **Waiver Enroll Date:** |       |  |  |  |
| **In this ISP, this person prefers to be called by this name:** | My Name |  |  |  |
|  |  |  |  |
| **Conservator or Other Legal Representative:** |  | **This ISP Edition Prepared By:** |
| **Name:**  |       |  | **Name:** |       |
| **Relationship:**  |       |  | **Position:** |       |
| **Street Address:** |       |  | **Agency:**  |       |
| **City, State, Zip:** |       |  | **Phone:** |       |
| **Phone:** |       |  | **Email:** |       |
| **Email:** |       |  | **Reason for Submission to DIDD:** |
|  |  |  |
| **Other Primary Contact:** |  |  |
| **Name:** |       |  | Additional submission details, if needed: |
| **Relationship:**  |       |  |       |
| **Street Address:** |       |  |  |
| **City, State, Zip:** |       |  |  |
| **Phone:** |       |  |  |
| **Email:** |       |  |  |
| **[ ]  Yes. [ ]  No.** | **Is the Primary Contact eligible to receive Protected Health Information in accordance with HIPPA requirements?** |  |  |
|  |  |  |  |
| **[ ]  Yes. [ ]  No.** | **If yes, is there a signed release of information?** |  |  |

|  |
| --- |
| **Purpose:** This section is written to ensure that the ISP is focused on the person. The information reflects what this person, his/her family and/or legal representative, and the persons they have chosen, have told the preparer of this ISP. Important information from the person’s records also is included as desired by the person, family or his/her legal representative. The Personal Focus is completed prior to, and distributed to everyone invited to the planning meeting. This information provides the foundation around which supports, services, outcomes, goals, actions, etc. are planned and carried out for this person. If in this Personal Focus, the person or his/his legal representative and/or family indicate that anything needs to be different, changed, or ensured in the person’s life, it will be addressed in the Action Plan of this ISP. |

| **1.** | **Description of the Person’s Current Life:**  |
| --- | --- |

| **Describe the Person‘s Current Situation andWhat is Important to the Person** |
| --- |
| ***What’s important to and for My Name and what do others need to know to support My Name in these areas of daily life?*** |
| **a.** | **Home:** |
|  | **What do people like and admire about My Name ? What are the good things that others say about My Name ?** |
|  | * (Click here and begin typing. To add another bullet, press Enter at the end of each sentence.)
 |
|  | **What is important to My Name ? What is important for My Name?** |
|  | * (Click here and begin typing. To add another bullet, press Enter at the end of each sentence.)
 |
|  | **What supports does My Name need at home (what should supports look like for My Name)?** |
|  | * (Click here and begin typing. To add another bullet, press Enter at the end of each sentence.)
 |
| **b.** | **Day:** |
|  | **What is important to My Name during the day? What is important for My Name during the day?** |
|  | * (Click here and begin typing. To add another bullet, press Enter at the end of each sentence.)
 |
|  | **What supports does My Name need during the day (what should supports look like for the person)?** |
|  | * (Click here and begin typing. To add another bullet, press Enter at the end of each sentence.)
 |
| **c.** | **Relationships/Natural Supports/Community Membership:** |
|  | **What is important to My Name? What important for My Name?** |
|  | * (Click here and begin typing. To add another bullet, press Enter at the end of each sentence.)
 |
|  | **What supports does My Name need in order to develop and maintain relationships?** |
|  | * (Click here and begin typing. To add another bullet, press Enter at the end of each sentence.)
 |
| **d.** | **Medical Conditions:** List chronic medical, psychiatric, and other health conditions. |
|  | **What is important for My Name to be healthy and safe? What is important to My Name in regards to his/her interest in helping to manage his/her healthcare?** |
|  | * (Click here and begin typing. To add another bullet, press Enter at the end of each sentence.)
 |
| **e.** | **Allergies:** List food, drug and other allergies. |
|  | * (Click here and begin typing. To add another bullet, press Enter at the end of each sentence.)
 |
| **f.** | **Mealtime:** List food likes and dislikes, special diets, dining issues, weight issues, etc. |
|  | **What is important to My Name? What is important for My Name?** |
|  | * (Click here and begin typing. To add another bullet, press Enter at the end of each sentence.)
 |
|  | **What is important for My Name to be healthy and safe at mealtime?** |
|  | * (Click here and begin typing. To add another bullet, press Enter at the end of each sentence.)
 |

|  |
| --- |
| **2. What is My Name’s Vision of a Preferred Life?** (What is the person’s vision for their life? What does the person want to accomplish? What supports will the person need in order to achieve their goals?) |
| (Click & Type Here) |

|  |
| --- |
| **3. Personal Funds Management:** Specify the person’s preferences regarding personal funds management. |
| (Click & Type Here) |

|  |
| --- |
| **4. Decision-Making:** Specify the person’s rights and responsibilities for making other decisions. |
| (Click & Type Here) |

|  |
| --- |
| **5. Communication:** Specify how the person communicates with others and the best way to communicate with the person. |
| (Click & Type Here) |

|  |
| --- |
| **6. Other Important Things that Supporters Should Know:** |
| * (Click here and begin typing. To add another bullet, press Enter at the end of each sentence.)
 |

|  |
| --- |
| **Purpose:** This Action Plan is developed based on information gathered from the person and the person’s family or legal representative during a meeting with the person’s support planning team and from assessments and other information sources.The Action Plan consists of:1. Identifying actions needed for the person to achieve the person’s vision of a preferred life;
2. Identifying actions for meeting the person’s needs and preferences;
3. Identifying actions for supporting the person’s activities of daily life;
4. Identifying actions to address any other risks in the person’s life;
 |

|  |
| --- |
| **1. OUTCOMES:** |

| **WHAT IS THE OUTCOME?** The focus for this section should be the person’s vision of a preferred life. What is their personal goal and where are they now in achieving that goal? |  **STRATEGIES FOR IMPLEMENTATION:** What are the barriers to implementation? What’s working and not working? What are the strategies to remove the barriers, and overcome what’s getting in the way? | **WHAT ARE THE ACTION STEPS NEEDED TO IMPLEMENT THE PERSONS GOALS?** | **HOW WILL PROGRESS BE MEASURED?**  | **WHO WILL DO?****WHEN?** |
| --- | --- | --- | --- | --- |
| (Click here to begin typing. Press TAB to move to next column.) | (Use TAB key to move to next column) | (Use TAB key to move to next column) | (Use TAB key to move to next column) | (Use TAB key or "Table", "Insert Rows" to add new rows) |

| **2. OTHER RISKS IN THIS PERSON’S LIFE:** If not addressed elsewhere in this Action Plan. |
| --- |

| **Risk & Personal Choice:** List risks identified from risk assessments or other assessments and the person’s choice regarding the risk. If the person does not have 24-hour supervision, the type of supervision needed must be specified. | **Action Needed:** Specify the actions needed to address, manage, or alleviate the risk and the type, frequency (hours/day, days/week), and location of supports and services needed. | **Responsible Person or Entity** | **Projected Timeframes** |
| --- | --- | --- | --- |
| (Click here to begin typing. Press TAB to move to next column.) | (Use TAB key to move to next column) | (Use TAB key to move to next column) | (Use TAB key or "Table", "Insert Rows" to add new rows) |

| **3. SUPPORTS FOR NON-ROUTINE EVENTS:** These are events that would vary from the regular routine and that reasonably could be anticipated and planned for in advance so that supports could be arranged. Significant events may require the ISP to be amended. |
| --- |

| **Non-Routine Event:** Examples include vacation, travel, visiting family, job loss, school closure, hospitalization, illness, crisis, respite, etc. | **Action Needed:** Specify the type, frequency (hours/day, days/week), and location of supports and services needed, including special equipment, technology, treatment, etc. | **Responsible Person or Entity** | **Projected Timeframes** |
| --- | --- | --- | --- |
| (Click here to begin typing. Press TAB to move to next column.) | (Use TAB key to move to next column) | (Use TAB key to move to next column) | (Use TAB key or "Table", "Insert Rows" to add new rows) |

| **PURPOSE**: The purpose of Section C is to identify the supports and services that are being used, or are required, to meet the needs of the person. |
| --- |
| 1. **Medicaid State Plan and Other Available Supports & Services:** Identified below are those non-HCBS Waiver benefits, services and supports that are available or in place for meeting the person’s needs identified in this ISP. Included should be any benefits provided through private resources; available under the Medicaid State Plan and TennCare, Medicare, and other government-mandated or eligibility-based programs. (Check all that apply)
 |
|  | (Non-Medicaid HCBS Waiver) Programs, Services & Benefits Available for Supporting the Person |
| [ ]  | Private, Third-Party Health Insurance Plan: (Non-Medicaid, Non-Medicare Health Plans) |
| Issuer/Plan Name:       |
| [ ]  | Medicare Benefits / Medicare Advantage Plan:  | Type(s) of Medicare Coverage:       |
|  | Advantage Plan Name:       |
| [ ]  | TennCare / Medicaid State Plan Services: | Name of MCO:       |
| Specify benefits to be coordinated:       |
| [ ]  | Private Dental Insurance / Benefits:  | Name of Carrier / Plan:       |
| [ ]  | Local Educational Services: | Specify Any Education-Related Services:       |
| [ ]  | Vocational Rehabilitation Services: | Specify:       |
| [ ]  | Federal / State Housing Assistance: | Specify:       |
| [ ]  | Advocacy Services: | Specify:       |
| [ ]  | Special Transportation Services: | Specify:       |
| [ ]  | Paid (Corporate) Conservatorship Services: | Name of Corporate Entity:       |
| [ ]  | Senior / Aging / Elder Support Services: | Specify type and purpose of service:       |
| [ ]  | Other, Specified:       |

**2. Medicaid HCBS Waiver Services:** The needs, outcomes, goals and actions to be addressed by the Medicaid HCBS Waiver services requested below are reflected in the Action Plan of this ISP. The providers approved below for these authorized services are responsible for carrying out this ISP and meeting the health and personal safety needs of this person.

|  | **A** | **b** | **c** | **d** | **e** | **f** | **g** | **(didd Use Only)** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Service Name****&****Type of Request** | **Service Code****&****Fund Source** | **Provider Name****&****Provider Code** | **Site Name****&****Site Code** | **Start Date****&****End Date** | **Unit Rate****&****Unit Type** | **Units of Svc&Cost of Svc** | **Approve** | **Deny** | **Deny &****Partially****Approve** |
| **1** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |
| **2** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |
| **3** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |
| **4** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |
| **5** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |
| **6** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |
| **7** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |
| **8** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |
| **9** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |

**[ ]  — If checked, the listing of requested / authorized services continues on the next page of this section.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DIDD Review and Authorization of Services:** |  | **Projected Total for ISP Year:**  | **$**      |  |
|  |  |  | *Note: The total units for any combination of day services listed here in Section C.2 will be shown just for the type of Day Service with the highest unit rate. Day Services are limited to 243 days across any and all combinations of day services and settings.* |
| *(Authorizing Signature)* | *(Title)* | *(Date)* |

**2. Medicaid HCBS Waiver Services (Continued):**

|  | **A** | **b** | **c** | **d** | **e** | **f** | **g** | **(didd Use Only)** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Service Name****&****Type of Request** | **Service Code****&****Fund Source** | **Provider Name****&****Provider Code** | **Site Name****&****Site Code** | **Start Date****&****End Date** | **Unit Rate****&****Unit Type** | **Units of Svc&Cost of Svc** | **Approve** | **Deny** | **Deny &****Partially****Approve** |
| **100** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |
| **11** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |
| **12** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |
| **13** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |
| **14** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |
| **15** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |
| **16** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |
| **17** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |
| **18** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |
| **19** |       |       |       |       |       |       |       | [ ] | [ ] | [ ] |
|  |  |  |       |       |       |  |       |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **DIDD Review and Authorization of Services:** |  | **Projected Total for ISP Year:**  | **$**      |  |
|  |  |  | *Note: The total units for any combination of day services listed here in Section C.2 will be shown just for the type of Day Service with the highest unit rate. Day Services are limited to 243 days across any and all combinations of day services and settings.* |
| *(Authorizing Signature)* | *(Title)* | *(Date)* |

**3. PARTIAL APPROVAL OF A SERVICE DENIED BY DIDD:**

**(This section is to be completed only by DIDD for partial approval of a HCBS Medicaid Waiver Service.)**

|  | **A** | **C** | **D** | **E** | **F** | **G** | **H** | **(DIDD Use Only)** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Service Name****&****Type of Request** | **Service Code****&****Fund Source** | **Provider Name****&****Provider Code** | **Site Name****&****Site Code** | **Start Date****&****End Date** | **Unit Rate****&****Unit Type** | **Units of Svc****&****Cost of Svc** | **Partial Approval of Denied Service** |
| **1.** |  |  |  |  |  |  |  | [  ] |
|  |  |  |  |  |  |  |  |
| **2.** |  |  |  |  |  |  |  | [  ] |
|  |  |  |  |  |  |  |  |
| **3.** |  |  |  |  |  |  |  | [  ] |
|  |  |  |  |  |  |  |  |
| **4.** |  |  |  |  |  |  |  | [  ] |
|  |  |  |  |  |  |  |  |
|  |
|  | **Revised Total Cost of Services Approved:** |  $ |  |

|  |  |  |
| --- | --- | --- |
| **DIDD Review and Authorization of Partially-Approved Services:** |  | *Note: The total units for any combination of day services listed here in Section C.3 will be shown just for the type of Day Service with the highest unit rate. Day Services are limited to 243 days across any and all combinations of day services and settings.* |
|  |  |  |
| *(Authorizing Signature)* | *(Title)* | *(Date)* |

|  |
| --- |
| **1. Attach a Copy of the Behavior Support Plan where applicable or, if being amended, attach the amended Behavior Support Plan.**      |