Department of Intellectual & Developmental Disabilities

INDIVIDUAL SUPPORT PLAN DISTRIBUTION LIST

The ISP is distributed to the recipients listed below.
This sheet serves only as a distribution cover.
It is not a part of the ISP and may be discarded by recipients.

PERSONS LISTED ON FACE SHEET

Name Listed on ISP Face Sheet	Address Listed on Face Sheet	Other Preferred Distribution Address
Person (Service Recipient)		
Legal Representative		
Other Primary Contact		

DIDD PROVIDERS & OTHERS	DISTRIBUTION EMAIL ADDRESS

FOR OFFICE USE ONLY	DISTRIBUTED BY	EMAIL DISTRIBUTION DATE	MAIL DISTRIBUTION DATE

Department of Intellectual & Developmental Disabilities

INDIVIDUAL SUPPORT PLAN

FULL NAME:

WHAT PEOPLE LIKE AND ADMIRE ABOUT ME

WHAT IS IMPORTANT TO ME

PLEASE ADD THE VISION STATEMENT HERE!

YOU CAN BEST SUPPORT ME BY

Department of Intellectual & Developmental Disabilities

INDIVIDUAL SUPPORT PLAN SIGNATURE FORM

PERSON:
MEETING DATE:
SIGNATURE /MARK OF THE PERSON:

Signing this form validates that you attended the meeting and you are in agreement with all information that was discussed, the content of your ISP and any changes that were made as a result of the meeting.

PRINTED NAME	AGENCY	RELATIONSHIP	DATE	SIGNATURE

SIGNATURE OF LEGAL REPRESENTATIVE (IF APPLICABLE):	DATE:

PEOPLE WHO CONTRIBUTED VIA PHONE/EMAIL/FAX:	DATE:

Department of Intellectual & Developmental Disabilities

INDIVIDUAL SUPPORT PLAN

FULL NAME:		
SELECT ONE: Amendment	ISP EFFECTIVE DATE:	DATE ISP AMENDED:

PERSON'S INFORMATION

STREET ADDRESS:	CITY, STATE ZIP:	
PHONE:	EMAIL:	
LAST FOUR OF SS#:	DATE OF BIRTH:	REGION: West
HCBS WAIVER: SDW	WAIVER ENROLLMENT DATE:	
PERSON'S PREFERRED NAME:	MEDICAID REDETERMINATION DATE:	

CONSERVATOR / LEGAL REPRESENTATIVE

NAME:	RELATIONSHIP:
STREET ADDRESS:	CITY, STATE ZIP:
PHONE:	EMAIL:

OTHER PRIMARY CONTACT

NAME:	RELATIONSHIP:
STREET ADDRESS:	CITY, STATE ZIP:
PHONE:	EMAIL:

Is the Primary Contact eligible to receive Protected Health Information in accordance with HIPAA requirements? O YES O NO

If **YES**, is there a signed release of information? O YES O NO

PLANNING MEETING

LOCATION:	DATE & TIME:

AMENDMENT (SECTIONS AMENDED ARE CHECKED BELOW)

O A. PERSONAL FOCUS O B. ACTION PLAN

O C. SERVICES & SUPPORTS O D. BEHAVIOR SUPPORT PLAN

ISP PREPARED BY

NAME:	AGENCY:
PHONE:	EMAIL:

SUBMISSION REASON

SELECT ONE:

SUBMISSION DETAILS (if needed):

Department of Intellectual & Developmental Disabilities

INDIVIDUAL SUPPORT PLAN	FULL NAME:	
SELECT ONE: Amendment	ISP EFFECTIVE DATE:	DATE ISP AMENDED:

A. PERSONAL FOCUS

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/her 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. WHAT IS MY 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? The vision is the person's desired life; It can be short term or long term. The vision is a guideline and in order to create good outcomes, you need to start with a good vision.

What's important to me? What's important for me?

What supports do I need to accomplish my vision? How does my vision connect to my outcomes and actions?

How can my vision connect to my outcomes and action steps?

Department of Intellectual & Developmental Disabilities

INDIVIDUAL SUPPORT PLAN

FULL NAME:		
SELECT ONE: Amendment	ISP EFFECTIVE DATE:	DATE ISP AMENDED:

A. PERSONAL FOCUS

2. DESCRIPTION OF PERSON'S CURRENT LIFE

*Describe the Person's Current Situation & What is Important to the person. What's important to and for **me** and what do others need to know to support **me** in these areas of daily life?*

A. HOME

What does my home life look like?

What is **important to me**? / What is **important for me** at home?

What supports do I need at home? What should supports look like for **me**?

B. EMPLOYMENT / DAY

How does my day look? Do I work? If yes, what supports do I need to be successful at work? Do I want to work? What kind of job would I like to have? What supports do I need to find a job? What challenges do I face in obtaining a job? What should day supports look like for me? What support do I need to be successful in the community? Are there things during the day that I would like to do more independently? Remember that when thinking about employment and day it is important to think about the three E's: Educate, Explore and Experience. Address retirement if the person is retired and also remember community memberships.

Department of Intellectual & Developmental Disabilities

INDIVIDUAL SUPPORT PLAN

FULL NAME:		
SELECT ONE: Amendment	ISP EFFECTIVE DATE:	DATE ISP AMENDED:

A. PERSONAL FOCUS

2. DESCRIPTION OF PERSON'S CURRENT LIFE (CONTINUED)

B. EMPLOYMENT / DAY (CONTINUED)

What supports do I need during the day? What should day supports look like for me? When addressing employment and day, remember to cover the entire day.

C. RELATIONSHIPS/NATURAL SUPPORTS/COMMUNITY MEMBERSHIP

What is important to me? What is important for me? Who am I close to? Who are my natural supports? Who do I want to spend my time with? How do I communicate/engage with them? How often? Is it enough for me? Do I want more friends/natural supports? Am I an active member of any groups? Does the person want to learn about various clubs, groups or civic organizations?

What supports do I need in order to develop and maintain relationships?

What is important to me with being involved in my community? What supports do I need to learn more about my community and how to get involved if I choose to?

2. DESCRIPTION OF PERSON'S CURRENT LIFE (CONTINUED)

D. MEDICAL CONDITIONS - LIST CHRONIC/ONGOING MEDICAL, PSYCHIATRIC AND OTHER HEALTH CONDITIONS

What is important to me to be healthy and safe? What is important to me in regards to my interest in helping to manage my healthcare? What steps am I taking to improve my health? Is there medical history that is important for my supporters to know?

Diagnosis/Diagnoses

Do I receive healthcare as recommended for my gender, age and health risks? Am I supported to be aware of my medical issues and their impact? Am I interested in learning about self-administration of medications with support as necessary? If I administer my own medications please explain the process.

E. ALLERGIES - LIST ALL FOOD, DRUG AND OTHER ALLERGIES. Please include a description of the person's reaction to each allergen.

2. DESCRIPTION OF PERSON'S CURRENT LIFE (CONTINUED)

F. MEALTIME - LIST FOOD LIKES/DISLIKES, SPECIAL DIETS, DINING ISSUES, WEIGHT ISSUES, ETC.

What is important to me? What is important for me?

What is important for me to be healthy and safe at mealtime?

3. MONEY MANAGEMENT

Specify the person's preferences regarding personal funds management. (Use the personal funds management policy as reference) Think about the following: Does the person have a will, a burial plan, a savings account, etc.?

What's important to me in terms of money management? What's important for me?

3. MONEY MANAGEMENT (CONTINUED)

What supports do I need in managing money/financial matters?

4. RIGHTS PROTECTION AND PROMOTION/DECISION MAKING / HCBS MODIFICATIONS

People with disabilities have the same rights as everyone. The exercise of rights is a function of informed personal choice. Each person defines which rights are most important. The role of supporters is to provide training and supports to help people recognize and understand rights and to assist the person to exercise rights and make choices.

Modification (HCBS)

A modification refers to those portions of the rule that cannot be implemented due to an actual health and safety risk for the person supported.

Additionally, according to CMS, any modifications to the person's plan of care, must be supported by a specific assessed need and justified in the person-centered service plan. The following requirements must be documented in the person-centered service plan:

- Identify a specific and individualized assessed need.
- Document the positive interventions and supports used prior to any modifications to the person-centered service plan.
- Document less intrusive methods of meeting the need that have been tried but did not work.
- Include a clear description of the condition that is directly proportionate to the specific assessed need.
- Include regular collection and review of data to measure the ongoing effectiveness of the modification.
- Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
- Include the informed consent of the person.
- Include an assurance that interventions and supports will cause no harm to the person.

Does the person have any rights restrictions? If yes, please explain. Is there a plan to have personal rights restored? Is there a phase out plan? Are rights restrictions being reviewed on a specific timeframe (6 months, 9 months, 12 months) and by whom?

Department of Intellectual & Developmental Disabilities

INDIVIDUAL SUPPORT PLAN

FULL NAME:		
SELECT ONE: Amendment	ISP EFFECTIVE DATE:	DATE ISP AMENDED:

A. PERSONAL FOCUS

4. RIGHTS PROTECTION AND PROMOTION/DECISION MAKING / HCBS MODIFICATIONS (CONTINUED)

What does the person know about their rights as a citizen? What rights are important to the person?

What information or support does the person need to help them exercise their rights?

What's important to me regarding decision making? What supports do I need with decision making?

5. COMMUNICATION

Specify how the person communicates with others and the best way to communicate with the person. I communicate by: The best way to communicate with me is:

Department of Intellectual & Developmental Disabilities

INDIVIDUAL SUPPORT PLAN

FULL NAME:		
SELECT ONE: Amendment	ISP EFFECTIVE DATE:	DATE ISP AMENDED:

B. ACTION PLAN - VISION OF A PREFERRED LIFE

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: Identifying actions needed for the person to achieve the person's vision of a preferred life; Identifying actions for meeting the person's needs and preferences; Identifying actions for supporting the person's activities of daily life; Identifying actions to address any other risks in the person's life;

☐ **Is there at least one functional outcome that connects to the person's vision?**

1. OUTCOMES

MY SECURITY	MY COMMUNITY	MY RELATIONSHIPS	MY CHOICES	MY GOALS
People... - are safe - are free from abuse and neglect - have the best possible health - experience continuity and security - exercise rights - are treated fairly - are respected	People... - use their environments - live in integrated environments - interact with members of the community - participate in the life of the community	People... - are connected to natural support networks - have friends - have intimate relationships - decide when to share personal information - perform different social roles	People... - choose where and with whom they live - choose where they work - choose services	People... - choose personal goals - realize personal goals

OUTCOME	**ACTION** (Must Include Measurement)	**TIMEFRAME** (By When)	**WHO'S RESPONSIBLE?** (Title)

Department of Intellectual & Developmental Disabilities

INDIVIDUAL SUPPORT PLAN

FULL NAME:		
SELECT ONE: Amendment	ISP EFFECTIVE DATE:	DATE ISP AMENDED:

B. ACTION PLAN - RISK IDENTIFICATION

2. RISK IDENTIFICATION

RISKS	WHAT DOES IT LOOK LIKE FOR ME?	HOW WILL I MANAGE IT? (Supports needed)
HEALTH & MEDICAL *Includes: Unmet medical needs, seizures, substance abuse, inability to tolerate a medical examination procedure, falls (increased or unusual falls) PICA, and lifestyle choices that significantly affect health. Unable to communicate basic needs such as pain, illness, hunger, or thirst.*		
FINANCIAL *Includes: Potential for financial abuse, inadequate financial resources (loss of benefits or significant reduction in benefits, loaning money or giving away money to others, or owes money to others for which the person has difficulty paying due to poor financial decisions).*		
MEALTIME *Includes: Significant weight gain/loss or change in eating patterns, choking and/or aspiration or swallowing disorders.*		
SAFETY *Includes: Fire evacuation safety, vehicle safety, significant risk of exploitation, safety of residence, household chemical safety, and other safety issues.*		
BEHAVIORAL RISKS *Includes: Physical aggression, self-injury, property destruction, substance abuse, illegal behavior, court-mandated restrictions, ingesting non-edible objects, refusing medical care, extreme food or liquid seeking behavior, illegal or high risk sexual behavior, undesirable sexual behavior, harm to animals, unsafe social behavior, other behavioral issues.*		

OTHER RISKS

Describe the risk(s) and what supports the person needs.

Department of Intellectual & Developmental Disabilities

INDIVIDUAL SUPPORT PLAN

FULL NAME:		
SELECT ONE: Amendment	ISP EFFECTIVE DATE:	DATE ISP AMENDED:

C. SERVICES & SUPPORTS

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)

O **PRIVATE, THRID-PARTY HEALTH INSURANCE PLAN:** (NON-MEDICAID, NON-MEDICARE HEALTH PLANS)

ISSUER/PLAN NAME:

O **MEDICARE BENEFITS / MEDICARE ADVANTAGE PLAN:**

TYPE(S) OF MEDICARE COVERAGE: | ADVANTAGE PLAN NAME:

O **TENNCARE / MEDICAID STATE PLAN SERCICES:**

NAME OF MCO: | SPECIFY BENEFITS TO BE COORDINATED:

O **PRIVATE DENTAL INSURANCE / BENEFITS:**

NAME OF CARRIER / PLAN:

O **LOCAL EDUCATION SERVICES:**

SPECIFY ANY EDUCATION-RELATED SERVICES:

O **VOCATIONAL REHABILITATION SERVICES:**

SPECIFY:

O **FEDERAL / STATE HOUSING ASSISTANCE:**

SPECIFY:

O **ADVOCACY SERVICES:**

SPECIFY:

O **SPECIAL TRANSPORTATION SERVICES:**

SPECIFY:

O **PAID (CORPORATE) CONSERVATORSHIP SERVICES:**

CORPORATE ENTITY:

O **SENIOR / AGING / ELDER SUPPORT SERVICES:**

TYPE & PURPOSE OF SERVICE:

O **OTHER, SPECIFIED:**

Department of Intellectual & Developmental Disabilities

INDIVIDUAL SUPPORT PLAN

FULL NAME:		
SELECT ONE: Amendment	ISP EFFECTIVE DATE:	DATE ISP AMENDED:

C. SERVICES & SUPPORTS

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	*for* **DIDD USE ONLY**		
Service Name & Request Type	**Service Code & Fund Source**	**Provider Name & Code**	**Site Name & Code**	**Start & End Date**	**Unit Rate & Type**	**Units of Service & Cost**	**Approve**	**Deny**	**Partially Approve**
1.							○	○	○
2.							○	○	○
3.							○	○	○
4.							○	○	○
5.							○	○	○
6.							○	○	○
7.							○	○	○
8.							○	○	○
9.							○	○	○
10.							○	○	○
11.							○	○	○
12.							○	○	○

O If checked, the listing of requested / authorized services continues on the next page of this section.

Department of Intellectual & Developmental Disabilities

INDIVIDUAL SUPPORT PLAN

FULL NAME:		
SELECT ONE: Amendment	ISP EFFECTIVE DATE:	DATE ISP AMENDED:

C. SERVICES & SUPPORTS

2. MEDICAID HCBS WAIVER SERVICES: (CONTINUED)

A	B	C	D	E	F	G	*for* DIDD USE ONLY		
Service Name & Request Type	**Service Code & Fund Source**	**Provider Name & Code**	**Site Name & Code**	**Start & End Date**	**Unit Rate & Type**	**Units of Service & Cost**	**Approve**	**Deny**	**Partially Approve**
13.							○	○	○
14.							○	○	○
15.							○	○	○
16.							○	○	○
17.							○	○	○
18.							○	○	○
19.							○	○	○
20.							○	○	○
21.							○	○	○
22.							○	○	○
23.							○	○	○

DIDD REVIEW & AUTHORIZATION OF SERVICES		
AUTHORIZING SIGNATURE:	TITLE:	DATE:

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.

Department of Intellectual & Developmental Disabilities

INDIVIDUAL SUPPORT PLAN

FULL NAME:		
SELECT ONE: Amendment	ISP EFFECTIVE DATE:	DATE ISP AMENDED:

C. SERVICES & SUPPORTS

3. PARTIAL APPROVAL OF A SERVICE DENIED BY DIDD:

THIS SECTION IS TO ONLY BE COMPLETED BY DIDD FOR PARTIAL APPROVAL OF A HCBS MEDICAID WAIVER SERVICE

A	B	C	D	E	F	G	*for* **DIDD USE ONLY**
Service Name & Request Type	**Service Code & Fund Source**	**Provider Name & Code**	**Site Name & Code**	**Start & End Date**	**Unit Rate & Type**	**Units of Service & Cost**	**Partial Approval of Denied Service**
1.							☐
2.							☐
3.							☐
4.							☐
5.							☐
6.							☐
7.							☐
8.							☐

DIDD REVIEW & AUTHORIZATION OF PARTIALLY-APPROVED SERVICES		
AUTHORIZING SIGNATURE:	TITLE:	DATE:

REVISED TOTAL *for* SERVICES APPROVED: $

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.

Department of Intellectual & Developmental Disabilities

INDIVIDUAL SUPPORT PLAN

FULL NAME:		
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D. BEHAVIOR SUPPORT PLAN

1. ATTACH A COPY OF THE BEHAVIOR SUPPORT PLAN WHERE APPLICABLE OR, IF BEING AMENDED, ATTACH THE AMENDED BEHAVIOR SUPPORT PLAN.

Department of Intellectual & Developmental Disabilities

INDIVIDUAL SUPPORT PLAN

FULL NAME:		
SELECT ONE: Amendment	ISP EFFECTIVE DATE:	DATE ISP AMENDED:

E. SELF-DIRECTION OF SERVICES

1. PLEASE INDICATE YOUR CHOICE FOR SELF-DIRECTION OF SERVICES

☐ I do not want to self-direct my services through the Tennessee Self-Determination Waiver Program at this time.

☐ I want to self direct the following services through the Tennessee Self-Determination Waiver Program:

- ☐ Personal Assistance
- ☐ Individual Transportation Services
- ☐ Day Services (excludes facility-based services)
- ☐ Respite Services (excludes out-of-home respite)

2. PLEASE COMPLETE THE FOLLOWING

FINANCIAL ADMINISTRATION ENTITY:
SUPPORTS BROKERAGE AGENCY:

SIGNATURE OF PERSON (OR THE GUARDIAN/CONSERVATOR):	TITLE OR RELATIONSHIP:	DATE: