

## Individualized Service Plan (ISP) Instructions

### SECTION BY SECTION INSTRUCTIONS

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#### The Header

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**Name of the person:**

Name of the person for whom the ISP is written.

**ISP Date:**

This is the date of the face-to-face ISP review meeting or the non face-to-face ISP review which results in a written or rewritten ISP. This date does not change unless the ISP is rewritten by the service coordinator.

**Medicaid Number or CIN Number:**

The person's Medicaid number, also known as the person's Client Identification Number (CIN).

**ISP Review Dates:**

List each date the ISP was reviewed. ISP reviews must take place at least twice annually. One of these reviews must be a face-to-face review meeting with the individual and major service providers. Use the check boxes to indicate whether the review was a face-to-face meeting. The annual face-to-face review meeting must occur within 365 days of the prior face-to-face meeting or by the end of the calendar month in which the 365<sup>th</sup> day occurs. It is suggested that, at a minimum, an ISP review occur every six months.

*For Willowbrook class members, ISP reviews should occur every six months, be convened as face-to-face meetings and involve the individual, his/her active representative, service coordinator, service providers and persons relevant to the plan of services. Willowbrook advocates may request quarterly meetings on behalf of an individual class member.*

**Section 1: The Narrative**

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**The Profile, the Person's Valued Outcomes, and Safeguards****The Profile**

The Profile is a narrative about the person. It includes selected person centered information about the person discovered during the planning process. The profile may address abilities, skills, preferences, accomplishments, relationships, health, cultural traditions, community service and valued roles, spirituality, career, recreational interests and enjoyment, challenges, needs, pertinent clinical information, or other information that impacts how supports and services will be provided.

The profile tells the reader about the person and his/her current needs and wants. It assists those helping the person provide supports and services with an understanding and sensitivity to what is important to the person. This information is necessary to successfully put the plan into action. The profile is not a static history of the person. It is updated regularly in order to accurately reflect the person's changing needs and goals. It is not necessary to indicate age, height, weight, etc. unless this information relates to the person's needs and services.

Use the following questions as a guide when writing the profile: Who is this person? What is important to this person? What are the individual's strengths and preferences? What is not working in the individual's life? What is unique about this individual? What does this individual want their life to be like? What are their goals? What will this plan accomplish? In what type of setting does the person live and in what type of setting would they prefer to live? Would this individual like to participate in paid, competitive employment? What type of work is this person interested in? Would this person be interested in an employment training program, such as an internship? Would this person like to be a volunteer? What type of volunteer work interests this person? What specialized supports would this person need in order to have a successful work or volunteer experience, such as transportation or travel training?

### **The Person's Valued Outcomes**

Valued outcomes are the person's chosen life goals and are the driving force behind the services and supports the person receives. The valued outcomes should simply state what the person wants to achieve. List the person's valued outcomes that derive from the profile and planning process. There must be at least one valued outcome for each HCBS Waiver service the person will be receiving. The Waiver Service is "authorized" only where the service relates to at least one of the person's valued outcomes.

### **Safeguards**

State the safeguards that must be in place to keep the person safe from harm. Safeguards are actions to be taken when the health or welfare of the person is at risk. The habilitation plans, or referenced documents, will provide greater detail about how safeguards are ensured within the context of the respective service environment. The "Individual Plan for Protective Oversight" can be referenced in the safeguards section for people who live in an Individualized Residential Alternative (IRA). However, the service coordinator should also include safeguards that pertain to other environments where the person spends time.

Fire safety must be discussed in the safeguard section of all ISPs unless it is discussed in the attached Individual Plan for Protective Oversight for people who live in IRAs. The service coordinator must ensure that there is a current and reasonable assessment of the person's specific needs relative to his/her capacity to evacuate the home in a timely manner in the event of a fire emergency. If the person lives in a non-certified site, the service coordinator must ensure that actions and recommendations relative to addressing a person's assessed fire safety needs are specified in the ISP.

In addition, the following areas should be considered: chronic medical conditions, allergies, ability to self-administer medications, special dietary needs, ability to manage finances, ability to give consent, level of supervision required in the home and community, ability to travel independently, and safety awareness.

*For Willowbrook class members, identify supports and coverage needed in the event the person is hospitalized, and list any circumstances that impact the individual's frequency of inclusion activities, i.e., clinical/health concerns, weather restrictions, preferences, etc. These areas must be discussed in the safeguard section of all ISPs for class members unless it is discussed in the attached Individual Plan for Protective Oversight for people who live in IRAs.*

## Section 2: The Individualized Service Environment

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Section 2 of the ISP lists all the supports and services necessary to help the person live a successful life in the community and pursue his or her valued outcomes. Supports and services are coordinated to keep the person healthy and safe from harm.

### Natural Supports and Community Resources

Natural Supports and Community Resources exist in the community for everyone. They are routine and familiar supports that help the person be a valued member of his or her community and live successfully on a day-to-day basis at home, at work, at school, or in other community locations. Assistance related to achieving a valued outcome should be noted.

*For Willowbrook class members, reflect whether the person self-advocates or whether family member(s) or the Consumer Advisory Board (CAB) serve as sole advocate or co-representative on their behalf. If family is involved, include the frequency of visits and/or participation with team members. Guardianship arrangements should also be identified when applicable.*

List people, places, or organizational affiliations that are a resource to the person by providing supports or services, such as family, friends, neighbors, associations, community centers, spiritual groups, school groups, volunteer services, self-help groups, clubs, etc. Include the name of the person, place or organization and a brief statement about what is being done to help the person. List the activities that the person likes to participate in. Consider these questions when completing this section: What does the person like to do? What are the person's favorite places? Who are the most important people in the person's life?

Example entry: "John's neighbor, Harry Smith, helps John with his grocery shopping every Saturday," or "John is a member of the local fire department and attends most of the scheduled activities, especially the Tuesday night meetings."

*For Willowbrook class members, include individual strategies that promote community life based on capabilities and needs; variety that reflects a rhythm of life appropriate for the person; frequency as often as possible given the individual's needs, interests and capabilities; group size as appropriate for the person and the community experience; and documentation to confirm implementation.*

### Funded Services

- **Medicaid State Plan Services** are those services that a person can access with his or her Medicaid card. These services include **Medicaid Service Coordination**, physician, pharmacy, laboratory, hospital, dental, physical therapy, audiology, durable medical equipment, day treatment, and psychology.

Services provided in **Article 16, 28, or 31 Clinics** should also be described in this section. These services may include Physical, Occupational, Speech, Rehabilitation Counseling, Nutrition, Psychology, Social Work, Psychiatry, nursing, or dental. Indicate what **type of Clinic** (16, 28, or 31) and the **specific service** being provided.

- **Federal, State, or County Funded Resources** are government services funded by agencies other than OPWDD. These include Vocational and Educational Services for Individuals with Disabilities (VESID), State Office for the Aging (SOFA), Housing and Urban Development (HUD), Board of Cooperative Educational Services (BOCES), Department of Health (DOH), Department of Social Services (DSS), public schools, Medicare, etc.
- **HCBS Waiver Services** are those services funded by the Home and Community-Based Services Waiver. These include residential habilitation, day habilitation, community habilitation, prevocational services, supported employment, respite, adaptive devices, environmental modifications, family education and training, plan of care support services, consolidated supports and services, financial management services, support brokerage, community transition services, and intensive behavioral services.
- **Other Services or 100% OPWDD Funded Supports and Services** are services that do not fit in the other categories or are solely funded by OPWDD and have no Medicaid funding. These include Family Support Services, Individualized Support Services, and some Community Service Plan services such as Non-Waiver Enrolled Service Coordination.

### **Required Information for HCBS Waiver Services**

- **Name of the waiver service provider or agency**
- **Type of waiver service** (e.g., residential habilitation, supported employment, consolidated supports and services, respite).
- **Frequency of the support or service.** The frequency of an HCBS Waiver Service must correspond to the billing unit of service (e.g., day, month, hour, or one time expenditure). See the Frequency of HCBS Waiver Services Appendix at the end of these instructions.
- **Duration of the support or service.** This means for how long the assistance is expected to last. If the service does not have an expected end date, write “ongoing.”
- **Effective date of the support or service.** This is the date the current provider first provided the service. Waiver services must have the exact and correct effective date and this date must be on or before the date the provider began delivering the service. A waiver service provider’s billing will be jeopardized if the date the provider billed for the service is prior to the effective date on the ISP. For a one time service or purchase, such as environmental modifications and adaptive devices, the anticipated purchase/completion date is used as the effective date.

**Note:** The above information (name and type of provider, frequency, duration, and effective date) must be accurate for HCBS Waiver Services since the ISP substantiates the payment of these services.

**Required Information for all other funded services** including Medicaid State Plan Services; Federal, State and County Funded Resources; and Other or 100% OPWDD Funded Services:

- **Name of the provider or agency** (e.g., Dr. Smith, Community General Hospital, VESID, Housing and Urban Development, or DDSO). For clinic services also indicate the type of clinic (Article 16, 28, or 31).
- **Type of provider or type of service** (e.g., physician, cardiologist, educational, housing, or Medicaid Service Coordination).

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## Signatures

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The ISP must be signed by the following:

- service coordinator
- service coordinator's supervisor
- the person
- advocate (if the person is not self-advocating)

Signatures are required every time a new ISP is written. Once the service coordinator writes the ISP he/she should sign the ISP then distribute it for signatures. The date of the service coordinator's signature should be within 45 days of the review that resulted in the rewritten ISP. Signature lines must not be left blank. If the person is unable or unwilling to sign, this should be noted on the signature line. If the person is a self-advocate and the advocate is not signing, "self-advocate" should be written on the line. Signatures must be dated MM/DD/YYYY.

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## Attachments

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The following are required attachments to the ISP if the person is receiving the service:

- Any Waiver Habilitation Service Plans including residential habilitation, day habilitation, prevocational services, supported employment plan, community habilitation, consolidated supports and services
- Individual Plan for Protective Oversight if the person lives in an IRA
- Medicaid Service Coordination Activity Plan (if the person has requested one or is a Willowbrook Class Member)
- Clinic treatment plan recommendations for long-term therapies provided by Article 16 Clinics.

## **REVIEWS, TIME FRAMES, and DISTRIBUTION**

The Initial ISP is written and signed by the service coordinator within 60 days of the HCBS Waiver enrollment date (which can be found on the HCBS Waiver Notice of Decision form) or within 60 days of the MSC enrollment date (which can be found on the MSC Notice of Authorization), whichever comes first.

### **Updating the ISP**

The service coordinator ensures that the ISP is kept current, adapted to the changing outcomes and priorities of the person as growth, temporary setbacks, and accomplishments occur.

### **Addendums**

The ISP does not need to be rewritten and re-dated every time there is a change or need for revision. Changes may be made by using an addendum. The addendum must include the name of the person, the date of the ISP to which it applies, the date of the change, the new or changed information, and the signature of the service coordinator.

Addendums require only the signature of the service coordinator. A note must be written in the MSC record indicating the change was discussed with and agreed upon by the individual and/or advocate. Addendums are filed with the current ISP and distributed to all appropriate parties.

Changes to the ISP must be communicated to day treatment providers and HCBS Waiver habilitation service providers. If an addendum is used, copies are distributed.

### **Reviews of the ISP**

The service coordinator is responsible for coordinating a review of the ISP and making any needed changes to the plan as a result of the review.

ISP reviews must take place at least twice annually. One of these reviews must be a face-to-face review meeting with the individual and major service providers. The annual face-to-face review meeting must occur within 365 days of the prior face-to-face meeting or by the end of the calendar month in which the 365<sup>th</sup> day occurs.

For example, a face-to-face ISP review meeting is held on March 15, 2010. The semi-annual review is held sometime in the month of September, 2010. The next face-to-face review meeting must be held no later than March 31, 2011.

It is recommended that, at a minimum, ISP reviews occur every six months. However, if it is in the best interests of the individual served to have the semi-annual review during a different month earlier or later than the six month point this is acceptable as long as the rationale is provided in the MSC monthly notes.

If there is some unforeseeable circumstance, such as a hospitalization, that causes an ISP review to exceed the allowable time frame, this should be noted in the service coordination record and all efforts should be made to reschedule and hold the review as soon as the individual's circumstances will allow.

*Again, for Willowbrook class members, ISP reviews should occur every six months, be convened as face-to-face meetings and involve the individual, his/her active representative, service coordinator, service providers and persons relevant to the plan of services. Willowbrook advocates may request quarterly meetings on behalf of an individual class member.*

The ISP with any addendums or revisions and the services described remain in effect until a new ISP is written. An individual may continue to receive the services described in the ISP regardless of whether the ISP review timeline described in these instructions is met.

If the service coordinator and individual determine that the semi-annual review does not require a face-to-face meeting the service coordinator contacts all habilitation providers to request any updates to the current habilitation plans. If there are changes to the ISP these may be communicated by the use of an addendum as described above or the ISP may be rewritten.

At the time of an ISP review, if there are no changes to the ISP the service coordinator may list the date of the review with his/her initials on the top of the ISP. The service coordinator must notify the individual and service providers verbally or in writing that there were no changes to the ISP. A record of this notification should be kept in the service coordination record and include the names of those contacted. Distribution of the ISP is not required when there are no changes.

As noted, at least annually the ISP review must be a face-to-face meeting. This meeting includes the individual, advocate, service coordinator and major service providers (including all HCBS waiver service, day treatment, or clinic service providers). Every major service provider invited should send a representative.

On an annual basis the service coordinator must review with the individual and/or advocate the contents of the Service Coordination Agreement and ensure that the individual has the current 24 hour contact information for the MSC provider in the event of an emergency. It is recommended that this be done at the time of the annual face-to-face ISP review meeting. Documentation that this review occurred should be made on the MSC monthly note.

### **Maintenance, Retention, and Distribution of the ISP**

The signed ISP (with attachments) is maintained by the person's service coordinator and filed in the service coordination record.

Copies of the signed ISP (with attachments) are forwarded by the service coordinator to:

- the person,
- his/her advocate,
- all waiver service providers (for example, residential habilitation, day habilitation, consolidated supports and services, supported employment, respite)
- Article 16, 28, or 31 Clinics
- day treatment
- other providers and individuals with the consent of the person and/or advocate

HCBS Waiver habilitation providers have 30 days from the date of the ISP review to make any necessary revisions to the **habilitation plan** and send the completed and revised plan to the service coordinator.

The service coordinator has 60 days from the date of the ISP review to send the full ISP or addendum and any revised habilitation plans to the individual, advocate, and appropriate service providers. The service coordinator must document distribution of the ISP indicating the parties to whom the ISP was sent and the date of distribution. Evidence of distribution may include, but is not limited to, a sheet stating when the document was distributed, a monthly service note indicating that the document was distributed, a page attached to the ISP indicating when it was distributed, or a notation on the ISP or addendum indicating when it was distributed.

If the 60 day time frame cannot be met because of delays in obtaining the signature of the individual and/or advocate, the service coordinator should still sign and send copies of the ISP to all appropriate parties without the individual and/or advocate signatures. The ISP must be sent with a note indicating that the original document with the required signatures can be found in the individual's service coordination record.

If the habilitation service provider fails to send the habilitation plan to the service coordinator within the allowed time frame the service coordinator should still distribute the ISP without the habilitation plan so as to not exceed the required distribution time frame for the ISP. In this case the habilitation provider is then responsible for distributing the habilitation plan to the service coordinator and all other required parties.

**Frequency for HCBS Waiver Services**

Note: The frequency of HCBS Waiver Service corresponds to the billing unit of service. These frequencies also apply to any OPTS services listed in the Waiver section of the ISP.

Residential Habilitation

IRA or Community Residence	Month
Family Care	Day

Day Habilitation

Group	Day
Individual	Hour

Community Habilitation (Phase I)	Hour
Community Habilitation (Phase II)	Month

Supported Employment (SEMP)	Month
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Pre-Vocational Services	Day
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Respite	Hour
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Adaptive Devices	One Time Expenditure
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Environmental Modifications	One Time Expenditure
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Plan of Care Support Services	Month
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Family Education and Training	1 or 2 Units per Year
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Consolidated Supports and Services	Month or Hour
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Community Transition Services	One Time Expenditure
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Agency with Choice/Financial Management Services	Month
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Intensive Behavioral Services	Product/Hourly
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