



Workforce and Talent Management Training Curriculum Series



Individualized Service Plan

Participant's Manual



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Introduction

The purpose of the training:

To outline the importance of designing a personal plan for a person with developmental disabilities. The ISP is a blue print that summarizes what the person wants, needs, and aspires to and the help needed to fulfill these wants, needs, aspirations.

Workbook:

This workbook will provide you with the written supports needed to effectively participate in the session on the “Individualized Service Plan” and as future reference. The workbook contains the following:

- Written information
- Activity worksheets
- The ISP form
- A copy of the power point slides for the course

OPWDD Mission:

We help people with developmental disabilities lead richer lives.

OPWDD Vision:

People with developmental disabilities enjoy meaningful relationships with friends, family and others in their lives, experience personal health and growth and live in the home of their choice and fully participate in their communities.



Module One: Defining the Individualized Service Plan (ISP)

Purpose of this module:

To start talking about the major philosophies involved in the development and implementation of the ISP.

Objective of this module:

To define what the ISP is and explain its importance for an individual.

Specifically we'll cover:

- What is an ISP?
- Who has an ISP?
- How is the ISP Used?
- What does Collaborative Planning and the Resulting ISP Accomplish?



Module One

Topic One: What is an ISP?

- **A written personal plan**

An ISP is an understandable and usable written personal plan for implementing decisions made during personal planning. It summarizes what a person wants and needs and his/her unique network of supports and services. This network is the person's Individualized Service Environment (ISE).

- **A plan that is developed through the collaborative planning process**

Collaborative planning produces the richness of personal information used to help the person plan and choose his/her personal valued outcomes.

- **An agreement**

The ISP is an agreement between the person with disabilities and the service coordinator about what the person needs and wants, who will assist in the pursuit of his/her valued outcomes, and the supports and services needed to live a successful life in the community.

- **A document that substantiates Medicaid billing for HCBS Waiver Services**

A plan is required by Medicaid to describe the billing of HCB Waiver Services. For this reason, accuracy and timeliness of the ISP is critical.



Module One
Topic Two: Who has an ISP?

An ISP is developed, written, and maintained for everyone enrolled in MSC or the HCBS Waiver regardless of where they live or what services and supports they receive.

The ISP is also maintained for people who are enrolled in the waiver and receive Plan of Care Support Services (PCSS).

Module One
Topic Three: How is the ISP Used?

- As a document that “locks on” to outcomes

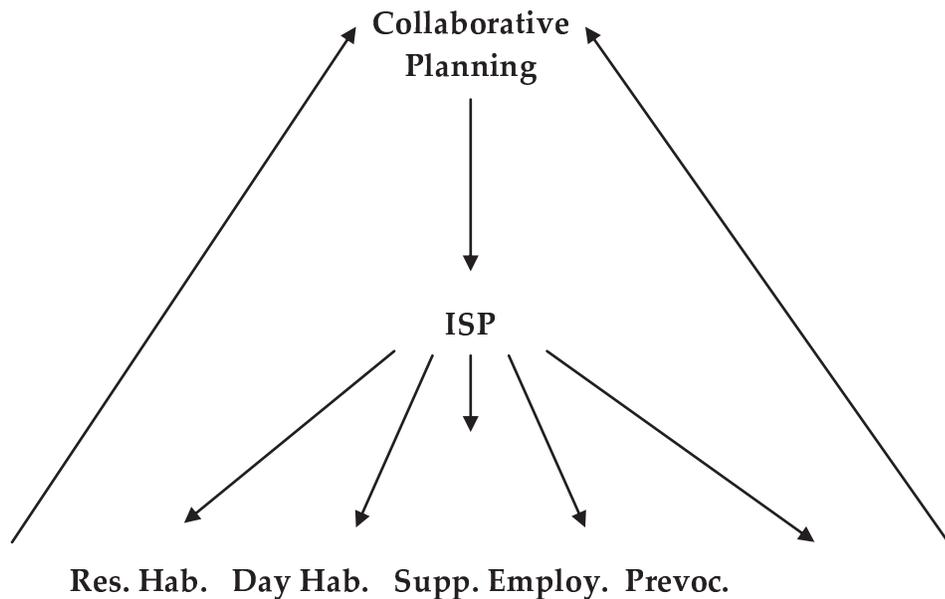
The ISP gives a clear understanding of the person’s valued outcomes for receiving supports and services.

- As a communication tool that gives direction and guidance to providers of supports and services.

It tells the reader about who the person is, what he/she needs and wants, and who is helping the person.

- As a master plan or blueprint for the person’s life resulting from collaborative planning.

The ISP is the over-all or umbrella plan. Other plans, for example residential or day habilitation plans, are more specific plans to help the person pursue his/her outcomes. There must be a relationship between the person’s valued outcomes in the ISP and these other types of service plans.





Collaborative planning comes first, followed by the completion of all other plans. The service coordinator writes the ISP and service providers develop their own plans after collaborative planning has begun.

- **As a written document that coordinates supports and services**

The ISP identifies and records the coordination of the person's Individualized Service Environment (ISE). It shows how supports and services are harmonized and funded. This prevents duplication of services and avoids unnecessary services.

- **As a tool that sets accountability**

The ISP clearly sets accountability for who will assist the person, why, how often, start date, and for how long. Motivation and responsibility often come from being accountable.

- **As a document required by Medicaid**

Medicaid requires the ISP for people enrolled in the HCBS Waiver and Medicaid Service Coordination (MSC). These Medicaid services must be provided according to a written plan.

- **As a Plan that "Describes" HCBS Waiver Services.**

The ISP "describes" HCBS Waiver Services. If a waiver service is not authorized in the ISP the provider of the waiver service cannot bill Medicaid.



Module One
**Topic Four: What does Collaborative Planning and the
Resulting ISP Accomplish?**

- Satisfaction with the supports and services received
- A successful and desirable life in the community based on the person's valued outcomes.
- Health and Safety
- Community membership and valued social roles



Module Two: Developing the ISP

Purpose of this module:

To introduce participants to the concept of ISP planning from a person centered perspective.

Objectives of this module:

- To give an overview of the significant characteristics of the person-centered approach to planning
- To introduce the five sequential steps to ISP planning
- To define “Assessment” under gathering information and provide examples of assessment tools
- To gain knowledge about assessing health and safety
- To practice using discovery tools

Specifically we’ll cover:

- Planning from a Person Centered Perspective
- Introduction to the Five Sequential Steps to ISP Planning
- Step #1: Gathering Information as the Basis for Planning
 - Definition of Assessment
 - Assessment Tools
 - Discovering Information
 - Activity #1: Areas of Discovery
 - Activity #2: Paint a Portrait of Yourself



Module Two
Topic One: Planning from a Person Centered Perspective

- Planning builds on the person’s abilities and skills
- Planning creates a clear vision of a positive and desirable future
- Planning is collaborative
- Planning is ongoing
- Planning fosters inclusion, valued social roles, informed choice and self-determination, and reflects culture and ethnic heritage.
- Planning takes patience and commitment
- Planning creates a balanced and big picture view

Module Two
Topic Two: Introduction to the Five Sequential Steps
(A Guide to Planning)

Step 1: Gather information as the basis for planning.

This is a listening and learning step that increases our understanding of the person.

The Big Picture





Step 2: Identify themes in the person’s life.

Themes are summary statements that are used as cues or indicators to what the person needs and wants for successful living and the keys that impact the person’s day-to-day life.

Step 3: Choose personal valued outcomes.

Valued outcomes are destinations or end results.

Step 4: Identify safeguards.

Safeguards are the actions needed to keep a person safe from harm.

Step 5: Develop next-step strategies and a personal network of assistance (Individualized Service Environment).

Action steps, strategies, resources, and funding sources are identified.



Areas of Discovery

| | | |
|---|---|--|
| <p><u>Relationships</u> Who is the person close to? React positively to? Who does the person trust? Does the person have friends? Who does the person go to or reach out for? Talk to?</p> <p><u>Abilities and Skills</u> What are the person's talents? Capabilities? Skills? Gifts?</p> <p><u>Preferences</u> What food does the person like? What are the persons Interests? Likes? Hobbies? Personal space needs?</p> <p><u>Places</u> Where does the person spend time? In segregated sites? In the community? During the day? During evenings and weekends? Where does the person like to be?</p> <p><u>Accomplishments</u> What has the person accomplished in life?</p> <p><u>Contributions</u> How does the person contribute to the richness of his/her own life and the lives of those around him/her? At home? At work? In the community?</p> | <p><u>Background</u> What is the overview of the person's life experiences? What positive experiences has the person had? Have there been any traumas, loss or grief? What hasn't worked in the past? Are there any stories about his/her life the person wants to tell?</p> <p><u>Health</u> Are there any conditions that threaten the person's health? Promote the person's health? Does the person have any physical limitations? Medical conditions?</p> <p><u>What works for the person?</u> What makes the person happy and bring joy? What things create comfort? When does the person smile?</p> <p><u>What doesn't work for the person?</u> What makes the person frustrated, angry, or cause boredom? What does the person dislike?</p> <p><u>Lifestyle</u> What is the person's daily routine? Life patterns? What characterizes the person's lifestyle?</p> | <p><u>Challenges</u> What are blocks to new opportunities? Obstacles to pursue outcomes? Any temporary setbacks? How does the person handle change?</p> <p><u>Culture</u> Does the person have any cultural traditions? Strong cultural ties? Beliefs? Values?</p> <p><u>Motivation</u> What has personal pay value for the person? What positively or negatively motivates the person?</p> <p><u>Hopes and Dreams</u> What does the person want to try? Achieve? Experience? What are Mom and Dad's hopes and dreams? What is the person's positive vision of the future?</p> <p><u>Fears</u> Is there anything the person is fearful of? Anticipated transitions? Harm?</p> <p><u>Decision Making and Control</u> What control does the person have over his/her own life? Does the person make decisions?</p> |
|---|---|--|



| | | |
|---|---|--|
| <p><u>Personal Characteristics</u> Are there any personal characteristics that earn the respect of others? That causes rejection?</p> <p><u>Communication</u> How does the person communicate feelings, fear, choices, decisions, joy, and sadness, pain? Is any special assistance needed?</p> <p><u>Community Inclusion</u> Is the person a valued community member? Does the person belong to clubs and organizations? Does the person do volunteer work? Does the person have valued roles at work and in the community at large? What are the person's reactions in large groups? Community outings? What help does the person need in the community?</p> <p><u>Spirituality</u> Does the person have a religious affiliation? Does the person attend or would like to attend church? How does spirituality impact his/her life?</p> <p><u>Clinical Information</u> That impacts planning</p> | <p><u>Choices</u> Does the person have opportunities to make choices? What personal choices does the person make on a daily basis? Are the person's choices listened to and supported? Does the person receive encouragement to make choices and decisions?</p> <p><u>Learning</u> Does the person have opportunities for new experiences? Does the person learn new skills? What skills would the person like to learn? What educational goals does the person have?</p> <p><u>Supports</u> What supports are currently available to help the person live a successful life? Are there any natural and community supports? Paid supports? What supports and services don't work for the person anymore?</p> <p><u>Non-Negotiables</u> What can't the person live without? What does the person feel very strongly about?</p> | <p><u>Satisfaction</u> Is the person satisfied with the supports and services received? With his/her lifestyle? Daily routine?</p> <p><u>Enjoyment</u> What does the person like to do for fun, leisure and recreation?</p> <p><u>Independence</u> Does the person have or want any freedoms? What would the person like to do independently? What level of supervision does the person need? Are there any mobility issues or needs?</p> <p><u>Safeguards</u> What needs to be in place to keep the person safe from harm? Adaptive equipment?</p> <p><u>Habits</u> What personal habits work for the person? What doesn't work anymore?</p> <p><u>Values</u> What does the person value in life? What is important to the person?</p> <p><u>Beliefs</u> What does the person believe in? About himself/herself? Others?</p> |
|---|---|--|



Activity # 2: Paint a Portrait of Yourself

1. Who am I?

2. What am I good at?

3. What do I have difficulty doing?

4. What do I like most about myself?

5. What do I like least about myself?

6. What kind of challenges do I have?

7. What could I use help with?

8. What personal goals do I have for myself?

9. What needs to change to make things happen for me?

10. Who's accountable to make things happen in my life?



Paint a Portrait of Yourself

| Reactions to the Activity | Best Practices |
|---------------------------|----------------|
| | |
| | |
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| | |
| | |



Module Three: Simulated ISP Planning

Purpose of this module:

To conduct a planning session using the person-centered approach to planning.

Objective of this module:

To practice ISP planning skills.

Specifically we'll cover:

- Step 1: Gather information as the basis for planning
- Step 2: Identify themes in the person's life
- Step 3: Choose personal valued outcomes



Activity # 3: Simulated ISP Planning

Each group will conduct a planning session using the person-centered approach to planning and completing the first three steps to planning. They are:

Step 1: Gather information as the basis for planning

Step 2: Identify themes in the person's life

Step 3: Choose personal valued outcomes

Instructions:

- **Identify a facilitator.** The role of the facilitator is to ensure that the process is person-centered, that people are listening and participating, and that the activity is moving forward.
- **Identify a recorder.** The function of the recorder is to write on the flip chart the information learned during the planning session. When one sheet is filled, remove it from the flip chart and hang it on a nearby wall. Tape will be made available. Colored markers may be used for emphasis: Green for strong likes or things that work for the person; Red for strong dislikes of things that don't work for the person. Blue and black are neutral colors.
- **Choose a focus person (this is not necessary if a self-advocate joins the group).** This is the person who will be the focus of the planning session. Someone in the group must volunteer to give information about a person with a disability that he or she knows well. It is more effective if more than one member of the group knows the person. You may want to choose someone who has challenges, difficulties, or is experiencing life transitions.



- It is the role of all group members to discover information by asking questions, exploring pathways, and learn as much as possible about the person. Refer to the list "Areas of Discovery" for assistance.
- Of course, do not reveal the person's identify. Use a different name.
- Each group has 30 minutes to complete Step 1: Gather information as the basis for planning.
- **Do not move on to Step 2 or 3 at this time.**

Step 2: Identify Themes in the Person's Life

As information is gathered patterns or themes in the person's life begin to emerge. Themes are summary statements of information learned so far that seem to thread through a person's life and keep on happening. They can reveal patterns in daily life. Sometimes themes are keys that open a new world of understanding about the person.

Themes are used as cues or indicators to:

- The person's valued outcomes and the vision of a positive and desirable future.
- What's not working for the person that should be minimized?
- An individualized quality life for the person.
- How service and supports should be provided.

Some examples are:

- | | |
|--|---|
| <ul style="list-style-type: none"> • Lack of friends that are not paid to be with him or her • Likes to be with others and enjoys friendships • Is a fighter and is determined • Has strong cultural interests • Is a survivor • Lacks community membership • Doesn't see himself/herself as a person with disabilities • Must be organized and have a routine | <ul style="list-style-type: none"> • Has many capacities, attributes, and skills • Has multiple health needs • Has no permanency in home or work • Values personal attention from others • Must be physically active • Is very easily bored and frustrated • Makes few choices and is not in control of his/her own life • Loves a certain type of music • Is strongly connected to family |
|--|---|



Step 3: Choose Personal Valued Outcomes

If themes give a direction, then outcomes are the destination or valued end result. The gathered information and an understanding of the person's themes in his/her life help the person decide needs, wants, and aspirations.

Outcomes are **anchors** for the services and supports that the person will receive. All providers of supports and services must know what they are. Some providers will provide services based on these outcomes (residential habilitation, day habilitation, day treatment, service coordination, etc.)

Outcomes can be dreams or simple day-to-day choices. They can be desires, needs, wants, or aspirations.

Examples of outcomes are:

- Living in a safe home in Rochester with my friend Sam
- Being understood by the staff around me, especially when I want or need something
- Enjoying the garden and backyard each day
- Learning how to speak up for myself, especially in group situations like my planning meeting
- Being comfortable in my wheelchair and without pain
- Joining my local fire department as a dispatcher
- Learning self-protection when I'm in my neighborhood alone

Outcomes are:

- **From the perspective of the person. They are not “externally” set without planning first.**
- **Clearly stated and as specific as possible at the time. Vague outcomes can leave the person’s life up to chance.**
- Chosen based on informed choice and empowerment.
- Built on capacities and interests. Assessments by themselves do not define outcomes.
- Responsive to change. Outcomes can change at any time.
- Not limited to skill development.
- Coordinated throughout the person’s network of supports and services.
- As anchors, everyone can help the person pursue the same outcome, but in different ways by emphasizing different skills or experiences.
- Pursued by omitting or limiting unnecessary prerequisites. Don’t erect barriers, break them down.
- Getting a clinical service is not an outcome. It supports an outcome. For example, “to get physical therapy” is not an outcome. “To have more flexibility in my arms and legs” is an outcome that is supported by receiving physical therapy.
- Parents often choose outcomes for their children. But remember, the child’s interests and choices must be considered.
- Though outcomes can help the person to maintain a skill, ability, interest, or life situation, please use them sparingly. Outcomes were designed to move a person’s life ahead and to have experiences and opportunities that do not simply repeat the past.

Characteristics of Outcomes:

- Outcomes are for everyone, not just those with more abilities. The key is they come from personal planning and are not just need-driven.
- The experience of caregivers and others who are close to the person when choosing outcomes is very important, especially for people who have difficulty expressing or deciding what is important in their lives, who have minimal community life experiences, or who have severe or complex disabilities.
- When children are the focus of planning, their parents help to choose outcomes. Sometimes these decisions help the family as a unit as well as benefiting the child. Examples are choice of respite, residential habilitation, or school supports. However, the child's needs and choices must be considered in planning.
- Though outcomes can change at any time after the plan has been designed and implemented, it is often wise not to rush or be overly anxious to make these decisions. A thoughtful process that is truly person centered takes time and should never be superficial.
- There does not have to be an outcome for each ISE value. (Individuality, Inclusion, Independence, and Productivity) Instead, the planning process should produce outcomes that are specific to the person's interest, desires and hopes.
- Outcomes are always chosen with concern for the person's health and safety.
- Outcomes are not just need-driven. They derive from the person's interests, talents, preferences, and choices.



Step 4: Identify Safeguards

- Safeguards are supports needed to keep the person safe from harm and actions to be taken when the health or welfare of the person is at risk.
- Safeguards are significant issues discovered during the planning process that are individualized and specific to the person.
- Safeguards are not meant to be so wide-ranging that routine supports, such as a yearly dental exam or receiving three meals each day, are always identified. Not every conceivable risk or danger is identified. A cookie-cutter approach to safeguards is discouraged.

Examples of safeguards are:

- fire safety (required in every ISP)
- medications (i.e. insulin) or specific health care.
- supervision needed for community inclusion strategies
- food consistency or special diets
- allergies and any immediate steps to be taken
- sun sensitivity because of certain medications
- action steps for self-abusive behaviors or behavior that could cause injury to others
- vulnerabilities at home and in the community
- the need for readily available written information about the health and medical status of the person
- needed hospital coverage or special instructions that should accompany a person if admitted to a hospital
- preventative actions to avoid (a) disease or infections, or (b) exacerbating an existing medical problem

The person's fire safety needs must be discussed in the ISP in the Safeguards Section or in the attached Plan for Protective Oversight if the person lives in an Individualized Residential Alternative (IRA). This is a reasonable and thought out approach to keeping the person safe in case of fire.

The following information on fire safety is from the MSC Review Instrument used by the Division of Quality Assurance.

- Does the Medicaid Service Coordinator **ensure there is a current and reasonable assessment** of the individual's specific needs relative to he/her capacity to evacuate the home in a timely manner in the event of a fire emergency?

Notes:

1. If the person lives in an **OPWDD certified site** (e.g., IRA, Family Care or Supportive/Supervised CR), the site is responsible for the person's fire safety and an assessment of each person's capacity to evacuate the home in the event of a fire emergency. **The Service Coordinator is responsible for ensuring that this assessment is current and reasonable based on the Service Coordinator's knowledge of the person.**
 2. If a person lives in a **non-OPWDD certified site**, the Service Coordinator discusses and reviews with the person or family his/her fire safety needs, but a formal written fire safety assessment is not required. Results of this discussion and review should be summarized in the Safeguard Section of the ISP and should include any actions taken based on the identified needs.
- Does the Medicaid Service Coordinator ensure that actions and recommendations relative to addressing an individual's assessed fire safety needs are specified in the ISP and does the Medicaid Service Coordinator advocate that these recommendations are implemented?

Note:

Service Coordinators are not required to routinely read fire drill reports or be present for fire drills. However, if the Service Coordinator determines that the person is in imminent danger due to lack of a current fire safety assessment or actions needed for fire protection, the Service Coordinator should contact his/her supervisor, as well as the individual responsible for fire safety at the residential site.



Step 5: Develop Next-Step Strategies and a Personal Network of Assistance (Individualized Service Environment)

- The purpose of this step is to bring to reality a very personal network, or Individualized Service Environment (ISE), of supports and services that helps the person to live a successful life in the community and pursue personal outcomes. . It is the culminating step for all the discussions, decisions, and discoveries made so far. It is the time to decide what has to be done, who will do it, and how it will be accomplished. Next-step strategies hold people accountable and encourage commitment to helping the person.
- The completion of this step results in an ISE that consists of a variety of resources that are compatible and work in collaboration with each other and the person. The ISE is a blending of unpaid and paid supports.
- As you design the person's ISE, the first and most important area to consider is help from friends, family, and community resources. Funded resources should complement rather than replace natural supports and community resources.
- Review existing supports and services and decide which ones may not work for the person anymore and may need to be changed or replaced.
- Some resources may need to be created or organizational changes made.
- It's important to identify next step strategies that can be completed in a short period of time like making a referral, requesting an assessment, locating transportation, contacting a family member, or immediate safety measures.
- The resulting list of service and supports will be documented in Section 2 of the ISP. We will review the specifics of these entries in the next section of this training.



The following questions are asked and decisions are now made that result in next step strategies and the person’s Individualized Service Environment. During a planning meeting, decisions should be written on a simple 4-column chart:

| <u>What</u> | <u>Who</u> | <u>How</u> | <u>When</u> |
|-------------|------------|------------|-------------|
|-------------|------------|------------|-------------|

What needs to be pursued and accomplished? This is the time to set priorities with the person and family.

- What are the person's desired outcomes? (Step 3 of the planning process)
- What are the person's needed safeguards? (Step 4 of the planning process)
- What additional assistance does the person need that may not be a personal valued outcome? For example, pain management or needed transportation.
- What clinical assessments are needed, if any?
- What community inclusion strategies should in place?

Who will help the person? Identify the natural support or paid service/provider. This is the time to obtain commitments. Multiple people can agree to help the person with the same outcome or need.

- What people or services are already in place?
- Consider new opportunities and ideas discovered during planning.
- Consider replacing existing supports and services that may not work for the person anymore.

How will it be accomplished? What action steps are needed?

- Consider how outcomes and other additional assistance will be pursued. Consider what skills should be taught, what supports should be given, and what new experiences should be explored. Acknowledge any barriers or obstacles that need to be overcome but avoid an emphasis on procedural problems that will be encountered



When will it be accomplished? This is a timeframe for a specific action, if needed.

- For example, in the next 6 months, the next month, or by a certain date. Timeframes help people to be accountable and help ensure progress is being made.

Module Four: Writing the ISP

Purpose of this module:

To understand how to assemble a person's ISP.

Objective of this module:

To assemble the ISP while meeting the requirements of OPWDD.

Specifically we'll cover:

- An overview of the ISP Format and Instructions
- Specific Components of the ISP
 - The Header
 - ISP Section 1: The Narrative: profile, person's valued outcomes, safeguards
 - ISP Section 2: The Person's Individualized Service Environment (ISE): Natural Supports and Community Resources, Medicaid State Plan Services, Federal, State or County Funded Resources, HCBS Waiver Services, Other Services or 100% Funded Supports and Services
 - Signatures
 - Attachments
- Reviewing and updating the ISP
 - Changes to the ISP
 - Reviews of the ISP
 - Documentation of the ISP Review
- Maintenance, Retention and Distribution of the ISP



Module Four
Topic One: Overview of the ISP Format and Instructions

- The ISP has two primary sections

Section 1: **The Narrative:** Profile, Valued Outcomes and Safeguards
Section 2: **Individualized Service Environment (ISE).** This section is further broken down into categories of assistance which include natural supports and community resources, Medicaid State Plan services, Federal, State, or County services, HCBS Waiver Services, and other services and 100% OPWDD funded supports and services.

- The basic format of the ISP must be adhered to, including all sections of the plan and the sequence of each section.
- **The first ISP is written 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, whichever comes first.**



Module Four

Topic Two: Specific Components of the ISP

The Header

The following must be in the header of the form:

- **The date of the ISP**

The ISP date 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.

For the very first ISP which is completed within 60 days of the MSC or HCBS Waiver enrollment date, a review of the ISP must occur within 6 months of the date of this first ISP.

- **The name of the person**
- **Medicaid Number or CIN Number**
- **The dates the ISP was reviewed, the MSC Initials and whether the ISP review was a face-to-face meeting.**



Section 1: The Narrative

Section 1 of the ISP is divided into three parts:

- **Profile**
- **The Person's Valued Outcomes**
- **Safeguards**

The Profile

- **The Profile is a narrative about the person.**

It summarizes some or all of what was learned during the planning process and tells the reader about the person and his/her current needs and wants.

This information assists those people helping the person to provide supports and services with an understanding and sensitivity to what is important to the person to successfully put the plan into action.

- The profile must include selected person centered information about the person discovered during the planning process.
- Highlight abilities and avoid a needless discussion of disabilities that do not relate to the person's valued outcomes or health and safety.
- Use plain English and avoid labels, acronyms, or professional jargon.
- Avoid changeable information as height, weight, or dosage of medication.
- Profile contents may vary depending on the service coordination agency or supervisory requirements.



- Don't let the length of a profile measure its value or effectiveness.
- The profile is not a comprehensive clinical report or assessment, or a complete social history.
- The ISP is not a repository of all information about the person and not a stand-alone document.

The Person's Valued Outcomes

The person's valued outcomes are listed in this section. These outcomes will be linked to supports and services in Section 2 of the ISP. There must be at least one outcome listed in this section for each waiver funded habilitation service the person receives (residential, day, prevocational, and supported employment).



Safeguards

- **The person's significant safeguard needs that generate from the planning process are identified directly after the profile.**
- **The Habilitation Plans will provide greater detail about how safeguards are ensured within the context of the respective service.**
- **"See attached Plan for Protective Oversight" can be written in the safeguards section for people who live in an IRA**
- **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.**



Section 2: Individualized Service Environment

- Section 2 of the ISP lists all the supports and services received to help the person live a successful life in the community and pursue his or her valued outcomes.
- Section 2 of the ISP clearly sets accountability for who will assist the person to pursue his/her valued outcomes.
- It also demonstrates the coordination between these supports and services.
- A well-developed and documented network keeps the person healthy and safe from harm.
- Section 2 of the ISP must “fit” with or complement the profile.



The ISE Categories

- **Natural Supports and Community Resources** are resources for supports and services that exist in the community for everyone. Natural supports and community resources are those 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. This can include family, friends, neighbors, associations and community centers, religious or school groups, continuing education, self-help groups, health club, hobby or collectors clubs, volunteers, transportation, etc.
- **Medicaid State Plan Services** are those medical services that a person can access with his or her Medicaid card. These services include Medicaid Service Coordination, physician, pharmacy, laboratory, hospital, clinic, dental, physical therapy, audiological, personal care, certified home health care, durable medical equipment, day treatment, psychology, etc. Medical, nursing or dental State Plan Service provided in an Article 16, 28 or 31 Clinic should be described in this section.
- **Federal, State, or County Services** 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.
- **HCBS Waiver Services** are those services funded by the Home and Community Based Waiver. Examples of these are Residential Habilitation, Day Habilitation, Prevocational Services, Supported Employment, Respite (including free-standing respite), Assistive Technologies, Environmental Modifications, Family Education and Training, Plan of Care Support Services, Consolidated Supports and Services, and Intensive Behavioral Services.



- **Other Services and 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. Examples are Family Support Services, Individualized Support Services, and some Community Service Plan Services such as mirrored service coordination. Private Medical Insurance can be listed in this section.

Natural Supports and Community Resources

The information needed for each network entry for natural supports and community resources should include:

- **People, places, or organizational affiliations that are an active resource to the person by providing supports or services.**

This is not intended to be an exhaustive list of all-generic community activities, places, or relationships experienced by the person such as extended family, grocery stores, parks, shopping centers, and restaurants. **Only those that provide a support or service.** A description of day-to-day community involvement is more appropriately included in the profile. Be sure to consider supports provided by family members, including the potential support of reunited members.

- **A brief statement or summary of what the support is doing to help the person. Be sure to include any relevant details that coordinate these supports with the rest of the network such as how often the support is provided, where, and extent of involvement.**

For example, “John’s neighbor, Harry Smith, helps John with his grocery shopping at Wegman’s every Saturday”; or “John is a member of the Red Hook fire department and attends most of the scheduled activities with his friend Sam, especially the Tuesday night meetings.”



All Funded Categories

Entries for all Medicaid **State Plan Services, Federal, State and County Funded Resources, and Other or 100% OPWDD Funded Services**) must include the information below.

- **Name of the provider** (e.g., Dr. Smith, Community General Hospital, VESID, Housing and Urban Development, Sunshine County ARC, or DDSO).
- **Type of service** (e.g., physician, cardiologist, educational, residential habilitation, housing, day treatment, or Medicaid Service Coordination).



For HCBS Waiver Services

- **Name of the provider** (e.g., Dr. Smith, Community General Hospital, VESID, Housing and Urban Development, Sunshine County ARC, or DDSO).
- **Type of service** (e.g., physician, cardiologist, educational, residential habilitation, housing, day treatment, or Medicaid Service Coordination).
- **Frequency of the support or 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 attached to the ISP instructions and included in this manual.
- **Duration of the support or service.** This means for how long, as a whole, the assistance is expected to last. If the service does not have an expected end date, write “ongoing”.
- **Effective date of the Service.** This is the date the current provider began to provide the service. Note: an authorized waiver provider’s billings will be jeopardized if the date the service provider actually billed for the service is prior to the effective date shown on the ISP.

NOTE: THE ABOVE INFORMATION (NAME OF PROVIDER, TYPE OF SERVICE, FREQUENCY, DURATION, AND EFFECTIVE DATE) MUST BE ACCURATE FOR HCBS WAIVER SERVICES SINCE THE ISP “PRESCRIBES” THE PAYMENT OF THESE SERVICES.

It is required that HCBS waiver habilitation services (i.e. residential, day, prevocational, and supported employment) help the person to pursue **at least one** of the person’s valued outcomes. This outcome(s) is repeated on the habilitation plan. There must be a “match” between at least one outcome(s) for a waiver habilitation service in the ISP and the outcome(s) in a habilitation plan.

NOTE: It is not necessary for the valued outcomes in the habilitation plans to match word for word with the valued outcomes as stated in the ISP. It is only necessary that there be an obvious connection.



Additional information:

- For a one time service or purchase, such as environmental modifications, the anticipated purchase/completion date is used as the effective date.

- When the ISP is rewritten (which requires a new ISP date in the masthead), some effective dates of services could predate the ISP date.

- Include Medicaid State Plan Services if used as secondary insurance to private coverage. Some families use Medicaid State Plan Services as secondary insurance to private coverage. If this applies, so state under Medicaid State Plan Services and list the primary insurance under the last category "Other". The name of the insurance company or program is all that is necessary.



Signatures

The last page of the ISP requires four signatures as follows:

- Service Coordinator
- Service Coordinator Supervisor
- the Person
- Advocate (if the person is not self-advocating)

The date of the service coordinator's signature should be within 45 days of the review that resulted in the rewritten ISP. This same rule applies to addendums as well.

If the person is unable to sign, state this fact on the line for his/her signature. If the person is a self-advocate, so note on the line for the advocate's signature.

It may be necessary to mail a copy of the ISP to a family member or advocate in order to obtain signatures. Briefly explain on the original ISP, maintained by the service coordinator, that a copy has been sent for the advocate's signature. Do not leave any blanks.

Signatures attest to the agreements and informed choices made during planning about what the person's needs and wants and who will assist the person to pursue his/her valued outcomes.

Explain any difficulties in obtaining signatures in the service coordinator's notes.



Attachments

Attached to the ISP are copies of the following plans, as applicable:

- 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.



Module Four

Topic Three: Reviewing and Updating the ISP

Changes to the ISP

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

- **Changes are made by attaching an addendum**

The addendum should include the name of the person, the effective date of the ISP to which it is attached, 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.**

All changes, however, are discussed and decided upon with the person and his/her advocate.

- **Changes in the ISP must be communicated to day treatment providers and HCBS Waiver service providers (e.g. residential habilitation, day habilitation, prevocational services and supported employment). If an addendum is used, distribute copies.**

It is not necessary to rewrite the ISP every year. Whenever there is a change to an ISP the MSC Vendor has the discretion to do an addendum or rewrite the ISP. It can be rewritten when the content is not clear (too many addendums) or the plan is not effectively meeting its purpose. Anytime the ISP is rewritten new signatures are required.



The ISP Review

- Follow the person’s agenda and discuss what the person wants to talk about. The OPWDD brochure “Getting Ready for your Personal Planning Meeting” explains how the person or family can prepare for the ISP review.
- Gather new information and determine if the strategies identified to help the person live a successful life in the community according to his/her valued outcomes worked or didn’t work.
- Determine if the person is successfully pursuing his or her valued outcomes, if outcomes need to be clarified, or if new outcomes need to be identified.
- Discuss any new themes in the person’s life that may be cues or indicators for planning.
- Review the person’s positive vision of the future for any changes, clarifications, or added details.
- Determine if the person is healthy and safe and, if not, what clinical assessments may be needed, what supports and services must be provided, or what safeguards need to be in place.
- Determine if planning and the ISP are encouraging community life and, if not, strategies to do so.
- Determine if the person is receiving services and supports according to the ISP and is satisfied with those services.
- Identify any obstacles to pursuing the person’s outcomes and actions to deal with them.



- Develop any changes to the person's network of assistance (Individualized Service Environment) as needed or requested by the person.
- Determine if habilitation plans, or other plans, need to be changed.
- Identify next step strategies or action steps and who will follow-up with each.



Reviews of the ISP

- **The service coordinator is responsible for coordinating a review of the ISP with the person, advocate, and major service providers, making any needed changes to the plan as the result of the review.**
- ISP reviews must take place at least twice annually.
- At least annually, the ISP review must be a face-to-face meeting with the service coordinator, individual, advocate and major service providers (i.e. residential habilitation, day habilitation, prevocational, supported employment, or day treatment). Each of these major service providers must send a representative.
- Annually, the habilitation plan must be reviewed at the ISP meeting with the service coordinator, person, advocate, and all other major service providers in attendance. This is a joint review of the ISP and all habilitation plans.

An effective review of the ISP also requires mutual sharing of information between the service coordinator and major service providers.

It is also important to **hold meetings at a convenient time** for everyone involved. For others a more informal approach is best. It may involve meeting with the person and his or her family in their home. However, input must still be received from the person's network (including major service providers) to effectively review the plan.

Documentation of the ISP Review

Documentation that a review of the ISP occurred is recorded in the **service coordinator's notes**.

ISPs are updated as a result of the review.



Module Four

Topic Four: 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, and**
 - **All waiver service providers**
 - **Day Treatment**
 - **Article 16, 28, or 31 Clinics**
 - **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 show proof of distribution indicating the parties to whom the ISP was sent and the date of distribution. This may be done on the ISP itself or a note in the service coordination record. 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.

The ISP with any addendums or revisions and the services described remain in effect until a new ISP is written.

This is the required ISP format that must be followed. MSC Vendors may use this template or create their own. Additional information may be added to the header of the form and additional sections may be added throughout the ISP. However, all minimum required sections of the plan, the required content for each section, and the sequence of each section cannot change. The instructions under each header are provided for guidance and may be removed for the final presentation of the ISP.

Individualized Service Plan

Name of Person: _____ **ISP Date:** _____

Medicaid Number (CIN#): _____

| Dates ISP Reviewed | Face to Face? | MSC Initials | Dates ISP Reviewed | Face to Face? | MSC Initials |
|--------------------|---|--------------|--------------------|---|--------------|
| | YES NO | | | YES NO | |
| _____ | <input type="checkbox"/> <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| _____ | <input type="checkbox"/> <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> <input type="checkbox"/> | _____ |
| _____ | <input type="checkbox"/> <input type="checkbox"/> | _____ | _____ | <input type="checkbox"/> <input type="checkbox"/> | _____ |

Section 1: The Narrative

(Profile, the Person's Valued Outcomes and Safeguards)

Profile: Include selected person-centered information about the person discovered during the planning process. For example, abilities, skills, preferences, relationships, health, cultural traditions, community service and valued roles, spirituality, career, challenges, needs, pertinent clinical information, or other information that affects how supports and services will be provided.

Valued Outcomes: List the person's Valued Outcomes that derive from the profile. Outcomes are brief, clearly stated and as specific as possible. Please ensure that there is at least one outcome for each HCBS Waiver Service the person will receive.

Safeguards: List the individualized supports needed to keep the person safe from harm and the actions to be taken when the health or welfare of the person is at risk. Fire safety and evacuation ability is required. 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 home and community, ability to travel independently, and safety awareness.

Section 2: The Person's Individualized Service Environment

Natural Supports and Community Resources: List people, groups or organizations that are a resource to the person. For example family, friends, neighbors, associations, community centers, spiritual, 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. Assistance related to achieving a Valued Outcome should be noted.

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Medicaid State Plan Services: Complete a section below for each Medicaid State Plan service including services provided by Article 16, 28, or 31 Clinics. Add more sections as needed. For each service state the **name** of the provider or agency (e.g., Dr. Smith, ARC Day Treatment Center, Southern DDSO Clinic) and the **type of service** (e.g., physician, day treatment, MSC, transportation, durable medical equipment, etc.). For **Clinic services**, for "Name of Provider" indicate the name of the provider and whether the clinic is an Article 16, 28, or 31 (e.g. UCP Article 28 Clinic) and for the "Type of Service" indicate the Clinic service type (e.g, Physical Therapy, Occupational Therapy, Speech Therapy, etc.).

| |
|---|
| Name of Provider: Type of Service: |
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|---|
| Name of Provider: Type of Service: |
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|---|
| Name of Provider: Type of Service: |
|---|

Federal, State or County Funded Resources: Complete a section below for each service. Add more sections as needed. For each service state the **name** of the provider or agency (e.g., VESID, HUD, NYS Office of the Aging, Education Department, BOCES, DOH, Department of Social Services); and the **type** of service (e.g., Senior Citizen Services, educational services, housing). This category does not include Medicaid Funded Services.

| |
|---|
| Name of Provider: Type of Service: |
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| Name of Provider: Type of Service: |
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| Name of Provider: Type of Service: |
|---|

HCBS Waiver Services: Complete a section below for each waiver service. Add more sections as needed. For each service state the **name** of the provider or agency (e.g., Sunshine Co. UCP, Southern DDSO), the **type** of service (e.g., residential habilitation, supported employment, environmental modification), the **frequency** of the service (billing unit of service), the **duration** (e.g., on-going), and **effective date** (e.g., 1/1/2010).

| |
|--|
| Name of Provider: Type of Service: Frequency: Duration: Effective Date: |
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|--|
| Name of Provider: Type of Service: Frequency: Duration: Effective Date: |
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|--|
| Name of Provider: Type of Service: Frequency: Duration: Effective Date: |
|--|

Other Services or 100% OPWDD funded supports and Services: Complete a section below for each service. Add more sections as needed. For each service briefly state the **name** of the provider or agency (e.g., Sunshine Co. UCP, Southern DDSO); and the **type** of service.

| |
|---|
| Name of Provider: Type of Service: |
|---|

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|---|
| Name of Provider: Type of Service: |
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| Name of Provider: Type of Service: |
|---|

Signatures:

Service Coordinator: _____ Date: _____

Service Coordinator Supervisor: _____ Date: _____

Person: _____ Date: _____

Advocate: _____ Date: _____

Individualized Service Plan (ISP) Instructions

SECTION BY SECTION INSTRUCTIONS

The Header

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 365th 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

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

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).

Signatures

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.

Attachments

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 365th 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

Supervised IRA or Community ResidenceDay
Supportive IRA or Community ResidenceMonth
Family Care.....Day

Day Habilitation

Group.....Day
Individual.....Hour

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

Supported Employment (SEMP).....Month

Pre-Vocational Services.....Day

Respite.....Hour

Adaptive Devices.....One Time Expenditure

Environmental Modifications.....One Time Expenditure

Plan of Care Support Services..... Month

Family Education and Training.....1 or 2 Units per Year

Consolidated Supports and ServicesMonth or Hour

Community Transitional ServicesOne Time Expenditure

Agency with Choice/

Financial Management Services..... Month

Intensive Behavioral Services.....Product/Hourly