

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.).

<b>Name of Provider:</b> <b>Type of Service:</b>
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<b>Name of Provider:</b> <b>Type of Service:</b>
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<b>Name of Provider:</b> <b>Type of Service:</b>
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**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.

<b>Name of Provider:</b> <b>Type of Service:</b>
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<b>Name of Provider:</b> <b>Type of Service:</b>
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<b>Name of Provider:</b> <b>Type of Service:</b>
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**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).

<b>Name of Provider:</b> <b>Type of Service:</b> <b>Frequency:</b> <b>Duration:</b> <b>Effective Date:</b>
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<b>Name of Provider:</b> <b>Type of Service:</b> <b>Frequency:</b> <b>Duration:</b> <b>Effective Date:</b>
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<b>Name of Provider:</b> <b>Type of Service:</b> <b>Frequency:</b> <b>Duration:</b> <b>Effective Date:</b>
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**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.

<b>Name of Provider:</b> <b>Type of Service:</b>
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<b>Name of Provider:</b> <b>Type of Service:</b>
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<b>Name of Provider:</b> <b>Type of Service:</b>
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**Signatures:**

Service Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_

Service Coordinator Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

Person: \_\_\_\_\_ Date: \_\_\_\_\_

Advocate: \_\_\_\_\_ Date: \_\_\_\_\_