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| **Person’s legal name:** |  | **Preferred name:** |  | **Plan effective dates:** | - |  |

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| **One Page Profile for:** | ---- |  |  | **How to best support**  ---- |
| *Complete this page based on communicating directly with the person. If additional information is needed, include information from people who have direct knowledge of the person’s perspective. For alternate templates and additional instructions, visit www.OregonISP.org/1pp*  What people like and admire about  ---- | | | |
| What is important to  ---- | | | |

**To edit the footer:** NAME and EFFECTIVE DATES fields are located on the top of the One Page Profile.

**Before printing:** View the document in “Print Preview.” This purple prompt text will disappear, which may affect page breaks.

# Desired Outcomes

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| **Desired Outcome**  **What is the desired result?** | **Key steps to work toward the outcome** | **Is there a paid service that supports this outcome? If so, what is it?** | **Who is responsible?** | **Timelines**  **Frequency or**  **by when?** | **Where to record progress** | **Note if written implementation strategies (Action Plans, Service Agreement, etc.) are expected** |

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# Career Development Plan (CDP)

***Oregon is an “Employment First” state.***

*We believe that each person:*

* *can work and there is a job for everyone.*
* *has something to contribute and needs to contribute.*
* *has the right to a competitive job in a typical community work setting, including self-employment, making comparative wages with sufficient hours to make a difference.*
* *may identify the direction of his/her employment based on skills, interests, and strengths.*
* *has a right to be informed about the employment services options that are available to him/her.*

*To receive an employment service, you must have a goal of pursuing individual, integrated employment.*

**Education level completed:**

**Students (age 16-20)**Expected date of exit from school:

Date by which CDP will be completed:

**Attending school and wants to work now.**

**Attending school and receiving employment supports elsewhere.**

**Has an IEP Post-Secondary Goal with employment or training focus.**

**Attending school and not receiving any employment supports.**

**Status with Vocational Rehabilitation (VR) (age 16 and up)**

Currently receiving VR services Want a referral to VR

Other/Not applicable, explain:

**Working age adults (age 21-60) must choose one of the following statements:** *If the person is at least 18 years old and has exited school, complete this section instead of the “Students (age 16-20)” section.*

**Employed in integrated employment and chooses to:** *Check all that apply.*

Retain current job.

Advance in current job (more hours, raise, new skills, promotion, etc.)

Get a new job.

Get an additional job.

Retire – is at least 60 or will be this ISP year. *Employment Outcomes are not required.*

No longer continue in integrated employment at this time. *Complete Decision Not to Explore Employment section.*

**Currently not working in integrated employment and chooses to:** *Check all that apply.*

Get integrated employment.

Explore interests in integrated employment through an Employment Path, Discovery, or other time-limited service.

Retire – is at least 60 or will be this ISP year. *Employment Outcomes are not required.*

Not explore integrated employment at this time. *Complete Decision Not to Explore Employment section.*

| **Potential barriers to working in an individualized, integrated job** | **How will this obstacle be addressed?** |
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**Decision Not To Explore Employment*****------ This section may be removed if not applicable; indicate by using the provided dropdown.***

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| *Complete this section only if the person chooses not to work in an integrated employment setting now and does not want a waiver-funded employment service at this time.* **Check at least one reason:** [] Discouraged by previous employment experiences []Discouraged by others  [] Transportation concerns []Reluctant to change routine []Behavior challenges []Unable to find a job that matches his/her skills, interests and abilities  [] Concern that he/she will lose his/her Social Security Disability and/or Medicaid benefit []Significant health problems and/or health-related needs  [] Does not want to work [] Does not believe he/she is able to work [] Other (describe):  **Answer these questions:** These answers must support the selections made above and must demonstrate how the decision was made. Ideally, these answers will provide a positive foundation for approaching employment in the future. Please ensure that the person and his/her supporters understand that he/she may change his/her mind at any time.   1. Does the person want to work now in integrated employment? -- Yes or No --. 2. Does the person want to work in integrated employment in the future? -- Yes, Maybe, or No --.    * If the answer was “no” to #1 and/or #2, please explain why the person does not want work now and/or in the future: 3. Has the person had an opportunity to experience integrated employment that meets his/her skills and interests? -- Yes or No --.    * If “yes,” please briefly describe his/her integrated employment experience:    * If “no,” please describe why he/she has not had this opportunity and if there is a plan to remedy this situation: 4. Share any additional information about this decision here: 5. Does the person understand that he/she can change his/her mind at any time during the next twelve months and decide to pursue, explore, or obtain individual, integrated employment? -- Yes or No --. |

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| Desired Employment Outcomes | | **Is there a paid service that supports this outcome? If so, what is it?** | **Who is responsible?** | **Timelines**  **Frequency or**  **by when?** | **Where to record progress** | **Note if written implementation strategies (Action Plans, Service Agreement, etc.) are expected** |
| **Desired Outcome**  **What is the desired result?** | **Key steps to work toward the outcome** |

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# Risk Management Plan

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| **Emergency preparedness** (natural disasters, power outages, community disasters, etc.) | **Preventing abuse** (physical, emotional, financial, sexual, neglect) | **What happens if the person can’t be reached?** (timelines for notifying others, who to contact, etc.) |

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| **Risk** | **X if High risk** | **How is the risk addressed?** |
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| Does this person have a Nursing Care Plan?  No  Needed  Yes, where found: | Home: |  | Work: |  |

# Back-up Plans, in the event that primary support is not available *Focus on known, significant support needs and immediate health and safety support needs of the person that must be addressed if primary support is not available. Example: Cell phone of back-up contact.*

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| **Home** |  |
| **Work/School/Day Supports** |  |
| **Other:** |  |
| **Other:** |  |

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| Chosen Case Management Services  |  |  |  |  | | --- | --- | --- | --- | | **Type:** | | **Chosen provider:** | **Prime number:** | | **Authorized dates:**  Plan year | Start and end, if not same as plan year: | | | | **Required frequency of case management monitoring:**  **Case management comments/descriptors of anticipated case management services during the year**;unless already described elsewhere in this plan. (Include any risks marked “Possible” on the Risk Identification Tool.): | | | | | **Person’s preference on how case management is provided**: | | | | |

# Natural Supports, Community Resources, and Other Voluntary Services and Supports

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| **Describe chosen services/supports** | **Provided by** |

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# Chosen State Plan Personal Care (SPPC) services *------ This section may be removed if not applicable; indicate by using the provided dropdown.*

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| ***Complete the following only if the person chooses State Plan Personal Care services:*** *(limited to 20 hours per month unless an exception is authorized)*   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | **Service Element** | **Service Code** | **# Units** | **Unit Type** | **Per**  (Frequency) | **Authorized dates** | | **Chosen provider type(s) & current rate(s)**  (PSW, independent contractor, provider organization, general business, etc.) | | Same as plan year [x] | Start and end, if not same as plan year | | --- | --- | --- | --- | --- | [] | --- | --- | | **List needs identified by the needs assessment that this service will address:** | | | | | **Person’s preference on how this service is delivered:** | | | |

# Chosen K Plan Services *------ This section may be removed if not applicable; indicate by using the provided dropdown.*

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| **Service Element & Service Code** | **# Units** | **Unit Type** (Hour(s), Mile(s), Day(s), Each, Event(s), Dollars) | **Per**  (Day, Week, Month, Plan year) | **Authorized dates** | | **Chosen provider type(s) & current rate(s)**  PSW, independent contractor, provider organization, general business, etc. |
| Same as plan year [x] | Start and end, if not same as plan year |

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| **List needs identified by the needs assessment that this service will address:** | | | | | | |
| **Person’s preference on how this service is delivered:** | | | | | | |

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| **List needs identified by the needs assessment that this service will address:** | | | | | | |
| **Person’s preference on how this service is delivered:** | | | | | | |

# Chosen Waiver Services *------ This section may be removed if not applicable; indicate by using the provided dropdown.*

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| **Service Element & Service Code** | **# Units** | **Unit Type** | **Per**  (Frequency) | **Authorized dates** | | **Chosen provider type(s) and rate(s)**  PSW, independent contractor, provider organization, general business, etc. |
| Same as plan year [x] | Start and end, if not same as plan year |

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| **List identified needs that this service will address:** | | | | | | |
| **Person’s preference on how this service is delivered:** | | | | | | |

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| **List identified needs that this service will address:** | | | | | | |
| **Person’s preference on how this service is delivered:** | | | | | | |

# Chosen K Plan Residential Service *------ This section may be removed if not applicable; indicate by using the provided dropdown.*

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| ***Complete the following only if the person chooses RESIDENTIAL services:***   |  |  |  |  | | --- | --- | --- | --- | | **Service setting:** Choose one. | | **Chosen provider:** Name of provider. | | | **Authorized dates:** []Same as plan year | Start and end, if not same as plan year: --- | | | | **The K Plan services already included in residential services:**  [X] Attendant care – ADL / IADL [X] Skill training [X] Community Transportation | | | **Additional K Plan services included in residential services:**  [] Behavior supports [] Nursing supports | | **List identified needs that this service will address (including results of needs assessment):** | | | | | **Person’s preference on how this service is delivered:** | | | |  Chosen K Plan Community Transportation Service *Specific to travel to and from vocational program. Complete DD 53 budget.*  | **Transportation type** | **Authorized dates** | | **Chosen provider type or description of service** | | --- | --- | --- | --- | | Same as plan year [x] | Start and end, if not same as plan year | | ---- | [] | --- | --- | | ---- | [] | --- | --- | | ---- | [] | --- | --- | |

# Additional Chosen Services

*Use to record General Fund services as well as overflow for any of the above Chosen Services.*

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| **Describe service setting, service code, # units, frequency, authorized dates, and chosen provider type as applicable** | **List identified needs that this service will address** | **Person’s preference on how this service is delivered** |

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| Differences **Note any differences between the contents of this plan and what the person wants.** *Consider if a change to this plan is needed to address the difference(s) and describe the decision.* |

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**Note any differences between the contents of this plan and what any other ISP contributor wants.** *Consider if a change to this plan is needed to address the difference(s) and describe the decision.*

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# Legal Relationships

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| Parent(s) of minor child who retain parental rights: | | | |  | | | | | | | | | | |
| Legal Representative/Guardian(s), if any: | | |  | | | | | Scope of authority: | | | |  | | |
| Designated Representative(s) for service planning, if any: | | | | | |  | | | | | | | | |
| Designated Representative(s) for employer representative/employer of record issues, if any: | | | | | | | | | | | | |  | |
| Health Care Representative, if any: | |  | | | Appointment Date: | | | | |  | Self-Appointed  ISP Team Appointed | | | |
| Representative Payee(s), if any: |  | | | | | | | | Conservator(s), if any: | | | | |  |
| Any other Legal Documents on file limiting personal decision making: | | | | | | |  | | | | | | | |

# Acknowledgments

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| **Describe the supports the person needs to understand his/her rights or to understand this plan, if any:** *Indicate who will be responsible for supporting the person and timelines for completing this.* | **Check here if no support is needed** |  |

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| **Person Receiving Services** |  | **Yes** | **No** | **Declined** |
| Does this ISP reflect the services the person chooses and the outcomes the person wants to work toward? |  |  |  |  |
| Has the person been provided information about the planning process and how to request changes and updates to the ISP? |  |  |  |  |
| Did the person choose the location of their ISP meeting? |  |  |  |  |
| Did the person choose who participated in their ISP development? |  |  |  |  |
| Did the SC/PA review the services that are available to the person? |  |  |  |  |
| Did the person receive notification of his/her DHS rights? |  |  |  |  |

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| **Families and/or Guardian who provide support** |  | **Yes** | **No** | **N/A** |
| Does this ISP reflect what is needed for the family to effectively provide supports? |  |  |  |  |
| **ISP Team** – Does this ISP reflect… | |  | **Yes** | **No** |
| **Independence:** Having control and choice over one’s own life. | |  |  |  |
| **Integration:** Living near and using the same community resources and participating in the same activities as, and together with, people without disabilities. | |  |  |  |
| **Productivity:** Engaging in contributions to a household or community; or engaging in income-producing work that is measured through improvements in income level, employment status, or job advancement. | |  |  |  |

**Describe the reason for any question above remaining “no” and the plan to address it:**

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| Agreement to this Plan These people agree to this plan and associated documents as reflecting the person’s strengths and preferences, support needs as identified by an assessment, and the services and supports that will assist the person to achieve identified desired outcomes.   * **Services Coordinator/Personal Agent/ODDS Residential Specialist:** Ensure the plan meets the person’s current service needs and complies with requirements for the chosen service setting(s) and associated funding. * **Providers:** Agree to implement and provide the supports that have been designated as their responsibility in this ISP. A signed contract, job description, or service agreement may be used in lieu of this signature page. |

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| **Name** | **Relationship to this person** | **Present at meeting?** | **Signature** | **Date** | **Comments** |

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|  | Self / Person Receiving Services | Yes or No |  |  |  |
|  | Choose one. | Yes or No |  |  |  |
|  | Legal Guardian | Yes or No |  |  |  |
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