**Individual Support Plan (ISP) Checklist for SC/PAs**

|  |  |
| --- | --- |
| Person’s name: |   |

Prior to planning:

[ ]  Identify any accommodations needed for the person to participate as fully as possible in his/her plan.

[ ]  Ask the person and/or family or guardian, if applicable, who he/she want involved in planning.

[ ]  Identify when and where the person wants to meet.

*The tool “*[*Who do you want involved in planning your life?*](http://oregonisp.org/wp-content/uploads/2015/01/Who-do-you-want-involved-in-planning-your-life.docx)*” is available to help guide you through the discussion and record the person’s preferences for who is involved in planning and where and when planning will happen. The tool can be downloaded at* [*www.OregonISP.org/forms*](http://www.OregonISP.org/forms)*.*

Prepare documents:

[ ]  Person Centered Information

[ ]  One Page Profile(s)

[ ]  Needs Assessment

[ ]  Risk Identification Tool

[ ]  ISP drafted

[ ]  ISP authorized *(appropriate signatures received)*

[ ]  Provider Service Agreement, if applicable *(appropriate signatures received)*

[ ]  Documents shared: *(see table below)*

|  |
| --- |
| *List the names of the people the person would like to share copies of each document with. Check off names once copies are shared. Add more rows, if needed.*  |
| **Person Centered Information** | **One Page Profile** |
| Who should receive a copy? | Who should receive a copy? |
| [ ]   | [ ]   |
| [ ]   | [ ]   |

|  |  |
| --- | --- |
| **ISP** | **Career Development Plan** |
| Who should receive a copy? | Who should receive a copy? |
| [ ]   | [ ]   |
| [ ]   | [ ]   |

|  |  |
| --- | --- |
| **Provider Service Agreement** | **Other Document(s):** |
| Who should receive a copy? | Who should receive a copy? |
| [ ]   | [ ]   |
| [ ]   | [ ]   |

**A Guide for Planning**

**Purpose of this checklist**

This tool can be helpful for training new Services Coordinators and Personal Agents. It may also be useful for more seasoned professionals looking for alternative ways to efficiently and effectively plan with people. It is not intended to replace the ISP instruction manual or training on the ISP process. Be familiar with all relevant Oregon Administrative Rules (OARs) and Office of Developmental Disabilities Services (ODDS) policy transmittals related to ISP process requirements.

**A note about meetings**

This guide refers to three separate planning meetings. You might find that you are able to combine more of the tasks into fewer meetings. In more involved situations, you might find that it is necessary to break up tasks into additional meetings or telephone calls. Planning will look different depending on what works best for the person you are planning with. Depending on the relationship you have with the person, the history you have with him/her, and many other factors, you may also find that some information can be effectively gathered by phone, in writing, or other creative means.

The more you can get done before the meeting(s), collaborate with others who know and care about the person, and delegate to others, the smoother the process will be for you and the people you support. Begin planning about two months in advance of the plan start date, though timelines might be narrower than two months if the person is new to services.

**Who should be involved, when and where?**

****Share the [Who do want involved in planning your life?](http://oregonisp.org/wp-content/uploads/2015/01/Who-do-you-want-involved-in-planning-your-life.docx) tool with the person and their family or guardian, if applicable. The person might fill out the tool on their own or with family or other supporters, if he/she feels comfortable doing so. If not, support the person to walk through the tool. Find out who should be involved, when and where is the best place to meet, and the person’s preferences on information sharing.

If you have this conversation in person, start the meeting by providing the person and their family or guardian, if applicable, with information about Department of Human Services (DHS) rights and those rights related to how planning occurs. Have the appropriate people sign any necessary documents like Release of Information, Level of Care (LOC), and the DHS Rights and Responsibilities.

**First meeting: Gather person centered information**

**Complete the Person Centered Information and One Page Profile (approximately 1 hour)**

**How this meeting occurs:** This information could be gathered face-to-face or over the phone, whatever works best for the person and those the person has invited to participate in planning. If the person lives in a residential setting, the providers, including employment providers, who support the person will gather person centered information and complete a one page profile with the person and forward it to the SC/PA according to agreed timelines.

**Before meeting with the person:** Think about what you already know. Document as much as you can on the Person Centered Information form before the meeting. You might have learned this information from past conversations or from reading other documents in the person’s file.

If you have received Person Centered Information and a One Page Profile from providers working with the person, review these documents before the meeting.

**During the conversation:** Gather any additional Person Centered Information and develop the One Page Profile, if not already done so by providers working with the person. Seeking to understand the person’s perspective, discussing what is important to the person, and focusing on the positive in this initial meeting can help start things off on the right track. Gathering the perspectives of others who know and care about the person, and whom the person has chosen to be involved, can help to validate contributor’s experience and respect the knowledge they have gathered over the years.

***Note***: *The Person Centered Information is not meant to be an interview. This is an opportunity to develop or strengthen a trusting relationship with the person and his/her family, if applicable. Have a conversation with the person and others who are at the meeting about what is important in the person’s life, what he/she is happy or concerned about and how he/she wants to be supported; take notes, and fill in the form back at the office. If there are things you missed or need clarification on, you can always call and gather missing information later. Make sure to follow any preferences the person has around contacting them.*

*Developing the One Page Profile with the person and those at an in-person meeting can be an empowering process. You might take some notes on the One Page Profile form and polish it up later at your office. For more information on developing meaningful One Page Profiles, visit the Oregon ISP website at* [*www.OregonISP.org/1pp*](http://www.oregonisp.org/1pp)*.*

If you haven’t already done so, start the meeting by providing the person with information about their rights and ask them to sign any necessary documents like Release of Information, Level of Care (LOC), Rights and Responsibilities, etc.

While you are gathering person centered information you begin to discover the person’s Desired Outcomes as you deepen your understanding of what is important to the person. Remember to take note of anything you discover about Desired Outcomes while gathering person centered information.

Use this opportunity to have the annual employment conversation, connecting what is important to the person to employment opportunities and the benefits of employment. Remember to ask about the hours the person wants to work and how much they are currently working, if applicable. If the person is not interested in exploring integrated employment, gather the information you will need to complete the Decision Not to Explore Employment (DNE).

During this time, start talking about what is working and not working for the person, what support is currently in place, and what the person, or family if applicable, wants or needs help with. This should be based on what is **important to** the person (the ***person’s perspective***, including what makes the person happy and content and his/her interests) and what is **important for** the person (***additional input*** from others, including what keeps the person healthy, safe, and seen as a valued member of his/her community). Having a conversation about what’s working and what’s not working will help the person and his/her family to think about what is in place right now and how Medicaid funds might be able to address unmet needs. This is also an opportunity to discuss the service options a person can choose from to meet assessed needs, as well as to find out more about where the person wants to live and receive services.

**Outcome of the conversation:** The information you gather should provide you with a starting place for developing meaningful Desired Outcomes, a drafted One Page Profile, and additional information to record on the Person Centered Information form. The discussion will help you to begin thinking about what paid and unpaid supports and services are available to address the person’s support needs based on what is important to and for the person and what they want life to look like. This information will also be useful when you complete the needs assessment.

**Second meeting: Assess needs and identify serious risks**

**Complete Functional Needs Assessment and Risk Identification Tool (approximately 1 hour)**

**How this meeting occurs:** Some people choose to combine this with the first meeting and accomplish it all at once. If the person lives in a residential setting, the providers who support the person will identify any known, serious risks and share that information with the SC/PA according to agreed timelines.

**Before meeting with the person:** Think about what you already know. Fill out as much as you can on the Risk Identification Tool and Needs Assessment beforehand. Take time to review the person’s file before conducting the needs assessment. If you have received a Risk Identification Tool draft from providers working with the person, review it before the meeting. You can use that same tool to add in anything new that you already know or learn at the meeting.

**During the meeting:** Conduct the functional needs assessment and complete the Risk Identification Tool. Assessing support needs and identifying risk simultaneously will save time and limit redundancy as many of the questions are similar in nature and it might help the team determine when things are well captured by the needs assessment (recorded in Chosen Services section) or rise to the level of a serious risk (recorded in the Risk Management Plan). Have a conversation about what is currently in place and what the person or family needs help with. Provide resources and referrals as needed.

Continue and finalize the discussion about service options so that the person is aware of the choices they have for where they can live and what services they can use to meet identified support needs. Remember to discuss any preferences the person has around service delivery. Take time to revisit the discussion about what supports are currently in place. This will help the person and their family or guardian, if applicable, to think about what is in place right now and how Medicaid funds might be able to address unmet needs.

***Note*:** *Depending on what works best for the person, you may decide not to bring out the assessment or the risk identification tool. Have the tools handy for reference, if needed. It might work best to just have a conversation with the person and others at the meeting, take notes, and then fill in the forms back at your office. If there are things you missed or need clarification on, you could call and gather missing information later.*

Collect any documentation you might need to review, like support documents (e.g. protocols, Financial Plan, Behavior Support Plan, etc.) and implementation strategies (e.g. Action Plans) that will help you build the plan. If documents do not reflect current support needs, ask providers to update them and send them to you for review. Determine a date by which you need the updated documents.

**Outcome of this meeting:** The information you collect at this meeting will help you to determine what available services the person will choose to meet identified support needs so that you can complete the Chosen Services Section of the ISP. The information you receive will also help you to complete the Risk Management Plan and determine what supports are in place or needed to address risks and meet support needs.

**Final meeting: Finalize the Plan**

**Agreement to the Plan and Provider Service Agreement (approximately 1.5 hours)**

**Before meeting with the person**: Ensure you have completed all sections of the ISP form. If you feel like you still need some clarification, you can call and ask follow-up questions from the person (follow any preferences the person has for contacting them), or another person who supports them as directed by the person, to fill in the things you are not clear about. At this point, if you have been following the guidance above, you should have had all the discussions necessary to answer the questions on the Acknowledgments page in the ISP and in the ISP Attachment.

Complete the Provider Service Agreement if the person will hire PSW(s) or will be sharing the Provider Service Agreement with other providers instead of the ISP. Be sure to meet all requirements on the Provider Service Agreement (see separate instructions).

***Note****: If you have a laptop and portable printer, you can make changes that are requested at the meeting before agreeing to the plan, make adjustments, reprint, and acquire signatures on the spot. If not, small changes can be made by writing directly onto the ISP form before being signed. Make sure to have the person initial these changes. For bigger changes, you may need to bring the ISP back to the office and make adjustments. Allow time for this circumstance.*

**At the meeting:** This is the time to review the plan with the person and their family or guardian/designated representative, if applicable. The person and the SC/PA will sign the plan. If there are others that need to sign the plan, like a guardian or designated representative who are not present, make time to gather their signatures at a later date before the plan starts.

If the person is hiring providers, make sure to get these signatures either now or make time to do so before services begin. A representative of the provider organization or the foster provider, when applicable, will either sign the ISP or a Provider Service Agreement instead of the ISP. Personal Support Workers (PSW) will sign a Provider Service Agreement.

Providers need to know what supports the ISP directs them to deliver; they need time to review the appropriate ISP documents, give input, ask for clarification, and develop effective implementation strategies, like action plans, by the plan start date. This may be accomplished by sending providers the documents for review or reviewing documents in-person with providers. Allow time for this. Once signed, share copies of the ISP or the Provider Service Agreement, as directed by the person, with providers so they have the documentation they need to develop implementation strategies and other support documents (e.g. protocols).

**Outcome of this meeting:** By this time, you should have a completed plan. It is time to make copies and distribute to the right people.Once the Individual Support Plan is authorized, file the plan along with any contributing documents, support documents, and implementation strategies following your organization’s procedures.

**Plan Implementation**

Ensure that providers have updated any necessary support documents and implementation strategies or determine a date by which providers will send you these documents for review.

Monitor and note progress following OARs. Revise the plan using a change form as needed to ensure the plan continues to be current and meet the person’s identified support needs, identified risks, and Desired Outcomes.

**Additional Instruction, Forms, and Resources**

****To access the ISP instruction manual, provided ISP forms, and other useful tools, visit the Oregon ISP website at [www.OregonISP.org](http://www.OregonISP.org). You can also submit questions related to the ISP process or register for an upcoming ISP training.

**ISP Manual**: [www.OregonISP.org/instructions/](http://www.OregonISP.org/instructions/)

**Provided forms**: [www.OregonISP.org/forms/](http://www.OregonISP.org/forms/)