|  |  |  |
| --- | --- | --- |
|  | ’s | Individualized Service Plan |

# MY CIRCLE OF SUPPORT

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| Name |  | Relationship |
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# OTHER AGENCIES THAT SUPPORT ME:

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| --- | --- | --- | --- | --- | --- |
|  | Division of Vocational Rehabilitation | |  | Child and Adolescent Mental Health | |
|  | Department of Education | |  | Adult Mental Health Division | |
|  | Other: |  | | |  |

I chose the people in my meeting.  I ran my meeting.

I helped plan my meeting.  I picked \_\_\_\_\_\_\_\_\_\_\_ to help me run

my meeting.

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| --- | --- | --- | --- |
| Case Manager: |  | Case Management Unit: |  |

|  |  |
| --- | --- |
| Case Manager’s Address: |  |
|  |  |
|  |  |
| Case Manager’s Telephone #: |  |

# THIS IS WHO I AM

(Great things about me; Strengths; Positive words that describe me)

# HOW I COMMUNICATE

*When I’m sad, (e.g., I cry; I am quiet; etc.),I need you to ... (e.g. leave me alone).*

*When I’m happy ...*

*When I’m angry ..., I need you to ...*

*When I’m sick/not feeling well ..., I need you to ... (e.g., take me to the doctor)*

*The language I speak is ...*

*I best communicate to others using . . .(e.g., my voice and words, sign language, my communication device, gestures)*

*Other:*

# WHAT’S IMPORTANT AND MEANINGFUL TO ME

(Control; Dignity; Respect; Choice; Relationships; Contributing to the Community; Responsibilities; Dreams)

**Put an asterisk (\*) next to the areas to be addressed as priority goals.**

*WHERE I WANT TO LIVE –*

*MY HEALTH AND WELL-BEING (concerns or goals I have) –*

*MY SAFETY (what I need to feel safe and secure at home, at work, at school, in the community) –*

*I WANT TO LEARN NEW THINGS/TRY NEW THINGS –*

*I WANT TO WORK AND MAKE MONEY –*

# WHAT’S IMPORTANT AND MEANINGFUL TO ME

(Control; Dignity; Respect; Choice; Relationships; Contributing to the Community; Responsibilities; Dreams)

**Put an asterisk (\*) next to the areas to be addressed as priority goals.**

*MY RELATIONSHIPS WITH FAMILY AND FRIENDS –*

Intimacy and Personal Choice - (e.g.., boyfriend/girlfriend, relationships, personal space)

*LEISURE AND RECREATIONAL ACTIVITIES –*

*I enjoy doing activities on my own like . . .*

*I enjoy doing activities with others like . . .*

*I enjoy doing activities in the community like . . .*

*THINGS I NEVER WANT IN MY LIFE ARE – (e.g. to be in noisy places, to be alone)*

*OTHER IMPORTANT THINGS IN MY LIFE (e.g. cultural, spiritual, religious traditions/celebrations)*

# MY GOALS

BASED ON “WHAT’S IMPORTANT AND MEANINGFUL TO ME”, THESE ARE MY MOST IMPORTANT GOALS FOR THIS YEAR:

**Put an “I” next to the goals identified by the individual.**

# INDIVIDUALIZED SERVICE PLAN – Action Plan (Page 1 of 2)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Services/Support | | | | | | Frequency and Duration | | | | | | Start Date | | | |
|  | | | | | |  | | | | | |  | | | |
| Name: | | | | | | Address: | | | | | | Phone: | | | |
| Rep: | |  | | |  | Rep: |  | | | |  | Fax: | | | |
|  | | Print Name | | |  |  | Signature | | | |  |  | |  | |
|  | | | | | | | | | | Status | | | | | |
| **GOAL #1**  Self  Circle | | |  | | | | | | |  | | | | | |
| Outcomes: | | |  |  | | | | | |
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| **GOAL #2**  Self  Circle | | |  | | | | | | |  | | | | | |
| Outcomes: | | |  |  | | | | | |
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| **GOAL #3**  Self  Circle | | |  | | | | | | |  | | | | | |
| Outcomes: | | |  |  | | | | | |
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|  | Signature of Individual, Guardian or Personal Rep. | | | | | | |  | Date | | |  |  | |  |
|  | Signature of Case Manager | | | | | | |  | Date | | |  |  | |  |

# INDIVIDUALIZED SERVICE PLAN – Action Plan (Page 2 of 2)

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|  | | | | | | Status | |
| **GOAL #4**  Self  Circle | |  | | | |  | |
| Outcomes: | |  |  | | |
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| **RISK AND SAFETY** (Potential risks and safety concerns to be addressed when supporting me)**:** | | | | | | | |
| POTENTIAL RISK | | | | SUPPORTS TO MINIMIZE RISK | | | |
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|  | Functional Behavior Assessment (FBA) | | | | Positive Behavior Support Plan | | None |
| Comments: | | | | | | | |

# INDIVIDUALIZED SERVICE PLAN – Action Plan (Page 1 of 2)

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| Services/Support | | | | | | Frequency and Duration | | | | | | Start Date | | | |
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| Name: | | | | | | Address: | | | | | | Phone: | | | |
| Rep: | |  | | |  | Rep: |  | | | |  | Fax: | | | |
|  | | Print Name | | |  |  | Signature | | | |  |  | |  | |
|  | | | | | | | | | | Status | | | | | |
| **GOAL #1**  Self  Circle | | |  | | | | | | |  | | | | | |
| Outcomes: | | |  |  | | | | | |
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| **GOAL #2**  Self  Circle | | |  | | | | | | |  | | | | | |
| Outcomes: | | |  |  | | | | | |
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| **GOAL #3**  Self  Circle | | |  | | | | | | |  | | | | | |
| Outcomes: | | |  |  | | | | | |
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|  | Signature of Individual, Guardian or Personal Rep. | | | | | | |  | Date | | |  |  | |  |
|  | Signature of Case Manager | | | | | | |  | Date | | |  |  | |  |

# INDIVIDUALIZED SERVICE PLAN – Action Plan (Page 2 of 2)

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|  | | | | | | Status | |
| **GOAL #4**  Self  Circle | |  | | | |  | |
| Outcomes: | |  |  | | |
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| **RISK AND SAFETY** (Potential risks and safety concerns to be addressed when supporting me)**:** | | | | | | | |
| POTENTIAL RISK | | | | SUPPORTS TO MINIMIZE RISK | | | |
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|  | Functional Behavior Assessment (FBA) | | | | Positive Behavior Support Plan | | None |
| Comments: | | | | | | | |

# INDIVIDUALIZED SERVICE PLAN – Action Plan (Page 1 of 2)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Services/Support | | | | | | Frequency and Duration | | | | | | Start Date | | | |
|  | | | | | |  | | | | | |  | | | |
| Name: | | | | | | Address: | | | | | | Phone: | | | |
| Rep: | |  | | |  | Rep: |  | | | |  | Fax: | | | |
|  | | Print Name | | |  |  | Signature | | | |  |  | |  | |
|  | | | | | | | | | | Status | | | | | |
| **GOAL #1**  Self  Circle | | |  | | | | | | |  | | | | | |
| Outcomes: | | |  |  | | | | | |
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| **GOAL #2**  Self  Circle | | |  | | | | | | |  | | | | | |
| Outcomes: | | |  |  | | | | | |
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| **GOAL #3**  Self  Circle | | |  | | | | | | |  | | | | | |
| Outcomes: | | |  |  | | | | | |
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|  | Signature of Individual, Guardian or Personal Rep. | | | | | | |  | Date | | |  |  | |  |
|  | Signature of Case Manager | | | | | | |  | Date | | |  |  | |  |

# INDIVIDUALIZED SERVICE PLAN – Action Plan (Page 2 of 2)

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|  | | | | | | Status | |
| **GOAL #4**  Self  Circle | |  | | | |  | |
| Outcomes: | |  |  | | |
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| **RISK AND SAFETY** (Potential risks and safety concerns to be addressed when supporting me)**:** | | | | | | | |
| POTENTIAL RISK | | | | SUPPORTS TO MINIMIZE RISK | | | |
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|  | | | |  | | | |
|  | Functional Behavior Assessment (FBA) | | | | Positive Behavior Support Plan | | None |
| Comments: | | | | | | | |

# MY INFORMATION

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Guardianship:** | | | | | | Family/Relative  Office of the Public Guardian  Department of Human Services | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | None  Other (specify) | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | |
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|  | Name | | | | | | | | | Address | | | | | | | City | | | | | | State | | | | Zip | | Telephone No.(s) | | | | |  |
|  |  | | | | | | | | |  | | | | | | |  | | | | | |  | | | |  | |  | | | | |  |
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|  | | Guardianship Document on file | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| **Conservator (Financial):** | | | | | | | | Family/Relative  Estate and Probate  Office of the Public Guardian | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | Department of Human Services  Other (specify) | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | |
|  | | | Representative Payee  None | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | |  |
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|  | Name | | | | | | | | | Address | | | | | | | City | | | | | | State | | | | Zip | | Telephone No.(s) | | | | |  |
|  |  | | | | | | | | |  | | | | | | |  | | | | | |  | | | |  | |  | | | | |  |
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| **Legal Issues:** (e.g. guardianship pending, on probation, court involvement, power of attorney) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Medicaid Eligibility:** | | | | | | | **As a reminder, failure to renew your Medicaid eligibility may result in the** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | **TERMINATION of your medical benefits and your DD/ID waiver services.** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Eligibility Worker | | | | | | | | | | Business Address | | | | | | | | Medicaid Unit | | | | Medicaid Eligibility Month (if known) | | | | | | Telephone No. | | | | |  |
|  |  | | | | | | | | | |  | | | | | | | |  | | | |  | | | | | |  | | | | |  |
|  | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| Person Responsible to complete Annual Medicaid Application: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | Name Relationship | | | | | | | | | | | | |  | | | |
| Medicaid Ineligible Date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Health Insurance: (check all that apply):** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Medicaid | | | | | Policy No: | | | |  | | | | | | | | QI Plan: | | | | | | |  | | | | | | | | | |  |
| Cost Share: | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | | | |
| Medicare: Part: A  B  D | | | | | | | | | | | | | | | Prescription Drug Plan Name: | | | | | | | | | | | | |  | | | | | |  |
| Dental: Name: | | | | | | |  | | | | | | |  | Policy No. | | | | | |  | | | | | | | | | | | | |  |
| Other: Name: | | | | | | |  | | | | | | |  | Policy No. | | | | | |  | | | | | | | | | | | | |  |
| Other: Name: | | | | | | |  | | | | | | |  | Policy No. | | | | | |  | | | | | | | | | | | | |  |
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# MY INFORMATION

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| **WHERE I LIVE** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| On my own | | | | | | | | | | | | | | | | | | | | Adult Foster Home (AFH) | | | | | | | | | | | | | | |
| Family/Relatives Home | | | | | | | | | | | | | | | | | | | | DD Domiciliary Home (Dom) | | | | | | | | | | | | | | |
| Adult Residential Care Home (ARCH) | | | | | | | | | | | | | | | | | | | | Other: specify: | | | | | | | | | | | | | | |
| My Parent/Caregiver’s Name: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |  |
| My Address and Telephone No.: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  |
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| **MY HEALTH** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diagnosis/Medical Condition | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. |  | | | | | | | | | | | | | | | | |  | | 5. |  | | | | | | | | | | | | |  |
|  | (ICD-10 Code and Diagnosis) | | | | | | | | | | | | | | | | |  | |  |  | | | | | | | | | | | | | |
| 2. |  | | | | | | | | | | | | | | | | |  | | 6. |  | | | | | | | | | | | | |  |
| 3. |  | | | | | | | | | | | | | | | | |  | | 7. |  | | | | | | | | | | | | |  |
| 4. |  | | | | | | | | | | | | | | | | |  | | 8. |  | | | | | | | | | | | | |  |
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| Allergies: | | Known: (Medications, Food, Environment) | | | | | | | | | | | | | | | | | | | | None | | | | | | | | | | | | |
| Specify: | | 1. | |  | | | | | | | |  | | | 3. |  | | | | | | | | | | | | Height: | | |  | | |  |
|  | | 2. | |  | | | | | | | |  | | | 4. |  | | | | | | | | | | | | Weight: | | |  | | |  |
| Physical Limitations: | | | | | |  | | | | |  | | G-Tube | | | | | | | J-Tube | | | | | Other (specify): | | | | | |  | | |  |
| Diet Type: | |  | | | | | | | | | | | | |  | | | | | | |  | | | | | | |  | | | | |  |
| Diet Texture: | | | Regular | | | | Chopped | | | | | | | Ground | | | | | Pureed | | | | | Liquid Consistency: | | | | | | | |  | |  |
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| Type of Examination/Procedure | | | | | | | | | Date  Completed | | | | | | | | Date  Next Exam Due | | | | | | | | | Comments | | | | | | | | |
| **Physical Exam** | | | | | | | | |  | | | | | | | |  | | | | | | | | |  | | | | | | | | |
| **Dental Exam** | | | | | | | | |  | | | | | | | |  | | | | | | | | |  | | | | | | | | |
| **Eye Exam** | | | | | | | | |  | | | | | | | |  | | | | | | | | |  | | | | | | | | |
| **Hearing Exam** | | | | | | | | |  | | | | | | | |  | | | | | | | | |  | | | | | | | | |
| **PPD or Chest x-ray** | | | | | | | | |  | | | | | | | |  | | | | | | | | |  | | | | | | | | |
| **Prostate Exam (Men)** | | | | | | | | |  | | | | | | | |  | | | | | | | | |  | | | | | | | | |
| **PAP Smear (Women)** | | | | | | | | |  | | | | | | | |  | | | | | | | | |  | | | | | | | | |
| **Mammogram (Women)** | | | | | | | | |  | | | | | | | |  | | | | | | | | |  | | | | | | | | |
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| MY HEALTH SUPPORTS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **MEDICATIONS:** | | | | Medications Current as of: | | | |  | |
|  | |  | |  | |  | |  |  |
| No. | Medication | | Dosage | | Frequency | | Purpose | | Prescribing M.D. |
| 1. |  | |  | |  | |  | |  |
| 2. |  | |  | |  | |  | |  |
| 3. |  | |  | |  | |  | |  |
| 4. |  | |  | |  | |  | |  |
| 5. |  | |  | |  | |  | |  |
| 6. |  | |  | |  | |  | |  |
| 7. |  | |  | |  | |  | |  |
| 8. |  | |  | |  | |  | |  |
| 9. |  | |  | |  | |  | |  |
| 10. |  | |  | |  | |  | |  |
| 11. |  | |  | |  | |  | |  |
| 12. |  | |  | |  | |  | |  |
| 13. |  | |  | |  | |  | |  |
| 14. |  | |  | |  | |  | |  |
| 15. |  | |  | |  | |  | |  |
| 16. |  | |  | |  | |  | |  |
| 17. |  | |  | |  | |  | |  |
| 18. |  | |  | |  | |  | |  |
| 19. |  | |  | |  | |  | |  |
| 20. |  | |  | |  | |  | |  |
| 21. |  | |  | |  | |  | |  |
| 22. |  | |  | |  | |  | |  |
| MY HEALTH SUPPORTS | | | | | | | | | |

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| **PRIMARY M.D.** | |  | | | | Specialty: | |  | | | Phone number: | | |  | |
| Address: |  | | | | | | | | Last Visit: |  | | | Next Visit: | |  |
| Medical Concerns/Precautions: | | | | |  | | | | | | | | | | |
|  | |  | | | |  | |  | | |  | | |  | |
| **Dentist** |  | | | | | Specialty: | |  | | | Phone number: | | |  | |
| Address: |  | | | | | | | | Last Visit: |  | | | Next Visit: | |  |
| Medical Concerns/Precautions: | | | | |  | | | | | | | | | | |
|  | |  | | | |  | |  | | |  | | |  | |
| **Other M.D./Specialist** | | |  | | | Specialty: | |  | | | Phone number: | | |  | |
| Address: |  | | | | | | | | Last Visit: |  | | | Next Visit: | |  |
| Medical Concerns/Precautions: | | | | |  | | | | | | | | | | |
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| **Other M.D./Specialist** | | |  | | | Specialty: | |  | | | Phone number: | | |  | |
| Address: |  | | | | | | | | Last Visit: |  | | | Next Visit: | |  |
| Medical Concerns/Precautions: | | | | |  | | | | | | | | | | |
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| **Other M.D./Specialist** | | |  | | | Specialty: | |  | | | Phone number: | | |  | |
| Address: |  | | | | | | | | Last Visit: |  | | | Next Visit: | |  |
| Medical Concerns/Precautions: | | | | |  | | | | | | | | | | |
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| **Other M.D./Specialist** | | |  | | | Specialty: | |  | | | Phone number: | | |  | |
| Address: |  | | | | | | | | Last Visit: |  | | | Next Visit: | |  |
| Medical Concerns/Precautions: | | | | |  | | | | | | | | | | |
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| **Other M.D./Specialist** | | |  | | | Specialty: | |  | | | Phone number: | | |  | |
| Address: |  | | | | | | | | Last Visit: |  | | | Next Visit: | |  |
| Medical Concerns/Precautions: | | | | |  | | | | | | | | | | |
|  | |  | | | |  | |  | | |  | | |  | |
| **Other M.D./Specialist** | | |  | | | Specialty: | |  | | | Phone number: | | |  | |
| Address: |  | | | | | | | | Last Visit: |  | | | Next Visit: | |  |
| Medical Concerns/Precautions: | | | | |  | | | | | | | | | | |
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| **I use the following ADAPTIVE EQUIPMENT/ASSISTIVE TECHNOLOGY** | | | | | | | | | | | | | | | |
| Equipment/Technology | | | | Purpose | | | Vendor | | | | | If known, last maintenance check | | | |
|  | | | |  | | |  | | | | |  | | | |
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|  | | | |  | | |  | | | | |  | | | |
| **I use the following MEDICAL SUPPLIES** | | | | | | | | | | | | | | | |
| Item | | | | Purpose | | | Vendor | | | | | | | | |
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| **BEHAVIORAL SUPPORTS** | | | | | | | | | | | |
| Attachments: | |  | Functional Behavior Assessment | | | | Date Completed: | |  |  | |
|  | |  | Positive Behavior Support Plan | | | | Date Completed: | |  |  | |
|  | | | | | | | | | | | |
| Identified Restraints: Check all that apply: | | | | | | Behavior Support Review Committee (BSRC): | | | | | |
| Chemical | Date Implemented: | | |  |  | Referral Date: | |  | | |  |
| Physical | Date Implemented: | | |  |  | Review Date: | |  | | |  |
| Mechanical | Date Implemented: | | |  |  | Review Date: | |  | | |  |
|  |  | | |  |  |  | |  | | |  |
| Comments: | | | | | | | | | | | |
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| EMERGENCY AND CRISIS PLANNING | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **A.** | | | **POLICE ASSITANCE OR MEDICAL EMERGENCY – CALL 911** | | | | | | | | | | | | | | | | | |
|  | | | Hospital Preference: | | | | |  | | | | | | | | | | |  | |
| **B.** | | | **CRISIS HOTLINE NUMBER:** | | | | | | | | **590-1769 (Oahu Only)** | | | | | | | | | |
|  | | | **For Behavioral Emergencies** | | | | | | | | **1-866-599-9211 (Neighbor Island Only)** | | | | | | | | | |
| **C.** | | | **Poison Center 1-800-222-1222** | | | | | | | | | | | | | | | | | |
| **D.** | | | **Other:** | |  | | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Other Contingency/Back-Up Supports (name, relationship, address, telephone)** | | | | | | | | | | | | | | | | | | | | |
| Identification of a natural support who is willing to provide back-up supports for individuals living on their own or with their family. | | | | | | | | | | | | | | | | | | | | |
|  | Name | | | | | | Relationship | | Address | | | | City | | State | Zip | | Telephone No.(s) | |  |
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| **DISASTER PREPAREDNESS**  **Items for Disaster Preparedness** | | | | | | | | | | | | | | | | | | | | |
| Personal Emergency Kit: | | | | | | | | | | Medical Identification Bracelet: | | | | | | | | | | |
| I have a kit | | | | | | I need a kit | | | | I have a bracelet | | | | I need a bracelet | | | Not applicable | | | |
|  | | | | | | | | | |  | | | | | | | | | | |
| A copy of the Guidelines for Personal Disaster Preparation for Individuals with Special Needs: | | | | | | | | | | | | | | | | | | | | |
| I have a copy | | | | | | | | | | | | I need a copy | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | |
| A “buddy” to help me if there is a hurricane or tsunami: | | | | | | | | | | | | | | | | | | | | |
| I have a “buddy” | | | | | | | | | | | | I need a “buddy” | | | | | | | | |
|  | | | | | | | | | | | |  | | | | | | | | |
|  | | Name of my “buddy”: | | | | | | | | | | Address and Telephone No. of my “buddy”: | | | | | | | | |
|  | |  | | | | | | | | | |  | | | | | | | | |
|  | |  | | | | | | | | | |  | | | | | | | | |
|  | | Who will help me get the items I need: | | | | | | | | | | When this will be done by: | | | | | | | | |
|  | |  | | | | | | | | | |  | | | | | | | | |
|  | |  | | | | | | | | | |  | | | | | | | | |
|  | | If evacuation is necessary, I will evacuate to (name at least two shelters in your area): | | | | | | | | | | | | | | | | | | |
|  | |  | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | | | | |
| Comments: | | | | | | | | | | | | | | | | | | | | |

# CONSENT FOR SERVICES

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| I/We have reviewed the attached Individualized Service Plan (ISP) for | | | |  |
| dated |  | **.** |

|  |  |  |
| --- | --- | --- |
| 1. | This plan was developed with me and/my guardian and other individuals of my choosing. It includes the goals that are important form my health and safety. |  |
|  |  | Initials |
| 2. | The choice of services and the providers of these service(s) were reviewed with me. The choice to self –direct (for Personal Assistance Habilitation (PAB), respite, and chore) was also offered to me. I, have, of my own free will, chosen to receive this service from the provider noted in the Action Plan of the ISP). |  |
|  |  | Initials |

PLEASE MARK THE APPROPRIATE BOX

I/We agree or consent to the ISP.

|  |  |  |
| --- | --- | --- |
|  | I/We would like to discuss the ISP. Please contact me at (Phone No.): |  |

|  |  |  |
| --- | --- | --- |
| If you were not present at the ISP meeting and would like to discuss any of the details in the ISP, you | | |
| can contact your case manager at |  | . You can also contact your case manager at |
| any time when you feel your plan needs to be updated or changed. | | |

**Your Rights:**

If you do not approve or do not sign the proposed ISP and the current ISP has expired, your services may be terminated, per Hawaii Administrative Rules § 11-88.1-10. **It is important that you sign and return this page to your case manager within 14 calendar days of receiving this form**.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| If you signed the Consent for Services but disagree with the services and/or supports in your ISP, you can request for an informal discussion at any time with staff from the Developmental Disabilities | | | | |
| Division. Please contact | | |  | , case management unit supervisor, at |
|  | |  | . You can also contact the Consumer Complaints Resolution Unit at 453-6669. | | |

For Medicaid waiver services, prior to any suspension, reduction, or termination of services, you will be notified in writing. If you disagree with the proposed action, the “Notice of Action” will explain your appeal options. These include an informal review with the Developmental Disabilities Division, an administrative hearing with the Department of Health, and/or an administrative hearing with the Department of Human Services.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | | |  | |  |  |  |
| Participant’s Signature | | |  | | Print Name |  | Date |
|  | | |  | |  |  |  |
|  | | |  | |  |  |  |
|  | | |  | |  |  |  |
| Signature of: |  | Parent |  | | Print Name |  | Date |
|  |  | Legal Guardian |  | |  |  |  |
|  |  | Personal Representative | |  |  |  |  |