



MENTAL RETARDATION BULLETIN

COMMONWEALTH OF PENNSYLVANIA-DEPARTMENT OF PUBLIC WELFARE

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SUBJECT:

Individual Support Plan Process

BY:

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SCOPE:

- County Mental Health/Mental Retardation Administrators
- Supports Coordination Entities
- Administrative Entities
- Community Home Directors
- Family Living Directors
- Adult Training Facility Directors
- Vocational Facility Directors

This Bulletin applies to anyone who applies for or receives services and supports from the Department of Public Welfare, Office of Mental Retardation (OMR), including Waiver funding, regardless of his or her residential setting, except for individuals who live in Intermediate Care Facilities for the Mentally Retarded (ICF/MRs).

Following the processes outlined in this statement of policy will satisfy the following Individual Support Plan (ISP) requirements of 55 Pa. Code:

- CH. 20 – Licensure or Approval of Facilities and Agencies
- CH. 2380 – Adult Training Facilities
- CH. 2390 – Vocational Facilities
- CH. 6400 – Community Homes for Individuals with Mental Retardation
- CH. 6500 – Family Living Homes

PURPOSE:

- To ensure that the Individual Support Plan (ISP) is an integrated document reflecting “Person Centered Planning”, the Core Values of “Everyday Lives” and “Positive Approaches” to result in an enhanced quality of life for everyone who receives mental retardation services and supports in Pennsylvania
- To identify a process for preparing, completing, documenting, implementing, and monitoring Individual Support Plans.

QUESTIONS AND COMMENTS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO THE APPROPRIATE REGIONAL PROGRAM OFFICE

BACKGROUND:

The ISP process means working together to share, plan, dream, and create a vision for the future. ISPs are based on self-determination and the philosophies of “Positive Approaches,” “Person Centered Planning” and “Everyday Lives”. The purpose of “Positive Approaches” is to enable individuals to lead their lives as they desire by providing supports for them to grow and develop, make their own decisions, achieve their personal goals, develop relationships, face challenges, and enjoy life as full, participating members of their communities. The Core Values of “Everyday Lives” are choice, control, quality, community inclusion, stability, accountability, safety, individuality, relationships, freedom, success, contributing to the community, collaboration, and mentoring. “Person Centered Planning” discovers and organizes information that focuses on an individual’s strengths, choices, and preferences. It involves bringing together people the individual would like to have involved in the planning process, truly listening to the individual, describing the individual as fully as possible with a true focus on understanding who he or she is, and dreaming and imagining with the individual of possible ways things could be different, both today and tomorrow. Integrating the values of “Positive Approaches”, “Everyday Lives”, and “Person Centered Planning” into the ISP maximizes individuals’ opportunities to incorporate their personal values, standards, and dreams into their “Everyday Lives” and their programs, services, and supports. Each team uncovers meaningful personal Outcomes and works towards realizing these Outcomes. (See Attachment # 1 – *Positive Approaches*, Attachment # 2 – *Guidelines for Addressing the Individual’s Core Values in the ISP*, and Attachment # 3 – *Person Centered Planning* for more information.)

The ISP is a standardized format for service planning that meets federal and state regulations. It contains essential information about the individual which is used for planning and implementing supports needed for the individual to successfully live the life that he or she chooses. To address the full range of individual needs, ISPs are based on written assessments or other documentation that supports the individual’s need for each Waiver and Non-Waiver funded service.

The Home and Community Services Information System (HCSIS) houses information electronically. The ISP in HCSIS stores information from an individual’s team in one plan and provides Supports Coordinators and designated Providers quick accessibility to information.

DISCUSSION:

OMR has adopted the ISP as the single planning document for all individuals who receive mental retardation services including Waiver funding, except for those who live in ICF/MRs. The development of the ISP is a process that identifies needs, including health and safety, and leads to the identification of specific services and supports provided by OMR. The length of the plan is determined by the process and regulation requirements, and is based on an individual’s available resources and funded services. The ISP developed by the Supports Coordinator is deemed equivalent to the Individual Program Plan and for the purpose of licensing the ISP will be the source document for regulations regarding assessment and planning. In addition, provider agencies are not obligated to develop their own separate Individual Program Plans. The ISP should be considered synonymous with “plan” as referenced in MR regulations.

The ISP process involves collaboration between the individual, his or her family, guardian or advocate, and other people important in the individual’s life via written correspondence, telephone conversations and/or face-to-face meetings. The individual and his or her family drive the process if

they choose to do so. The individual and all team members are invited to the Annual Review. For regulated services, at least three members of the individual's team, in addition to the individual if the individual chooses to attend, are required to be present at the Annual Review. All team members play vital roles in the ISP process by participating fully to share knowledge, perspective and insight in supporting the individual to recognize and work toward his or her Outcomes. This is an individualized process, so one or more team meetings may be required.

Completing a person centered Individual Support Plan is a process that has some specific guidelines while providing opportunities for flexibility with different approaches and creativity with planning. The process starts with assessment and information gathering, followed by an Annual Review at which the gathered information is reviewed, Outcomes are developed and services, supports and providers are identified. Information from the Annual Review is then documented in HCSIS, the ISP is approved and authorized by the administrative entity and services are implemented, then monitored. (See Attachment # 4 - *ISP Activities Timeline and Role Clarification* for more information.)

An ISP is completed on everyone applying for or receiving services from the Office of Mental Retardation. Once eligibility has been determined, the ISP process is initiated, beginning with assessments to gather information which leads to identification of preferences and needs.

After the ISP is completed, if OMR services are not available to meet the individual's needs, a Prioritization of Urgency of Need for Services (PUNS) assessment is completed. The ISP and subsequent reviews are developed within the timelines indicated by the applicable licensed service regulations, and Outcomes are developed prior to the implementation of services.

The ISP is updated as changes occur, and is reviewed and rewritten at least annually (within 365 days). This annual meeting is referred to as the Annual Review and should occur within approximately 60 to 90 days prior to the expiration of the current plan to allow sufficient time to complete all documentation and obtain all necessary approvals and authorizations for continuity of services when the new plan starts. (See Attachment # 5 – *ISP Process Flow Chart* for more information).

Assessment and Information Gathering

The Supports Coordinator begins the assessment and information gathering process by coordinating the information gathering methods with the team. Providers are responsible to provide information to the Supports Coordinator. (See Attachment # 4 - *ISP Activities Timeline and Role Clarification* for more information.)

A key step in developing a meaningful ISP is to gather information that reflects the Core Values of "Everyday Lives". Information should be gathered from the individual and those people who know him or her best in order to capture person centered information to determine the individual's wants, preferences, strengths and needs. If the person uses an alternate means of communication or if his or her primary language is not English, the information gathering process needs to use his or her primary means of communication, an interpreter or someone who has a close enough relationship with the individual to accurately speak for him or her.

There are several different formal and informal tools and methods for collecting information. Information gathering should include physical development, communication styles, learning styles,

educational background, social/emotional information, medical information, personality traits, environmental influences, personal preferences, interactions, relationships that impact the person's quality of life, and an evaluation of risk. A Lifetime Medical History and the Supports Intensity Scale Plus (SIS+) are completed or reviewed and updated. Lifesharing and employment are discussed to gather information about the individual's preference regarding where he or she wishes to live and work.

ISP Meeting/Annual Review

Review of Information Gathered

The team reviews information that was gathered during the assessment/information gathering stage of the process to ensure that identified needs lead to Outcomes and services that are based upon those needs. Information relevant to the individual from Independent Monitoring For Quality on satisfaction, OMR monitoring of counties, Health Care Profiles, Incident Management, complaint resolution, and other feedback shall be incorporated and reviewed annually during the Annual Review when that information will impact individuals' health and safety, services and supports, or the individuals' ability to have an everyday life. Each team member ensures that information provided during the ISP process is current and is presented professionally and with sensitivity.

Outcome Development

The individual and his or her family, friends, and team develop Outcome Summaries and Actions to support the attainment of what is important to and for the individual. Outcomes should build on gathered information, reflect the individual's preferences, represent desired changes or important things that should be maintained, make a difference in the person's life and signify a shared commitment to take action. There is a clear connection between the person's preferences, choices, life aspirations, strengths and needs that were revealed during the information gathering process and the Outcomes that are developed at the ISP meeting.

The ISP outlines the actions and supports necessary for the person to successfully attain his or her Outcomes. The team uses Outcomes as a guide to determine what services and supports are needed and to ensure that services and supports reflect the actions needed to promote the Outcomes. Any barriers or concerns that prevent the Outcomes from being tangible and reachable need to be addressed at this time, especially if they can impact the individual's health and safety. The team and individual work together to find acceptable Outcomes that enable the individual to exercise his or her choices while at the same time minimize risk and achieve or maintain good health. Outcomes may need to be broken down into achievable segments to maximize the individual's opportunities for success.

Identification of Services and Supports

After the development of Outcomes, the types, duration and frequency of services and supports are identified. Each service or support is linked to an Outcome. When identifying services and supports, the individual, family and team consider all available resources, including natural supports in the community such as friends, family, neighbors, businesses, schools, civic organizations and employers. OMR offers a set of services that can be utilized to support the person's needs. A list of

services can be found in the *Service Definitions Bulletin (Bulletin # 00-04-10)*. OMR-funded services acknowledged through the planning process shall be identified in the individual's SIS+ assessment.

Choosing Provider

Qualified providers who have indicated that they are willing and able to provide services necessary to support the individual achieve his or her Outcomes are reviewed with the individual and his or her family, guardian, or advocate. The individual and his or her family exercise choice in the selection of willing and qualified providers.

Documentation

OMR's signature page should be signed and dated by those attending the meeting. (See Attachment # 6 - *Individual Support Plan Attendance Sheet and Due Process Notification Concurrence* for more information.) It is essential to have the individual attend his or her own ISP meeting. However, should the individual or his or her family choose not to be present, the reason is documented in a Service Note.

HCSIS is used by the Supports Coordinator to record, update, or revise ISPs. There are several types of reviews that are documented in the ISP in HCSIS: Annual Review, Bi-annual Review, Critical Revision, General Update, Plan Creation and Quarterly Review. The Review Date in HCSIS is the date that services are implemented. Quarterly and Annual Reviews originate from the Review Date. The authorization of services is based on the fiscal year, so the Start Date in HCSIS is July 1. All services that the individual receives are listed in his or her plan. The individual's plan specifies the amount, frequency, duration, provider name, provider type and the authorized rate of each service.

Implementation of Services

After the ISP is approved and authorized, supports and services are implemented and those responsible are accountable for actions, services and supports as indicated in the ISP. An important factor is to continue to keep people focused on the Outcomes from the ISP meeting and to keep the meeting's focus and energy alive, moving, and dynamic. The Supports Coordinator and team gather information and review the Outcomes and selected services on an on-going basis to assure that the ISP continues to reflect what is important to and for the individual. Revisions are discussed with the individual and/or his or her family, guardian or advocate and team. They are entered into the plan in HCSIS and shared with the team and service providers.

Monitoring

Supports Coordination monitoring ensures that the individual is receiving the appropriate quality, type, duration, and frequency of services. Quality services require a system that acknowledges its strengths and weaknesses through a Quality Improvement Cycle of Plan-Do-Check-Act. After the ISP is completed, it is implemented, checked or monitored and action is taken as needed.

ISP monitoring is completed by a variety of entities. As a provider of services, the Provider reviews the ISP to ensure that the information is complete and accurate and that services are implemented as recommended by the team. Administrative Entity monitoring ensures that reasonable safeguards exist for the person's health and well being in the home and community. OMR monitors individuals'

ISPs for compliance with planning Outcomes and expectations outlined in the ISP Bulletin. In addition, the person may be asked to participate in other monitoring, such as Independent Monitoring for Quality surveys and monitoring by county or state Mental Retardation staff. Monitoring findings are entered into HCSIS.

CLOSING THOUGHT

In the 1991 “Everyday Lives” publication, John McKnight wrote:

“Our goal should be clear. We are seeking nothing less than a life surrounded by the richness and diversity of community. A collective life. A common life. **An Everyday Life.** A powerful life that gains its joy from the creativity and connectedness that comes when we join in association as citizens to create an inclusive world.”

ATTACHMENTS:

Attachment # 1 – *Positive Approaches*

Attachment # 2 – *Guidelines for Addressing the Individual’s Core Values in the ISP*

Attachment # 3 – *Person Centered Planning*

Attachment # 4 – *ISP Activities Timeline and Role Clarification*

Attachment # 5 – *ISP Process Flow Chart*

Attachment # 6 – *Attendance Sheet and Concurrence Due Process Notification*

Attachment # 7 – *ISP Key Terms*

Attachment # 8 – *ISP Pa Code Title 55 Crosswalks*

Attachment #1 - DRAFT**Positive Approaches****HISTORY:**

Beginning in the late 1980's, the Office of Mental Retardation (OMR) supported the "Positive Approaches" networks and trainings, which stemmed from a grassroots movement made up of people receiving services, families, friends and supporters who advocated for individuals with MR to have more control over their own lives. They addressed issues such as reducing and eliminating restrictive and aversive procedures, maintaining contacts with family and friends and interacting with the community. They also developed practices, supports, trainings and publications that came to be known as "Positive Approaches."

PURPOSE:

The purpose of "Positive Approaches" is to support individual growth and development, to enable people to make their own decisions, achieve their personal goals, develop relationships, and enjoy life as full, participating members of the community.

The Concept of "Positive Approaches":

- enables people to achieve self-determination by supporting them to grow and develop, make their own decisions, achieve their personal goals, develop relationships and enjoy life as full members of the community;
- involves working WITH people rather than FOR people;
- requires getting to know each person by examining all aspects of the person's life, including each person's living environment, relationships, activities, personal dreams, unique qualities, and personal history;
- requires that all people involved are comfortable enough to speak freely, that we listen carefully and respectfully, take each person seriously, and honor what we hear;
- encourages us to see that all behavior has meaning and that an individual's behavior can be a method to communicate needs and wants, or the manifestation of clinical issues, which lead to the development of viable alternatives and eliminate the need to rely on aversive and coercive methods; and
- measures success by the satisfaction of the person being supported.

"Positive Approaches" requires the ongoing effort of the entire support team to establish and ensure the likelihood that each individual will achieve an "everyday life" based on the principles of "Everyday Lives", which are choice, control, quality, stability, safety, individuality, relationships, freedom, success, contributing to the community, accountability, mentoring, and collaboration. The team must attempt to look through the eyes and experiences of individuals and listen to their words, look at their actions, pay attention to their reactions, and attempt to identify what might be missing from their lives.

"Positive Approaches" requires continually exploring, educating, and advocating for creative and innovative ways for individuals to regain or establish their own "everyday lives."

Attachment #2 - DRAFT

**Guidelines for Addressing the Individual's Core Values in the ISP
And
For Supports Coordinator Supervisors to Use for Plan Review**

OMR is discussing the development of guidelines for Supports Coordinator Supervisors to use as criteria for plan review to ensure that the "Everyday Lives" Core Values are incorporated into the ISP. The following are statements describing each of the "Everyday Lives" Core Values, along with a quality indicator and guiding questions for the team, individual and family to consider when developing Outcomes for the year. The goal is to pilot these statements first before using them as criteria for plan approval. Teams are strongly encouraged to use this document during the ISP planning process to ensure that the plan meets criteria.

Accountability

Government (state and county), agencies, and support people are responsible for carrying out their roles, obligations and activities.

Quality Indicator: The plan clearly defines who will do what as identified in the "Outcomes," "Outcome Actions," "Health Promotions," and "Financial Issues" sections of the plan.

Guiding Questions:

1. Does the ISP clearly state who is responsible for each Outcome?
2. Do the Outcomes and Action Plans developed support and promote the Individual Preferences and needs identified in the plan?
3. Does the ISP identify all the supports that the individual is receiving that he or she needs, when he or she needs them, and who is responsible for providing them?
4. Has the individual lost or is he or she in danger of losing supports that he or she needs? If so, what steps have been included in the ISP to accommodate, restore, or prevent the loss of those services?

Choice and Control

Having the power to make decisions in all areas of life and the power or authority to influence and direct decisions over all aspects of life

Quality Indicator: The plan provides documentation that the individual has the power to make, influence and direct decisions in all aspects of his or her life.

Guiding Questions:

1. Does the information gathering include how the individual makes choices and exercises control in his or her life as well as the barriers to making choices?
2. Does the information gathering and Action Plan describe and promote the type of supports needed for the individual to make choices and exercise control in all areas of his or her life?

3. Do the information gathering and Outcome sections of the plan reflect the individual's style of communication and identify steps to promote increased access to communication?

Community Inclusion and Contribution to the Community

Having opportunities to participate in the community and pursue chosen interests and relationships; a sense of fellowship, social connection, participation, sharing something in common with other people in the same area, town, etc.

Quality Indicator: The plan represents actions that connect the individual to the community and provides evidence that the individual is supported to contribute to the community in ways that he/she values and chooses.

Guiding Questions:

1. Does the Outcome and Action Planning support the individual in exercising his/her choices and rights to actively participate in and contribute to his/her community?
2. Is the plan individualized to support the individual in developing, maintaining, or enhancing community connections and relationships?

Collaboration

All people/ community /services /systems, etc. involved with the individual are communicating, cooperating, aiding each other, and working together to support the individual in achieving or maintaining his or her "everyday life?"

Quality Indicator: The plan provides evidence of communication and cooperation between all people and entities involved in planning with and supporting the individual.

Guiding Questions:

1. Does the ISP include what collaborative planning is needed for a seamless bridge to support the individual's movement through various life events (i.e. changing jobs, new living arrangement, graduation, etc.)?
2. Is the individual included and supported as needed in the collaborative process with the people/ community/ services/ systems?

Freedom

The individual has the freedom to have the life he or she wants and to negotiate risk.

Quality Indicator: The plan provides evidence of respect and support for the individual's liberty and rights (including taking risks, determining the course of one's life and living the life one chooses without being stigmatized or under another's control).

Guiding Questions:

1. Does the individual's ISP reflect his or her freedom to express wants, needs, satisfaction and dissatisfaction in his or her everyday life?
2. Does the individual have the opportunity to exercise the rights that are afforded to all citizens?

3. Does the plan reflect the individual's expressions and the type and level of support necessary for the individual to pursue a self-determined life?
4. Does the plan provide evidence of efforts to ensure that the individual has the knowledge, experience and opportunities necessary to make informed decisions?

Individuality

Being known for their distinguishing character or qualities; being called by their name, and having privacy

Quality Indicator: The plan provides evidence of respect and support of the characteristics, qualities, hopes, and dreams that make the individual unique.

Guiding Questions:

1. Are the "Individual Preferences" sections of the plan individualized and descriptive of the positive traits, qualities, preferences, hobbies, hopes, and dreams for the future, etc. that illustrate the uniqueness of the individual?
2. Does the action plan clearly describe the type and level of support necessary for the individual to pursue his or her hopes and dreams and participate in preferred activities?
3. Does the information gathering and action plan outline, promote and respect the privacy needs and wants of the individual (his or her mail, files, history, personal life, personal space, need for down time, etc.)?

Mentoring

Learning from and working with trained people with disabilities and families toward increased understanding until they can do things on their own.

Quality Indicator: The plan reflects and promotes the individual's awareness or expression of interest in a mentoring experience.

Guiding Questions:

1. Has mentoring been explained to the individual and his or family?
2. Does the individual or his or her family know where to get mentoring advice/information?
3. Does the individual or family member want additional information or training available through mentorship?
4. Is the individual or his or her family interested in becoming a mentor and are the needed supports reflected in the ISP?
5. Does the information gathering and planning reflect the supports needed for the individual to access mentoring?

Quality

Quality of life determined by the individual; having a life encompassing all core values of "Everyday Lives".

Quality Indicator: The plan provides documentation that the Outcomes to be achieved reflect what is important to the individual and are within the context of his or her everyday life.

Guiding Questions:

1. Are the core values of “Everyday Lives” evidenced in the individual’s ISP and life?
2. Are the supports that enable the individual to achieve or maintain the life that he or she desires included in the ISP?
3. Are the people responsible for supporting the individual to achieve his or her Outcomes clearly defined in the ISP?
4. Are clear timeframes set for achieving the Outcomes in the plan?
5. Are the Outcomes sections of the plan individualized (based on personal preferences, wants and desires) and written to be achievable within the context of the individual’s everyday life?
6. Do the Outcome Actions consider obstacles or barriers to achieving the Outcomes along with strategies to address all identified obstacles or barriers?

Relationships

The ISP supports and promotes the individual’s connection to community, a sense of belonging to family, and close associations with friends and loved ones.

Quality Indicator: The plan documents and supports the individual’s personal relationships (including family, friends, partners, community connections, etc.).

Guiding Questions:

1. Does the plan identify people with whom the individual has personal relationships (including family, friends, partners, community connections, etc.)?
2. Are the supports needed to maintain and develop the individual’s relationships with family and friends who are important to him or her included in the ISP and Action Planning?
3. Does the ISP include meaningful activities which provide and expand community connections for the individual to meet, develop and nurture a variety of relationships?

Safety

The plan ensures freedom from harm or danger in the individual’s everyday life without being overly protective or restricting the individual’s supports and services.

Quality Indicator: The plan provides evidence of efforts to ensure the individual’s health and safety without being overly protective.

Guiding Questions:

1. Are the Health and Safety focus areas of the plan individualized and clearly addressed in the individual’s environment, both community and residential?
2. Does the ISP reflect and incorporate the individual’s demonstrated safety skills in a way that advances the individual’s life experience without being overly protective?
3. Do the Action Plan(s) and Health Promotion Section of the ISP reflect a balance between what is important TO the individual and what is important FOR the individual?

Stability

Changes in the individual's life are only made with his or her input and support, agreement, approval or permission.

Quality Indicator: Changes to the plan reflect the individual's input and support, agreement, approval, or permission.

Guiding Questions:

1. Is there evidence in the plan that changes in the individual's life (including life experiences, options and availability of supports and services, staffing, etc.) are presented and shared with the individual and his or her family along with opportunities for them to provide feedback regarding those changes?
2. Does the plan demonstrate that the individual has the primary influence over changes that occur in his or her life?
3. Does information gathering and planning show consistent and available access to things and people that are meaningful to the individual?

Success

Accomplishing or gaining something desired, intended or attempted that brings fulfillment and happiness to the individual

Quality Indicator: The plan provides evidence that the individual is supported to experience big successes or small celebrations in areas of his or her choosing (including employment, independence, financial prosperity, etc.).

Guiding Questions:

1. Does the plan clearly describe areas in which the individual would like to strive for and experience success (including areas such as employment, independence, financial prosperity, relationships, etc.)?
2. Do the ISP Outcomes and Action Plans incorporate the individual's abilities, capacities, gifts and interests in providing opportunities to expand his or her successful experiences?
3. Do the ISP and Action Planning provide the individual with the necessary supports to successfully incorporate his or her desires and values into an "everyday life?"

Attachment #3 - DRAFT**“Person Centered Planning”**

In 1993, the Office of Mental Retardation published “*Finding A Way Toward Everyday Lives, The Contribution of Person Centered Planning.*” This document introduced the concepts of “Positive Approaches” and “Everyday Lives” into the Annual Review process by emphasizing the importance of empowering the person receiving services to drive and direct the planning process. Since then, OMR has supported numerous trainings on “Person Centered Planning” across Pennsylvania.

Key components of “Person Centered Planning”:

- **Action oriented** – Planning identifies effective ways to address concerns and/or barriers that may interfere with attaining Outcomes.
- **Collaborative and Respectful** –The individual and people who are important to and know the individual best are always viewed as experts in the development of the ISP.
- **Community focused** –The person’s membership and participation in the community is valued and supported.
- **Individualized** – Outcomes, services, and supports reflect what is important to the individual and are tailored for the individual and the Outcomes they wish to achieve.
- **Outcome based** – Planning focuses on what is important to the person to have a meaningful, quality everyday life.
- **Process based** – Involves an open exchange that allows the team to be guided by the individual. Discussions are facilitated to help a person describe how they want to live and to engage others in making this happen.
- **Skill, gift, talent based** – The focus is on discovering each person’s strengths and capacities by understanding the person’s interests, sources of pride and talents that are already present, as well as identifying emerging gifts and interests to be nurtured.
- **Supportive to the individual** – Time is taken to determine what is needed to assist the individual in creating a quality everyday life.

Attachment #4 - DRAFT

ISP Activities Timeline and Role Clarification

Days Before ISP Due Date	Activity	Supports Coordinator (SC)	Administrative Entity/County	Providers	Individuals and Families
90	Information Gathering	<p>Coordinate information gathering and assessment activity, including the Supports Intensity Scale Plus (SIS Plus)</p> <p>Collaborate with individual/family/provider agency/team to coordinate invitations and ISP/Annual Review meetings dates, times, and locations</p> <p>Coordinate invitations with individual/family, send out invitations, and file copies</p> <p>Record relevant assessment information into ISP in HCSIS</p> <p>Review and share assessment results, monitoring results, and incident reports with individual and family. Include external reviews.</p> <p>Enter information into ISP Draft</p>	If not initial ISP, provide funded amount and last year's expenditures before ISP Meeting	<p>If not initial ISP:</p> <p>Receive invitation</p> <p>Complete assessments and send to SC in an ISP-ready format</p>	<p>Respond to communication from SC to coordinate invitations and establish ISP/Annual Review meetings, dates, times, and locations</p> <p>Receive invitation</p> <p>Provide assessment information</p> <p>Review assessment results</p> <p>Choose Services/Provider</p>
	ISP Meeting/ Annual Review	Conduct ISP meeting/Annual Review with individual/family, and team to adapt or create Outcomes and identify services and supports to address those Outcomes	Attend and participate in ISP Meeting/Annual Review (optional)	Attend and participate in Annual Review	Attend and participate in ISP Meeting/ Annual Review
60	Documentation	<p>Complete ISP in HCSIS, contact Administrative Entity/County if total cost of services exceeds funded amount, submit completed ISP to Supervisor for review, and respond to revision request</p> <p>Complete/update PUNS with individual/family if OMR services are not available</p> <p>Search Services and Supports Directory and select services for Outcomes based upon individual's/family's choices</p>	If initial ISP or if financial need changes, provide funded amount after Annual Review		
	Approval	<p>Submit ISP to County for approval</p> <p>Receive and respond to alert for approval notice or revision request</p>	Approve ISP in HCSIS or request revisions		
	Financial Authorization	<p>Receive and respond to alert for authorization notice or revision request</p>	<p>Authorize services in HCSIS or request revisions</p> <p>Send authorizations to Providers</p>	Receive authorization	Receive authorization
14	Distribution	<p>Notify Providers plan is approved and available in HCSIS</p> <p>Send approved ISP to team members who cannot access HCSIS</p>		Receive ISP	Receive ISP
0	Service Implementation	Monitor services after implementation		Implement services	Receive services

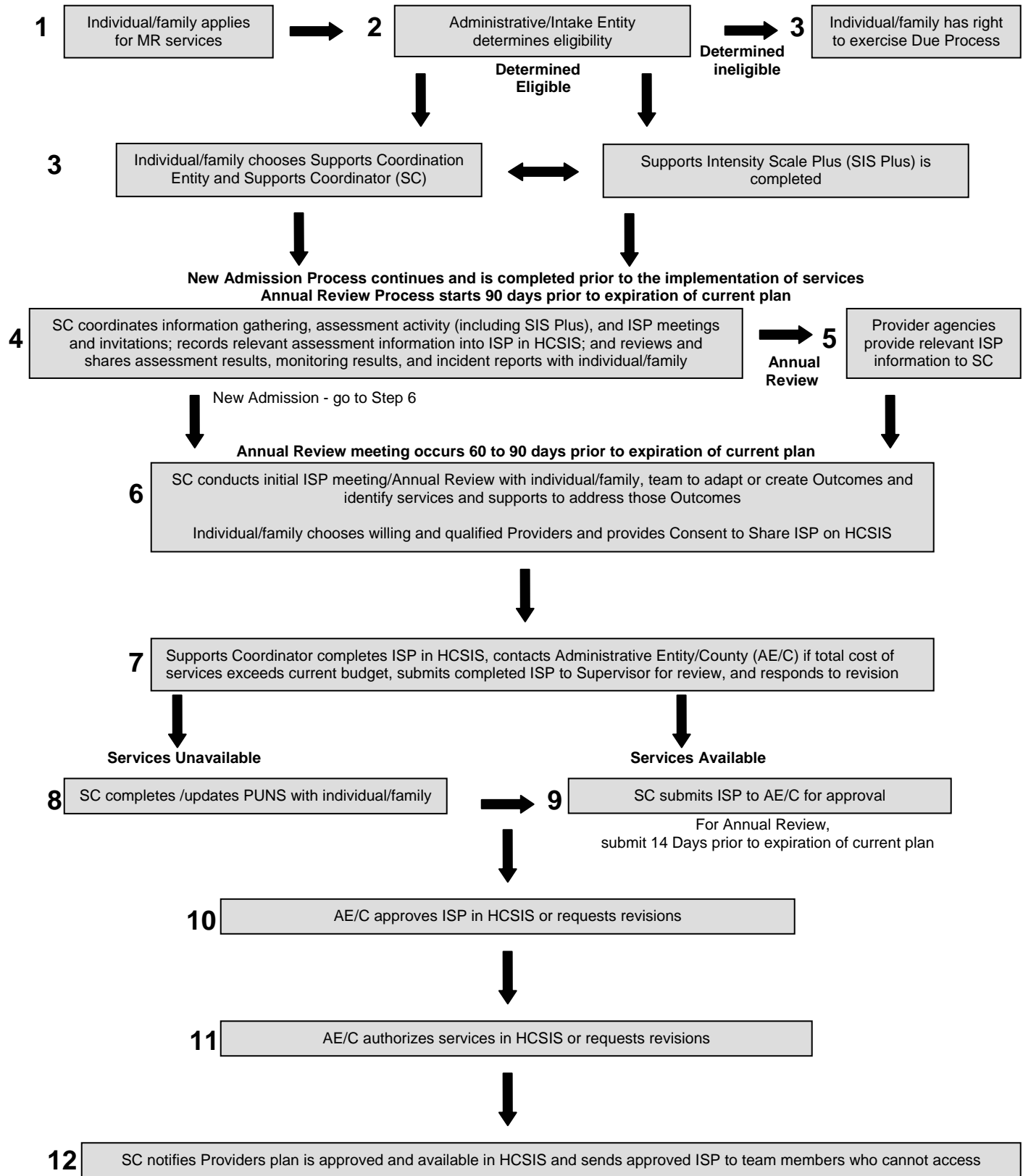
The purpose of the ISP Activities Timeline and Role Clarification document is to provide families, individual, providers, Administrative Entities/Countries, and Supports Coordination Entities with a guideline for expectations regarding time frames and who will complete various steps in the process. Although there is some latitude in the planning process, the requirement is that the ISP must be completed, approved, and authorized before services are implemented and/or before the current plan expires.

QUESTIONS AND COMMENTS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO THE APPROPRIATE REGIONAL PROGRAM OFFICE

Attachment #5 - DRAFT

ISP Process Flow Chart

New Admission



QUESTIONS AND COMMENTS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO THE APPROPRIATE REGIONAL PROGRAM OFFICE

Attachment #6 - DRAFT

Individual Support Plan
Attendance Sheet and Concurrence/Due Process Notification

Individual Support Plan for:
Master Client Identification:

ISP/Annual Review meeting date(s):
Service Implementation Start Date: End Date:

CONFIDENTIALITY NOTICE: My signature indicates that I recognize the confidentiality of all individual-related information, both verbal and written, received during this Individual Support Plan meeting.

Table with 4 columns: Print name, Signature, Contact Information, Present: (Yes/No checkboxes). Rows include Individual, Family Member, Advocate, Supports Coordinator, Residential Provider, Day Program, and Other Service Provider.

* If not present at meeting, please provide an explanation.
+If not present at meeting, please provide an explanation and document how plan was reviewed with individual.

Have a concern or an issue that has not been addressed in a satisfactory manner? Contact:

Table with 4 columns: Administrative Entity, Name, Phone, OMR Customer Service Number. Value: 1-888-565-9435

I have been notified of my right to choose a supports coordination entity. Yes No

I have been notified of my right to choose a willing and qualified provider for Waiver services. Yes No

I consent to the services in my individual plan. This consent is made with the understanding that I have the right to request a change in these services at anytime. Yes No

The supports coordinator has reviewed the information that will be included in the plan with me. Yes No

I agree that the information included in the plan is appropriate to the plan. Yes No

If the information included in the plan is not appropriate, I wish to meet with the supports coordinator to discuss the plan before it is shared with other team members and providers of service. Yes No

I acknowledge that I (or my representative) have been informed of my rights to an Administration Entity meeting, independent mediation, and Fair Hearing and Appeal at my planning meeting. Yes No N/A

Signature: (Individual, parent, or guardian) Date:

Attachment #7 - DRAFT**Individual Support Plan Key Terms**

Abbreviated Plan – a shortened ISP that can be used for someone who receives under \$2,000 in non-waiver services. An example of an abbreviated plan could be Family Supports Services (FSS) (Family Driven) or Life Management Plan. When completing an abbreviated plan, the following minimum screens must be completed:

- Demographics
- Outcome Summary
- Outcome Actions
- Services and Supports Directory (Provider, Vendor, and/or ISO)
- Service Details

Administrative entity – a county/joinder or non-governmental entity that performs waiver operational and administrative functions delegated by the Department, under the Department's approved Consolidated and Person/Family Directed Support Waivers.

Alert - an electronic message triggered from an action in HCSIS to inform the user of an event that occurred or did not occur as expected within the system. Alerts may be used for informational, reminder or escalation purposes.

Annual Review/ISP Meeting – Part of the ISP process that includes the review of the information gathered, outcome development, identification of services and supports, and choosing a provider.

Annual Review Date – for the ISP is the date that the plan will be implemented. Monthly and quarterly reviews originate from this date.

Bi-annual Review - used for ISP's requiring reviews twice a year, or every six months. Can be used to edit or update an existing plan.

Consent To Share Plan – the individual and his or her guardian or advocate provide consent regarding whether or not providers can access the ISP online in HCSIS after it is approved.

Critical Revision – a revision to the ISP when a plan changes because of a major life change or emergency, such as a waiver transfer, a change in services or a change in the amount of funding.

Desired Activities – a section in the ISP used to record activities that the individual would like to continue, begin, or explore further.

Draft Plan – is created in HCSIS as a plan that can be edited or used to add or change information in a plan.

Eligibility - the functional qualification of an individual to receive MR services funded by OMR.

General Update –a revision to the ISP that is used to update demographic or medical information, not when modifying services and supports.

Important To – is a section of the ISP that lists and prioritizes things that are important to the individual, need to stay the same in the individual's life, and/or changes that would be important for the team to address. Things that are important to an individual should be linked to outcomes.

Essential - must be present in the individual's life in order for a good day to occur.

Strongly desired - would strongly contribute to the individual's happiness, but, would not be detrimental to their well being if not present.

Independent Monitoring for Quality (IM4Q) - part of the larger Monitoring for Quality (M4Q) initiative to collect and track outcome measures from the Core Indicators Survey and the Independent Monitoring Survey

Individual Monitoring - the regularly scheduled and ongoing monitoring of an individual's plan to ensure that services and supports are provided as indicated on the plan.

Individual Support Plan (ISP) - an individual's summary of their planned services and supports, identified as a result of the individual, family, and Supports Coordinator's review of preferences, outcomes, health and safety information, and medical information. The ISP is used to ensure that publicly funded services and supports meet assessed needs and are in keeping with the individual's preferences.

ISP: Traditional Model vs. Fiscal Year Model - The Traditional Model ISP refers to plans that span two fiscal years. The Fiscal Year Model ISP refers to plans that are dated based on the fiscal year, i.e. plan effective dates do not cross the fiscal year end date of 6/30. With the implementation of the "Individual Support Plan Process" Bulletin all plans will be on the fiscal year.

Intermediate Care Facility for the Mentally Retarded (ICF/MR) - a state operated or non-state operated facility, licensed by the department in accordance with Chapter 6600 relating to intermediate care facilities for the mentally retarded, providing a level of care specially designed to meet the needs of persons who are mentally retarded, or persons with related conditions who require specialized health and rehabilitative services.

Like and Admire – a section of the ISP, that is a list of attributes that people like and find admirable about the individual.

Know and Do – a section of the ISP that describes information that people who support the individual need to know and do in order for the individual to get what is important to him or her or for him or her to stay healthy and safe.

Monitoring for Quality (M4Q) - an integral part of HCSIS that will collect data and track outcome trends from each of the quality management initiatives: Waiver Monitoring, the Health Risk Profile and Incident Management processes.

Outcomes – describe in the ISP what is currently important for the individual to work on or maintain; changes an individual would like to see for him or herself. Outcomes are based on priorities identified by the individual and his or her family, are responsive to formal and informal information gathering, and are linked to the appropriate informal and formal supports and services. Outcomes supported by MR funds must be in the context of supporting the health and safety of the individual and assuring their continued life in the community. Outcomes that address other priorities of the individual should be represented and supported with other community, family, or non-traditional support services.

Plan Creation –a term used in the ISP in HCSIS if a plan is being created for the first time or if there needs to be a time-span between two plans. The Supports Coordinator role sets proposed plan start and end dates.

Prioritization of Urgency of Needs for Services (PUNS) - current process for categorizing a person's need for services; focuses on the existing services and supports received by the individual, the prioritization of urgency of need for requested services, and the categories of services needed. This information is used by counties to prioritize waiting lists and for budgeting.

Emergency Need - indicates an immediate need for MR services.

Critical Need - indicates the need for MR services within the next year.

Planning for Need - indicates a need for MR services greater than one year but less than five years in the future.

Qualified Mental Retardation Professional (QMRP) – person in this position who certifies that the individual has impairment in adaptive behavior based on the results of a standardized assessment of adaptive functioning. The person in this position must meet specific requirements that include at least one year of experience working directly with persons with mental retardation or developmental disability and hold at least a bachelor's degree.

Qualified Provider – a professional or agency that meets the qualifications that are specified in the current approved Consolidated and Person/Family Directed Support Waivers for the service that the Provider renders.

Quarterly Review - used by the provider agency Program Specialist for ISP's that must be reviewed at least every 3 months or four times a year originating from the date of the Annual Review. This form is used when conducting Quarterly Reviews.

Service Notes – documentation of meetings and other contacts with an individual, the individual's family or other support staff that will be completed in HCSIS

Services and Supports Directory – an on-line database of all the service providers registered in HCSIS that is accessible to families and individuals during the registration process to locate providers within a geographic area. The directory is intended to expand individuals' ability to make informed choices.

Start Date – within a fiscal year model, begins with the fiscal year. The services are authorized based on the fiscal year.

Supports Coordinators - facilitate individual plan development, locate provider services, coordinate the provision of services and supports, and monitor services and supports.

Supports Coordination Entity (SC Entity) - any organization that has been approved to provide supports coordination services within a county.

Supports, Natural - unpaid assistance to an individual provided by family and friends.

Supports, Community - services or organizations available within the individual's community.

What Makes Sense – a section of the ISP used to capture information about what experiences do and do not make sense in the life of the individual RIGHT NOW; the aspect of the planning process that bridges the gap between what is important to and for the individual, and the specific actions that will be taken to ensure that those things occur in balance; helps to set the agenda for what should be changed and what needs to continue.

Willing provider –a provider who agrees to accept the State payment as payment in full for rendering a service and to abide by all the Medicaid provider requirements, including executing a provider agreement.

Attachment #8 - DRAFT

ISP

PA Code

Title 55

Crosswalks

The ISP PA Code Title 55 Crosswalks document lists licensing regulations as they apply to sections of the ISP. The right side of the table contains sections of the ISP, and the left side contains the applicable regulations. There are different crosswalk documents for each of the following regulation chapters:

- Chapter 2380 – Adult Training Facilities
- Chapter 2390 – Vocational Facilities

- Chapter 6400 – Community Homes for Individuals with Mental Retardation
- Chapter 6500 – Family Living Homes

ISP/PA Code Title 55
Chapter 2380 – Adult Training Facilities

ISP	Chapter 2380 Regulation
<p><u>ANNUAL REVIEW</u> 2380.102, 103, 104, and 105</p> <p>The plan must start after the existing plan ends.</p> <p><u>CRITICAL REVISION</u> 2380.102, 103, 104, and 105</p> <p>Used when individual supports, services, or funding changes in the existing or future plan. Upon admission, a critical revision or a new plan should be completed.</p> <p><u>PLAN CREATION</u> 2380.102, 103, and 105</p> <p>Used when plan is being created for first time.</p>	<p><u>§ 2380.102. Assessment.</u></p> <p>(a) Each individual shall have a written assessment within 1 year prior to or 20 individual attendance days after admission and annually thereafter.</p> <p>(b) The assessment shall be completed and updated, or coordinated, by the program specialist.</p> <p>(c) The program specialist shall sign and date the assessment.</p> <p>(d) The assessment shall be based on assessment instruments, interviews, progress notes and observations.</p> <p>(e) The assessment shall include the following information:</p> <ol style="list-style-type: none"> (1) Functional strengths, needs and wants of the individual. (2) The likes, dislikes and interests of the individual. (3) The individual's current level of performance and progress in the areas of the acquisition of functional skills, personal needs, communication and personal adjustment. (4) The individual's need for supervision. (5) If the individual is not able to self-administer medications, the individual's progress toward self-administration. (6) Documentation of the individual's disability, including functional and medical limitations. (7) A lifetime medical history. (8) Additional evaluations as necessary. <p>(f) A copy of the assessment shall be kept in the individual's record. The individual, the individual's parent, guardian, advocate or residential service provider, if appropriate, and the funding agency, if applicable, shall be informed of the results of the assessment. Documentation of transmittal of this information shall be kept.</p> <p><u>§ 2380.103. Development of IPP.</u></p> <p>(a) An IPP shall be developed for each individual based upon the individual assessment, within 30 individual attendance days after the individual's admission date.</p> <p>(b) The IPP shall be developed by the interdisciplinary team.</p> <p>(c) Members of the interdisciplinary team shall include the individual, the program specialist, the individual's parent, guardian or advocate, if appropriate, direct service staff persons who work with the individual, staff persons from the funding agency, staff persons from the individual's residential program, if applicable, and other specialists, such as medical, nursing, behavior management, speech, occupational or physical therapy specialists if appropriate for the individual's special needs.</p> <p>(d) At least three members of the interdisciplinary team, in addition to the individual if the individual chooses to attend, shall be present at the interdisciplinary team meeting at which the IPP is developed. Members of the interdisciplinary team who attend the meeting to develop the IPP shall sign and date the IPP.</p> <p><u>§ 2380.104. Review, update and rewrite of IPP.</u></p> <p>(a) A review of each individual's progress on the IPP, and a revision of the IPP if necessary, shall be completed or coordinated by the program specialist at least every</p>

	<p>65 individual attendance days.</p> <p>(b) The IPP shall be revised in accordance with subsection (a) if there has been no progress on a goal, if a goal is no longer appropriate or if a goal needs to be added.</p> <p>(c) The IPP shall be reviewed and rewritten by the interdisciplinary team at least annually.</p> <p>(d) At least three members of the interdisciplinary team, in addition to the individual if the individual chooses to attend, shall be present at the annual interdisciplinary team meeting at which the IPP is reviewed and rewritten.</p> <p>(e) Members of the interdisciplinary team who attend the meeting to rewrite the IPP shall sign and date the new IPP.</p> <p>The IPP shall be discussed with, dated by and signed by the individual, the individual's parent, guardian or advocate if appropriate, and the program specialist after each 65-day review and annual rewrite of the IPP.</p> <p><u>§ 2380.105. Participation in the development of the IPP.</u> The individual's parent, guardian or advocate, if appropriate, and the funding agency shall be invited, in writing, to participate in the initial development and annual rewrite of the IPP. A copy of the written invitations shall be kept.</p> <p><u>§ 2380.108. Copies of IPP.</u> (a) A written copy of IPPs and adjustments made during reviews shall be kept in the individual's record. (b) The individual, the individual's parent, guardian or advocate, if appropriate, the residential service provider, if applicable, and the funding agency shall be provided with a copy of all IPPs. Documentation of transmittal of each IPP shall be kept.</p>
<p><u>QUARTERLY REVIEW</u> Used for ISP's that must be reviewed at least every 3 months originating from the date of the Annual Review.</p>	
<p><u>INDIVIDUAL PREFERENCES:</u> Like and Admire Know and Do Desired Activities Important To What Makes Sense</p>	
<p><u>MEDICAL</u> Medications/ Supplements (and treatments) Allergies Health evaluations Medical contacts Medical history</p>	
<p><u>HEALTH & SAFETY</u> General health & safety risks Fire safety Traffic Cooking/appliance use Outdoor appliances Water safety (including temperature regulation) Safety precautions Knowledge of self-identifying information Stranger awareness Meals/eating Supervision Care Needs Behavioral support plan Health care</p>	

Health promotion	
<u>FUNCTIONAL INFORMATION:</u> Functional level Educational/vocational Employment Understanding communication Other non-medical evaluation	
<u>FINANCIAL</u> Financial information Financial management Financial resources	
<u>SERVICES AND SUPPORTS</u> Outcome summary Outcome actions	<p><u>§ 2380.101. Program activities.</u></p> <p>(a) Program activities shall include assistance, training and support for the acquisition of functional skills, personal needs, communication and personal adjustment.</p> <p>(b) The facility shall provide opportunities and support for participation in community life, including work opportunities.</p> <p>(c) Program activities shall be provided as specified in each IPP. Program activities shall be age and functionally appropriate.</p> <p><u>§ 2380.106. Content of IPP.</u></p> <p>Each IPP shall include:</p> <ol style="list-style-type: none"> (1) The goals for the individual in specific areas of growth and development. (2) An evaluation of the individual's skill level for each goal. (3) Monthly documentation of the individual's progress on each goal. (4) Specific activities and services that meet the needs of the individual. (5) A program and schedule for allowing the individual to be without direct staff supervision for specific periods of time, aimed at achieving a greater level of independence, if the individual's assessment states the individual may be without direct supervision. <p>A planned program to address the social, emotional and environmental needs of the individual, if a medication is prescribed to treat maladaptive behavior.</p> <p><u>2380.107. Implementation of IPP.</u></p> <p>Each IPP shall be implemented as written.</p>

**ISP/PA Code Title 55
Chapter 2390 – Vocational Facilities**

ISP	Chapter 2390 Regulation
<p><u>ANNUAL REVIEW</u> 2390.94, 95, 96, 97, 98, 100</p> <p>The plan must start after the existing plan ends.</p> <p><u>CRITICAL REVISION</u> 2390.94, 95, 96, 97, 98, 100</p> <p>Used when individual supports, services, or funding changes in the existing or future plan. Upon admission, a critical revision or a new plan should be completed.</p> <p><u>PLAN CREATION</u> 2390.94, 95, 96, 98, 100</p> <p>Used when plan is being created for first time.</p>	<p><u>§ 2390.94. Initial assessment.</u></p> <p>(a) A client shall have an initial written assessment within 20 client attendance days of admission.</p> <p>(b) The assessment shall be performed by the program specialist or the vocational evaluator.</p> <p>(c) A copy of the written assessment shall be kept in the client's file.</p> <p>(d) The written assessment shall include the following information:</p> <ol style="list-style-type: none"> (1) Documentation of the client's disability including functional and medical limitations. (2) The client's current level of vocational functioning. (3) The vocational interests of the client. (4) The client's ability to receive, retain and carry out instructions. (5) The recommendations for specific areas of training or placement. <p>(e) The client, or parent or guardian when appropriate, shall be informed of the results of the assessment. A statement acknowledging receipt of this information shall be signed by the client, parent or guardian and kept in the client's file.</p> <p><u>§ 2390.95. Development of individual written program plan.</u></p> <p>(a) An individual written program plan shall be developed for a client within 30 client attendance days of the client's admission date.</p> <p>(b) The plan shall be developed by the interdisciplinary team. The members of the interdisciplinary team shall sign and date the plan.</p> <p><u>§ 2390.96. Content of individual written program plan.</u></p> <p>The plan shall include the following information:</p> <ol style="list-style-type: none"> (1) Specific short-term objectives including measurable steps for completion. (2) Evaluation of client's current skill level in the area of the objective. (3) Time frames for expected completion of objectives. (4) Method of evaluation used to determine mastery of objective. (5) Service areas to which the client will be assigned. (6) Staff responsible for the outcome of the individual written program plan. (7) Assessment of the client's placement potential. <p><u>2390.97. Review, update and rewrite of individual written program plan.</u></p> <p>(a) The plan for clients, except those clients in a training program, shall be reviewed and updated by the program specialist at least every 65 client attendance days.</p> <p>(b) The plan for clients in a training program shall be reviewed and updated by the program specialist at least every 20 client attendance days.</p> <p>(c) The plan shall be discussed with the client and signed by the program specialist and the client and dated after each review.</p> <p>(d) The plan shall be reviewed and rewritten by the interdisciplinary team at least annually. The members of the interdisciplinary team shall sign and date the revised plan.</p> <p><u>§ 2390.98. Copies of individual written program plan.</u></p> <p>(a) A written copy of the plan and adjustments made during reviews shall be kept in the client's file.</p> <p>(b) The client, or parent or guardian when appropriate, shall be invited, in writing, to</p>

	<p>participate in the initial development and reviews of the program plan. A copy of the written invitations shall be kept in the client's file. A client, parent or guardian shall be provided with a copy of a plan.</p> <p><u>§ 2390.100. Vocational evaluation.</u> If the facility provides vocational evaluation, the following apply: (1) Evaluations shall be performed by the vocational evaluator. (2) A copy of the written evaluation shall be kept in the client's file. (3) The written evaluation shall include the following information: (i) The client's current level of vocational functioning. (ii) The employment objectives for the client. (iii) The vocational interests of the client. (iv) The client's level of personal and social adjustment. (v) The client's work attitude. (vi) The client's fatigue levels. (vii) The client's ability to receive, retain and carry out instructions. (viii) The recommendations for specific areas of training or placement. (4) The client, parent or guardian shall be informed of the results of the evaluation. A statement acknowledging receipt of this information shall be signed by the client, parent or guardian and kept in the client's file.</p>
<p><u>QUARTERLY REVIEW</u> Used for ISP's that must be reviewed at least every 3 months originating from the date of the Annual Review.</p>	
<p><u>INDIVIDUAL PREFERENCES:</u> Like and Admire Know and Do Desired Activities Important To What Makes Sense</p>	
<p><u>MEDICAL</u> Medications/ Supplements (and treatments) Allergies Health evaluations Medical contacts Medical history</p>	
<p><u>HEALTH & SAFETY</u> General health & safety risks Fire safety Traffic Cooking/appliance use Outdoor appliances Water safety (including temperature regulation) Safety precautions Knowledge of self-identifying information Stranger awareness Meals/eating Supervision Care Needs Behavioral support plan Health care Health promotion</p>	
<p><u>FUNCTIONAL INFORMATION:</u> Functional level Educational/vocational Employment Understanding communication</p>	

Other non-medical evaluation	
<u>FINANCIAL</u> Financial information Financial management Financial resources	
<u>SERVICES AND SUPPORTS</u> Outcome summary Outcome actions	<p><u>§ 2390.91. Activities.</u> Activities for a client shall include work experience and other developmentally oriented, work training activities designed to promote movement into a higher-level vocational program or into competitive employment. Activities shall be provided as specified in the individual written program plan.</p> <p><u>§ 2390.93. Developmental programming.</u> During times when there is no work available for clients, the facility shall have work training or planned developmental programming available for the clients.</p> <p><u>§ 2390.99. Interdisciplinary team responsibility for individual written program plan.</u> The interdisciplinary team is responsible for ensuring that the client needs specified in the plan are met.</p>

ISP/PA Code Title 55
Chapter 6400 - Community Homes

ISP	Chapter 6400 Regulation
<p><u>ANNUAL REVIEW</u> 6400.121, 122, 123, and 124</p> <p>The plan must start after the existing plan ends.</p> <p><u>CRITICAL REVISION</u> 6400.121, 122, and 124</p> <p>Used when individual supports, services, or funding changes in the existing or future plan. Upon admission, a critical revision or a new plan should be completed.</p> <p><u>PLAN CREATION</u> 6400.121, 122, and 124</p> <p>Used when plan is being created for first time.</p>	<p><u>§ 6400.121. Assessment.</u></p> <p>(a) An individual shall have a written assessment within 45 calendar days after admission and annually thereafter.</p> <p>(b) The assessment shall be completed and updated, or coordinated, by the program specialist.</p> <p>(c) The program specialist shall sign and date the assessment.</p> <p>(d) The assessment shall be based on assessment instruments, interviews, progress notes and observations.</p> <p>(e) The assessment shall include the following information:</p> <ol style="list-style-type: none"> (1) Documentation of the individual's disability, including functional and medical limitations. (2) An assessment of adaptive behavior and level of skills completed within 6 months prior to admission. (3) A lifetime medical history. (4) The individual's current level of functioning including the ability to perform personal needs activities with or without assistance from others. (5) Functional strengths and needs of the individual. (6) The likes, dislikes and interests of the individual. (7) The individual's level of personal and social adjustment. (8) The individual's progress and growth in the areas of health, motor and communication, activities of residential living, personal adjustment, socialization and recreation and financial independence. (9) The individual's ability to manage the individual's own finances and property. (10) The individual's need for supervision. (11) The individual's ability to safely use or avoid poisonous materials, if poisonous materials are not kept locked or made inaccessible to individuals. (12) The individual's understanding of the danger of heat sources and ability to sense and move away from heat sources quickly, if heat sources exceeding 120°F accessible to the individual are not insulated. (13) The individual's progress toward self-administration, if the individual is not able to self-administer medications. (14) Recommendations for specific areas of training, programming and services. (15) Additional evaluations as necessary. <p>(f) A copy of the assessment shall be kept in the individual's record.</p> <p>(g) The individual, the individual's parent, guardian or advocate, if appropriate, and the county case manager if the individual is funded through the county mental retardation program, shall be informed of the results of the assessment. Documentation of transmittal of this information shall be kept.</p> <p><u>§ 6400.122. Development of the IPP.</u></p> <p>(a) An IPP shall be developed for each individual, based on the individual assessment, within 60 calendar days of the individual's admission date.</p> <p>(b) The IPP shall be developed by an interdisciplinary team.</p> <p>(c) Members of the interdisciplinary team shall include the individual, the individual's direct care staff, the program specialist, the individual's parent, guardian or advocate, if appropriate, the county case manager if the individual is funded through the county mental retardation program, the program specialist for the individual's day program, and other specialists, such as medical, nursing, behavior management, speech, occupational or physical therapy specialists if appropriate for the individual's special needs.</p> <p>(d) At least three members of the interdisciplinary team, in addition to the individual if the individual chooses to attend, shall be present at the interdisciplinary team</p>

	<p>meeting at which the IPP is developed.</p> <p>(e) Members of the interdisciplinary team who attend the meeting to develop the IPP shall sign and date the IPP.</p> <p><u>§ 6400.123. Review, revision and rewrite of the IPP.</u></p> <p>(b) The IPP shall be revised in accordance with subsection (a) if there has been no progress on a goal, if a goal is no longer appropriate or if a goal needs to be added.</p> <p>(c) The IPP shall be reviewed and rewritten by the interdisciplinary team at least annually.</p> <p>(d) At least three members of the interdisciplinary team, in addition to the individual if the individual chooses to attend, shall be present at the annual interdisciplinary team meeting at which the IPP is reviewed and rewritten.</p> <p>(e) Members of the interdisciplinary team who attend the meeting to rewrite the annual IPP shall sign and date the new IPP.</p> <p>(f) The IPP shall be discussed with, dated by and signed by the individual, the individual's parent, guardian or advocate if appropriate and the program specialist after each 3-month review and annual rewrite of the IPP.</p> <p><u>§ 6400.124. Participation in the development of the IPP.</u></p> <p>The individual's parent, guardian or advocate if appropriate and the county case manager if the individual is funded through the county mental retardation program shall be invited, in writing, to participate in the initial development and the annual rewrite of the IPP. A copy of the written invitations shall be kept.</p>
<p><u>QUARTERLY REVIEW</u> Used for ISP's that must be reviewed at least every 3 months originating from the date of the Annual Review.</p>	<p><u>§ 6400.123. Review, revision and rewrite of the IPP.</u></p> <p>(a) A review of each individual's progress on the IPP and a revision of the IPP, if necessary, shall be completed or coordinated by the program specialist at least every 3 months.</p> <p>(b) The IPP shall be revised in accordance with subsection (a) if there has been no progress on a goal, if a goal is no longer appropriate or if a goal needs to be added.</p> <p>(d) At least three members of the interdisciplinary team, in addition to the individual if the individual chooses to attend, shall be present at the annual interdisciplinary team meeting at which the IPP is reviewed and rewritten.</p> <p>(e) Members of the interdisciplinary team who attend the meeting to rewrite the annual IPP shall sign and date the new IPP.</p> <p>(f) The IPP shall be discussed with, dated by and signed by the individual, the individual's parent, guardian or advocate if appropriate and the program specialist after each 3-month review and annual rewrite of the IPP.</p>
<p><u>INDIVIDUAL PREFERENCES:</u> Like and Admire Know and Do Desired Activities Important To What Makes Sense</p>	<p><u>§ 6400.121. Assessment</u></p> <p>(e) The assessment shall include the following information:</p> <p>(4) The individual's current level of functioning including the ability to perform personal needs activities with or without assistance from others.</p> <p>(5) Functional strengths and needs of the individual.</p> <p>(6) The likes, dislikes and interests of the individual.</p> <p>(10) The individual's need for supervision.</p> <p>(14) Recommendations for specific areas of training, programming and services.</p>
<p><u>MEDICAL</u> Medications/ Supplements (and treatments) Allergies Health evaluations Medical contacts Medical history</p>	<p><u>§ 6400.121. Assessment</u></p> <p>(e) The assessment shall include the following information:</p> <p>(1) Documentation of the individual's disability, including functional and medical limitations.</p> <p>(3) A lifetime medical history.</p> <p>(4) The individual's current level of functioning including the ability to perform personal needs activities with or without assistance from others.</p> <p>(5) Functional strengths and needs of the individual.</p> <p>(8) The individual's progress and growth in the areas of health, motor and communication, activities of residential living, personal adjustment, socialization and recreation and financial independence.</p> <p>(10) The individual's need for supervision.</p> <p>(13) The individual's progress toward self-administration, if the individual is not able to self-administer medications.</p> <p>(14) Recommendations for specific areas of training, programming and services.</p>

<p><u>HEALTH & SAFETY</u> General health & safety risks Fire safety Traffic Cooking/appliance use Outdoor appliances Water safety (including temperature regulation) Safety precautions Knowledge of self-identifying information Stranger awareness Meals/eating Supervision Care Needs Behavioral support plan Health care Health promotion</p>	<p><u>§ 6400.121. Assessment</u> (e) The assessment shall include the following information: (4) The individual's current level of functioning including the ability to perform personal needs activities with or without assistance from others. (5) Functional strengths and needs of the individual. (7) The individual's level of personal and social adjustment. (8) The individual's progress and growth in the areas of health, motor and communication, activities of residential living, personal adjustment, socialization and recreation and financial independence. (10) The individual's need for supervision. (11) The individual's ability to safely use or avoid poisonous materials, if poisonous materials are not kept locked or made inaccessible to individuals. (12) The individual's understanding of the danger of heat sources and ability to sense and move away from heat sources quickly, if heat sources exceeding 120°F accessible to the individual are not insulated. (14) Recommendations for specific areas of training, programming and services.</p>
<p><u>FUNCTIONAL INFORMATION:</u> Functional level Educational/vocational Employment Understanding communication Other non-medical evaluation</p>	<p><u>§ 6400.121. Assessment</u> (e) The assessment shall include the following information: (1) Documentation of the individual's disability, including functional and medical limitations. (2) An assessment of adaptive behavior and level of skills completed within 6 months prior to admission. (4) The individual's current level of functioning including the ability to perform personal needs activities with or without assistance from others. (5) Functional strengths and needs of the individual. (6) The likes, dislikes and interests of the individual. (8) The individual's progress and growth in the areas of health, motor and communication, activities of residential living, personal adjustment, socialization and recreation and financial independence. (14) Recommendations for specific areas of training, programming and services.</p>
<p><u>FINANCIAL</u> Financial information Financial management Financial resources</p>	<p><u>§ 6400.121. Assessment</u> (e) The assessment shall include the following information: (8) The individual's progress and growth in the areas of health, motor and communication, activities of residential living, personal adjustment, socialization and recreation and financial independence. (9) The individual's ability to manage the individual's own finances and property. (14) Recommendations for specific areas of training, programming and services.</p>
<p><u>SERVICES AND SUPPORTS</u> Outcome summary Outcome actions</p>	<p><u>§ 6400.125. Content of the IPP.</u> An IPP shall include: (1) The goals for the individual in specific areas of growth and development. (2) An evaluation of the individual's skill level for each goal. (3) Monthly documentation of the individual's progress on each goal. (4) A plan for the individual to participate in community life. (5) Specific activities and services that meet the needs of the individual. (6) A program and schedule for allowing the individual to be without direct staff supervision for specific periods of time, aimed at achieving a greater level of independence, if the individual's assessment states the individual may be without direct supervision. (7) A planned program to address the social, emotional and environmental needs of the individual, if a medication is prescribed to treat maladaptive behavior.</p> <p><u>§ 6400.126. Implementation of the IPP.</u> An IPP shall be implemented as written.</p> <p><u>§ 6400.127. Copies of the IPP.</u> (a) A copy of IPPs and adjustments made during reviews shall be kept in the individual's record. (b) The individual, the individual's parent, guardian or advocate, if appropriate, the county case manager if the individual is funded through the county mental retardation program and the individual's day service facility shall be provided a copy of all IPPs. Documentation of transmittal of each IPP shall be kept.</p>

§ 6400.128. Program activities.

(a) Program activities shall include developmental activities and programming designed to advance or maintain the individual's ability to perform personal needs activities without assistance from others. Examples of personal needs activities are physical exercise and training in the areas of toileting, bathing, cooking, eating, self-help, socialization, communication, safety, nutrition, use of public transportation and utilization of community resources.

(b) Staff persons shall provide assistance and training to individuals in personal needs activities as required by each individual.

§ 6400.129. Day services.

(a) Day services or activities, such as employment, education, training and other meaningful activities shall be provided to each individual.

(b) Day services and activities shall be provided at a location other than the building where the individual lives, unless there is written annual documentation by a licensed physician that it is medically necessary for the individual to remain at the home or written annual documentation by the interdisciplinary team that it is in the best interests of the individual to remain at the home.

(c) For homes opened prior to March 15, 1982, subsection (b) is not applicable until November 8, 1994

§ 6400.130. Recreational and social activities.

(a) Recreational and social activities shall be provided at and away from the home. Time away from the home may not be limited to time in school, work, vocational services and developmental training.

(b) Documentation of recreational and social activities shall be kept.

ISP/PA Code Title 55
Chapter 6500 – Family Living Homes

ISP	Chapter 6500 Regulation
<p><u>ANNUAL REVIEW</u> 6500.111, 112, 113, and 114</p> <p>The plan must start after the existing plan ends.</p> <p><u>CRITICAL REVISION</u> 6500.111, 112, 113, and 114</p> <p>Used when individual supports, services, or funding changes in the existing or future plan. Upon admission, a critical revision or a new plan should be completed.</p> <p><u>PLAN CREATION</u> 6500.111, 112, and 114</p> <p>Used when plan is being created for first time.</p>	<p><u>§ 6500.111. Assessment.</u></p> <p>(a) An individual shall have a written assessment:</p> <ol style="list-style-type: none"> (1) Prior to the individual living in the home. (2) Within 60 calendar days after living in the home based on observation of the individual in the home. (3) Annually thereafter. <p>(b) The assessment shall be coordinated by the family living specialist.</p> <p>(c) The family living specialist shall sign and date the assessment.</p> <p>(d) The assessment shall be based on assessment instruments, interviews, progress notes and observations.</p> <p>(e) The assessment shall include the following information:</p> <ol style="list-style-type: none"> (1) Documentation of the individual's disability, including functional and medical limitations. (2) An assessment of adaptive behavior and level of skills completed within 6 months prior to living in the home. (3) A lifetime medical history. (4) The individual's current level of functioning, including the ability to perform personal needs activities with or without assistance from others. (5) Functional strengths and needs of the individual. (6) The likes, dislikes and interests of the individual. (7) The individual's level of personal and social adjustment. (8) The individual's ability to manage the individual's own finances and property. (9) The individual's need for supervision. (10) The individual's ability to evacuate in the event of a fire. (11) The individual's ability to safely use or avoid poisonous materials, if poisonous materials are not kept locked or made inaccessible to individuals. (12) The individual's understanding of the danger of hot water and other heat sources and the ability to sense and move away from heat sources quickly, if heat sources exceeding 120°F accessible to the individual are not insulated or if hot water in bathtubs and showers exceeds 120°F. (13) The individual's ability to understand water safety and swim if there is a swimming pool. (14) The individual's ability to self-administer medications. (15) If the individual is not able to self-administer medications, the individual's progress toward self-administration. (16) Recommendations for specific areas of training, programming and services. (17) Additional evaluations as necessary. <p>(f) A copy of the assessment shall be kept in the individual's record.</p> <p>(g) The individual, the individual's parent, guardian or advocate if appropriate and the county case manager if the individual is funded through the county mental retardation program, shall be informed of the results of the assessment. Documentation of transmittal of this information shall be kept.</p> <p><u>§ 6500.112. Development of the IPP.</u></p> <p>(a) An IPP shall be developed for each individual, based in the individual's assessment, within 3 months after the individual lives in the home.</p> <p>(b) The IPP shall be developed by the family living specialist in conjunction with the individual and the family.</p> <p>(c) The family living specialist and the family members who assisted in developing the IPP shall sign and date the IPP.</p> <p><u>§ 6500.113. Review, revision and rewrite of the IPP.</u></p>

	<p>(a) The IPP shall be reviewed and revised if necessary, by the family living specialist in conjunction with the individual and the family at least every 3 months.</p> <p>(b) The IPP shall be revised in accordance with subsection (a) if there has been no progress on a goal, if a goal is no longer appropriate or if a goal needs to be added.</p> <p>(c) The IPP shall be reviewed and rewritten by the family living specialist in conjunction with the individual and the family at least every 12 months.</p> <p>(d) The IPP shall be discussed with, dated by and signed by the individual, the individual's parent, guardian or advocate if appropriate, the family living specialist and the family members who assisted in revising or rewriting the IPP after each 3 month review and annual rewrite of the IPP.</p> <p><u>§ 6500.114. Participation in the development of the IPP.</u> The individual's parent, guardian or advocate if appropriate and the county case manager if the individual is funded through the county mental retardation program shall be invited, in writing, to participate in the initial development and the annual rewrite of the IPP. A copy of the written invitations shall be kept.</p>
<p><u>QUARTERLY REVIEW</u> Used for ISP's that must be reviewed at least every 3 months originating from the date of the Annual Review.</p>	<p><u>§ 6500.113. Review, revision and rewrite of the IPP.</u></p> <p>(a) The IPP shall be reviewed and revised if necessary, by the family living specialist in conjunction with the individual and the family at least every 3 months.</p> <p>(b) The IPP shall be revised in accordance with subsection (a) if there has been no progress on a goal, if a goal is no longer appropriate or if a goal needs to be added.</p> <p>(c) The IPP shall be reviewed and rewritten by the family living specialist in conjunction with the individual and the family at least every 12 months.</p> <p>(e) The IPP shall be discussed with, dated by and signed by the individual, the individual's parent, guardian or advocate if appropriate, the family living specialist and the family members who assisted in revising or rewriting the IPP after each 3 month review and annual rewrite of the IPP.</p>
<p><u>INDIVIDUAL PREFERENCES:</u> Like and Admire Know and Do Desired Activities Important To What Makes Sense</p>	<p><u>§ 6500.111. Assessment.</u></p> <p>(e) The assessment shall include the following information:</p> <p>(4) The individual's current level of functioning, including the ability to perform personal needs activities with or without assistance from others.</p> <p>(5) Functional strengths and needs of the individual.</p> <p>(6) The likes, dislikes and interests of the individual.</p> <p>(9) The individual's need for supervision.</p> <p>(16) Recommendations for specific areas of training, programming and services.</p>
<p><u>MEDICAL</u> Medications/ Supplements (and treatments) Allergies Health evaluations Medical contacts Medical history</p>	<p><u>§ 6500.111. Assessment.</u></p> <p>(e) The assessment shall include the following information:</p> <p>(1) Documentation of the individual's disability, including functional and medical limitations.</p> <p>(3) A lifetime medical history.</p> <p>(4) The individual's current level of functioning, including the ability to perform personal needs activities with or without assistance from others.</p> <p>(5) Functional strengths and needs of the individual.</p> <p>(9) The individual's need for supervision.</p> <p>(14) The individual's ability to self-administer medications.</p> <p>(16) Recommendations for specific areas of training, programming and services.</p>
<p><u>HEALTH & SAFETY</u> General health & safety risks Fire safety Traffic Cooking/appliance use Outdoor appliances Water safety (including temperature regulation) Safety precautions Knowledge of self-identifying information Stranger awareness Meals/eating Supervision Care Needs Behavioral support plan</p>	<p><u>§ 6500.111. Assessment.</u></p> <p>(e) The assessment shall include the following information:</p> <p>(4) The individual's current level of functioning, including the ability to perform personal needs activities with or without assistance from others.</p> <p>(5) Functional strengths and needs of the individual.</p> <p>(7) The individual's level of personal and social adjustment.</p> <p>(9) The individual's need for supervision.</p> <p>(10) The individual's ability to evacuate in the event of a fire.</p> <p>(11) The individual's ability to safely use or avoid poisonous materials, if poisonous materials are not kept locked or made inaccessible to individuals.</p> <p>(12) The individual's understanding of the danger of hot water and other heat sources and the ability to sense and move away from heat sources quickly, if heat sources exceeding 120°F accessible to the individual are not insulated or if hot water in bathtubs and showers exceeds 120°F.</p>

<p>Health care Health promotion</p>	<p>(13) The individual's ability to understand water safety and swim if there is a swimming pool. (16) Recommendations for specific areas of training, programming and services.</p>
<p>FUNCTIONAL INFORMATION: Functional level Educational/vocational Employment Understanding communication Other non-medical evaluation</p>	<p><u>§ 6500.111. Assessment.</u> (e) The assessment shall include the following information: (1) Documentation of the individual's disability, including functional and medical limitations. (2) An assessment of adaptive behavior and level of skills completed within 6 months prior to living in the home. (4) The individual's current level of functioning, including the ability to perform personal needs activities with or without assistance from others. (5) Functional strengths and needs of the individual. (6) The likes, dislikes and interests of the individual. (16) Recommendations for specific areas of training, programming and services.</p>
<p>FINANCIAL Financial information Financial management Financial resources</p>	<p><u>§ 6500.111. Assessment.</u> (e) The assessment shall include the following information: (8) The individual's ability to manage the individual's own finances and property. (16) Recommendations for specific areas of training, programming and services.</p>
<p>SERVICES AND SUPPORTS Outcome summary Outcome actions</p>	<p><u>§ 6500.115. Content of the IPP.</u> Each IPP shall include: (1) Goals for the individual in specific areas of growth and development. (2) An evaluation of the individual's skill level for each goal. (3) Monthly documentation of the individual's progress on each goal. (4) A plan for the individual to participate in community and family life. (5) Specific activities and services that meet the needs of the individual. (6) A program and schedule for allowing the individual to be without direct supervision for specific periods of time, aimed at achieving a greater level of independence, if the individual's assessment states the individual may be without direct supervision. (7) A planned program to address the social, emotional and environmental needs of the individual, if a medication is prescribed to treat maladaptive behavior.</p> <p><u>§ 6500.116. Implementation of the IPP.</u> The IPP shall be implemented as written.</p> <p><u>§ 6500.117. Copies of the IPP.</u> (a) A copy of all IPPs shall be kept in the individual's record. (b) The individual, the individual's parent, guardian or advocate, if appropriate, and the county case manager if the individual is funded through the county mental retardation program, and the individual's day service facility shall be provided a copy of all IPPs. Documentation of transmittal of each IPP shall be kept.</p> <p><u>§ 6500.118. Day services.</u> (a) Day services or activities, such as employment, education, training and other meaningful activities shall be provided to each individual. (b) Day services and activities shall be provided away from the home, unless there is written annual documentation by a licensed physician that it is medically necessary for the individual to remain at home or written annual documentation by the family living specialist that it is in the best interests of the individual to remain at home.</p>