DIVISION OF DEVELOPMENTAL DISABILITIES

COMMUNITY SERVICES
COVER SHEET

Name: _____ SS#: _____ Sex: _____

Birth Date: _____ Race/Ethnicity (optional): _____ Primary Language: _____

Address: _____

Apartment #: _____ County of Residence: _____ Phone #: _____

Religion(optional): _____ Significant Allergies: _____

Annual IHP Date: _____ Modifications: _____

Case Manager: _____ Phone #: _____

Current Type of Residence: _____ Admission Date: _____

Residential Provider: _____ Phone #: _____

Contact Person: _____

Current Work/Program/School: _____ Admission Date: _____

Contact Person: _____ Phone #: _____

Legal Guardianship Determined: ☐Yes ☐No Type: _____ Status: _____

Guardian: _____ Relationship: _____ Phone #: _____

Address: _____ Date Appointed: _____

_____ BGS On Call #: _____

Relative: _____ Relationship: _____ Phone #: _____

Address: _____

Relative: _____ Relationship: _____ Phone #: _____

Address: _____

CCW Effective Date: _____ DDD Serial ID#: _____ CCW Status: _____

County Medicaid #: _____ Medicare #: _____ 90 Medicaid #: _____

Other Medical Insurance and/or HMO: _____ Policy #: _____

Benefit SSI: _____ SSA: _____ Payee: _____

Other: _____

MY I.H.P.

NAME: **DATE:**

TABLE OF CONTENTS

NAME: _____ **IHP DATE:** _____

SECTION 1: BIOGRAPHY SUMMARY UPDATE (Important Background Information)

We would like to get to know you in order to plan with you. Please tell us about yourself. It is important to include your family history where you have lived, where you have gone to school or worked, what you like and don't like to do and information about your family and friends. Please add anything about yourself that you think is important.

NAME: _____ **IHP DATE:** _____

SECTION 2: LIFE PLAN SUMMARY

The purpose of your life plan is to help you and others understand the direction you want your life's journey to take. It is a process in which you clearly outline your personal hopes and dreams for the future.

What are your personal dreams for your future?

What things do you want to learn?

What things do you need help with?

How was this information obtained?

NAME: _____ **IHP DATE:** _____

SECTION 3: RELATIONSHIPS

Who are the people (friends, family and staff) that are important in your life?

How do you keep in touch with the people that are important to you? (Phone calls, visits, letters, etc.)

Meeting discussion/Recommendations:

Action Required (if necessary) / Person Responsible:

NAME: _____ **IHP DATE:** _____

SECTION 4: RESIDENTIAL

Where do you live?
Where would you like to live now? In 3 to 5 years?
Please describe your future home and community setting (Location, number of roommates, access to transportation)

Do you have special needs at home? (Adaptive equipment, personal assistance and/or environmental modifications)

Meeting discussion / Recommendations:

Action Required (if necessary) / Person Responsible:

NAME: _____ **IHP DATE:** _____

SECTION 5: WORK/PROGRAM/SCHOOL

Where do you work?
How do you get there?
What type of work do you do?

Where do you go to school and how do you get there?
Are there any changes you would like in your work/school? (If so, please specify)

Do you have special needs at work/school? (Adaptive equipment, personal assistance and/or environmental modifications)

Meeting discussion / Recommendations:

Action Required (if necessary) Person Responsible:

NAME: _____ **IHP DATE:** _____

SECTION 6: COMMUNITY AND RECREATION

What are the things you like to do during your free time? (Include things you like to do alone or with others)

Do you have any preference with regards to spiritual/religious activities? (Include any interest in participating in a community congregation of your choice)

What kind of things do you do in your community? Do you volunteer, belong to any clubs, or attend other community group activities?

Are there any new things and/or groups that you would like to become involved with in your community? (Include any new hobbies, classes you would like to pursue, trips and/or vacations you would like to go on, etc.)

Meeting discussion / Recommendations:

Action Required (if necessary) / Person Responsible:

NAME: _____ **IHP DATE:** _____

SECTION 7: PHYSICAL AND EMOTIONAL WELL BEING

What are the things you need in order to be healthy? (Include, if applicable, medication, special diet, adaptive equipment, medical tests, dental care, counseling or specific behavior intervention, PT, OT, Speech etc.)

What are the things you should stay away from in order to stay healthy? (Include, if applicable, smoking, specific foods, medications and/or substances such as alcohol and drugs)

What are some of the things that upset you or make you mad? How do you show that you are upset?

NAME: _____ **IHP DATE:** _____

SECTION 7 - CONTINUED: PHYSICAL AND EMOTIONAL WELL BEING

When you are upset, what helps you feel better?

Meeting discussion / Recommendations:

Action Required (if necessary) / Person Responsible:

NAME: _____ **IHP DATE:** _____

SECTION 8: CLINICAL INFORMATION

Allergies/reactions (Food, Drugs [over the counter or prescription], Environmental, etc.):

Current Medications (Not including over the counter)

MEDICATIONS	DOSAGE/ FREQUENCY	CONDITION/PURPOSE	PRESCRIBED DATE PHYSICIAN NAME

Significant Diagnoses	Date of Diagnosis	By Whom

Date of last physical examination: _____ Date of last dental examination: _____

Hospitalizations in the last 2 years? ☐Yes ☐No If yes please describe: _____

_____

_____

_____

Professionals That You See

PROFESSIONAL	REASON	WHEN / HOW OFTEN

NAME: _____ **IHP DATE:** _____

SECTION 8 - CONTINUED: CLINICAL INFORMATION

Meeting discussion / Recommendations:

Actions Required (if necessary) / Person Responsible:

SECTION 9: MEDICATION ADMINISTRATION

Do you need help taking your medication? ☐Yes ☐No
Would you like to learn how to take your own medication? ☐Yes ☐No

Meeting discussion / Recommendation:

Action Required (if necessary) / Person Responsible:

NAME: _____ **IHP DATE:** _____

SECTION 10: GUARDIANSHIP REVIEW: Annual review is required

Do you have a guardian? ☐Yes ☐No
If yes, do you want that person to continue to be your guardian? ☐Yes ☐No
What decisions does your guardian help you make?

Do you think you need help making these decisions? ☐Yes ☐No
What changes if any, do you want to make in your guardianship?

Meeting discussion / Recommendations:

Action Required (if necessary) / Person Responsible:

SECTION 11: FINANCIAL REVIEW:

What do you like to do with your money?
Do you feel comfortable making purchases on your own? ☐Yes ☐No
Do you need assistance with making purchases or planning for purchases? ☐Yes ☐No
If yes, what do you need assistance with?
Do you know where or how to obtain monies to purchase items you want or need? ☐Yes ☐No
How much money can you currently hold without staff assisting you?
Do you need assistance with your finances? ☐Yes ☐No
If yes, in what areas?

Fee for service review completed? ☐Yes ☐No ☐N/A

Meeting discussion / Recommendations:

Action Required (if Necessary) / Person Responsible:

NAME: _____ **IHP DATE:** _____

SECTION 12: SUPERVISION

Do you have opportunities to be alone?
At Home: ☐Yes ☐No In Community: ☐Yes ☐No
Where, When, and for How long?

Do you want to spend some time by yourself?
At Home: ☐Yes ☐No In Community: ☐Yes ☐No
Where, When and for How long?

Vehicle safety:
Can you be left alone in a vehicle? ☐Yes ☐No
(Include conditions when you should not be left alone in a vehicle)

Meeting discussion / Recommendations:

Action Required (if necessary) / Person Responsible:

NAME: _____ **IHP DATE:** _____

SECTION 13: TRANSPORTATION

Do you travel independently?	☐ Yes	☐ No
Do you want to learn how to travel independently in your community?	☐ Yes	☐ No
Do you want to learn how to use public transportation?	☐ Yes	☐ No

Meeting discussion / Recommendations:

Actions Required (if necessary) / Person Responsible:

SECTION 14: ADDITIONAL SUPPORT SERVICES

What additional support services do you need?

Are you on the waiting list for?	Day:	☐ Yes	☐ No
	Residential:	☐ Yes	☐ No
Are you on the Residential Transfer List?		☐ Yes	☐ No

Meeting discussion / Recommendations:

Action Required (if necessary) / Person Responsible:

NAME: _____ **IHP DATE:** _____

SECTION 15: ADDITIONAL IMPORTANT INFORMATION

Is there anything else that should be added to your plan? (TEAM NOTES) Please let us know if you are interested in self-advocacy information, voting information, sexuality information, etc.

SECTION 16: ACTION REQUIRED SUMMARY

Please consolidate all Action Required items from Sections 3-15 below:

ACTION REQUIRED	PERSON RESPONSIBLE	DATE COMPLETED

NAME: _____ **IHP DATE:** _____

SECTION 17: REVIEW OF LAST IHP

Last year's goals:

Progress on related objectives: Status/Comments

Review of last year's recommendations for future planning:

NAME: _____ **IHP DATE:** _____

SECTION 18: RATIONALE FOR GOAL IDENTIFICATION

IHP Goals are to be derived either from the aspirations listed in the LIFE PLAN or from clear health and safety concerns identified by the team. Give a brief explanation of why this year's goals were chosen.

In conjunction with the LIFE PLAN the following 5 principles should be used in developing goals:

1. **Facilitates connections / relationships**
2. **Maximizes independence**
3. **Enhances self-worth**
4. **Encourages self-determination**
5. **Enhances physical well-being**

NAME: _____ **IHP DATE:** _____

SECTION 19: IHP IMPLEMENTATION

Goal # :

Objective # :

Implementing agency/person:

Implementation/start date:

Target Completion date:

Implementation plan/methods/supports:

Method for evaluating progress and outcomes:

Staff training/material needed: (Note any preparation needed before implementation)

NAME: _____ **IHP DATE:** _____

SECTION 19 - CONTINUED: IHP IMPLEMENTATION

Goal # :

Objective # :

Implementing agency/person:

Implementation/start date:

Target Completion date:

Implementation plan/methods/supports:

Method for evaluating progress and outcomes:

Staff training/material needed: (Note any preparation needed before implementation)

NAME: _____ **IHP DATE:** _____

SECTION 19 - CONTINUED: IHP IMPLEMENTATION

Goal # :

Objective # :

Implementing agency/person:

Implementation/start date:

Target Completion date:

Implementation plan/methods/supports:

Method for evaluating progress and outcomes:

Staff training/material needed: (Note any preparation needed before implementation)

NAME: _____ **IHP DATE:** _____

SECTION 19 - CONTINUED: IHP IMPLEMENTATION

Goal # :

Objective # :

Implementing agency/person:

Implementation/start date:

Target Completion date:

Implementation plan/methods/supports:

Method for evaluating progress and outcomes:

Staff training/material needed: (Note any preparation needed before implementation)

NAME: _____ **IHP DATE:** _____

SECTION 19 - CONTINUED: IHP IMPLEMENTATION

Goal # :

Objective # :

Implementing agency/person:

Implementation/start date:

Target Completion date:

Implementation plan/methods/supports:

Method for evaluating progress and outcomes:

Staff training/material needed: (Note any preparation needed before implementation)

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SECTION 19 - CONTINUED: IHP IMPLEMENTATION

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SECTION 19 - CONTINUED: IHP IMPLEMENTATION

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Staff training/material needed: (Note any preparation needed before implementation)

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SECTION 19 - CONTINUED: IHP IMPLEMENTATION

Goal # :

Objective # :

Implementing agency/person:

Implementation/start date:

Target Completion date:

Implementation plan/methods/supports:

Method for evaluating progress and outcomes:

Staff training/material needed: (Note any preparation needed before implementation)

NAME: _____ **IHP DATE:** _____

SECTION 19 - CONTINUED: IHP IMPLEMENTATION

Goal # :

Objective # :

Implementing agency/person:

Implementation/start date:

Target Completion date:

Implementation plan/methods/supports:

Method for evaluating progress and outcomes:

Staff training/material needed: (Note any preparation needed before implementation)

NAME: _____ **IHP DATE:** _____

SECTION 19 - CONTINUED: IHP IMPLEMENTATION

Goal # :

Objective # :

Implementing agency/person:

Implementation/start date:

Target Completion date:

Implementation plan/methods/supports:

Method for evaluating progress and outcomes:

Staff training/material needed: (Note any preparation needed before implementation)

NAME: _____ **IHP DATE:** _____

SECTION 20: MEETING SUMMARY

Recommendations for future planning:

Exceptions to plan:

Barriers to the plan:

Level of participation of individual:

NAME: _____ **IHP DATE:** _____

SECTION 21: SIGN OFF

IHP Plan Coordinator: _____

Team members present: _____

PRINTED NAME	RELATIONSHIP	SIGNATURE

Members absent: _____

Community Care Waiver Certification

The following individual has reviewed the individual's plan of care and has determined that he/she continues to have functional limitations and requires active treatment and ICF/MR level services for the period _____ to _____.

_____ Signature

_____ Title
Qualified Mental Retardation Professional