

Individual’s Picture

This Is My Plan:

Annual IHP Meeting Date:

IHP Revision date (if applicable):

**Home Address:**   **Home Phone #**:

**Birth Date: Guardian:**

**Medicaid #: Guardian Address:**

**Medicare #:**

**State ID (EXP Date): Guardian Phone #:**

**Admission Date (to this site):**

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**Interdisciplinary Team Members:**

**Print Name Signature Title/Relation Agency Phone**

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I understand and \_\_\_ consent / \_\_\_ do not consent to the supports described in this plan. I understand I may revoke my consent at any time.

**If you/your guardian are dissatisfied with the strategies described in this plan or the process used for their development, you may seek administrative resolution by contacting Gina Kerman, Executive Director at (440) 724-7571.**

**Individual’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Guardian Signature (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**(Completed/Signed cover page to be scanned and saved to electronic documentation)**

**WHAT WE LIKE AND ADMIRE ABOUT YOU**

To get to know the person and what others appreciate about their gifts, ask the team to think about what attracts others to this person.

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| What do people like and admire about this person? How would we introduce this person to someone they do not know? What compliments does he/she receive? What is he/she good at? What do people thank this person for? |

**MY HOPES & DREAMS**

What is your best future? What are your long term hopes and dreams?

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| What will you be doing, with whom and where? What do you hope to achieve? Don’t be afraid to dream big! |

**MY GIFTS, TALENTS & THINGS I’M GOOD AT**

What things do you enjoy doing in your neighborhood, at home, during the day and at night? What are things you are especially good at?

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| Think about things the individuals enjoys. What are clubs or community groups they could get involved in? Are there any possible paid opportunities? |

**GOOD DAY/BAD DAY**

What makes me happy/safe? What makes a great day and what supports need to be in place to assist me in having a successful day. Additionally, what makes a bad/frustrating day? This will help the team be aware of things that are stressful and/or aggravating and can be minimized/avoided.

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| **GOOD DAY**   * What makes me happy * What needs to be in place for me to be successful | **BAD DAY**   * What makes a bad/frustrating day |

**WHAT IS IMPORTANT “TO” ME IN EVERDAY LIFE**

*What is important TO a person includes what makes them feel happy, content, fulfilled and comforted. Include what the person considers important in relationships, places to spend time, things to do, the rhythm or pace of life. Document what really matters in their life.*

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| **What is important “TO”:** |

**WHAT IS IMPORTANT “FOR” ME IN EVERDAY LIFE**

What is important FOR a person includes Health and Safety, Wellness and Prevention, Emotional Health, Things that help the person be a valued member of their community. (Example: support with safety in the kitchen, having food pureed and thick it in liquids, staff need to be able to see him/her at all times, etc.)

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| **What is important “FOR”:** |

**MY ROUTINES AND RITUALS**

Routines and rituals ease us through our days, comfort us when we need it and help us mark special occasions.

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| Some areas to consider are daily rituals (must haves), special events, how to transition to new activities, weekday/weekend routines, holiday traditions, etc. |

**HOW DO I COMMUNICATE?**

How do I express my wants, needs and desires?

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| Verbal, non-verbal, use of communication device, pictures, etc. How do my staff support me so that they can understand me? |

**ACTIONS THAT MAY NOT BE UNDERSTOOD BY OTHERS**

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| **When I Do This** | **It Means This** | **You Should Do This** |
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**MY RELATIONSHIPS/COMMUNITY MEMBERSHIPS**

People I like to have in my life, people who help me, who I have fun with, people who I love and support, and people who make me feel loved and supported. My connections in the community I live in.

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| Remember: Increasing community memberships enhances natural supports. How are we supporting this individual in expanding/increasing their network of community memberships and personal contacts? |

**WHO HELPS ME MAKE DECISIONS:** (Guardianship)

Identify guardianship and document if individual and his/her team agrees that guardianship status is appropriate.

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| Identify guardian status if it is different for medical/estate, and/or if a Power of Attorney is in place. My team/staff also help me make decisions. |

**MY SUPERVISION NEEDS:**

Level of supervision I need to ensure my health and safety.

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| Include the staff-to-individual ratio during identified timeframes and specialty needs of the individual (i.e.” Joe is claustrophobic on the bus – needs staff to sit directly with him.”) Example: The Individual will receive typically up to 24 hours per day of staff supports at a 1:4 ratio during waking hours and 1:4 during sleeping hours in order to accomplish the following and ensure my health and safety. The Individual will receive supervision in the community at a 2:1 ratio due to seizure disorder. The Individual requires 2:1 for doctor appointments due to seizure disorder. Anytime the Individual is in a vehicle, two staff should be present due to seizure disorder. The Individual will receive supervision at their day program at a 1:3 ratio. Individual receives sleep checks every \_\_\_\_ minutes. |

**MY MONEY AND POSSESSIONS:** (Financial Management)

I will need the following assistance with maintaining my current benefits and finances. To ensure I am informed of my finances I review and sign off on my “Client Banking – Transactions Inquiry” account monthly which indicates funds available to me. In addition Rose-Mary Center Finance Department audits my personal allowance spending on a monthly basis. This helps to keep my money protected.

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| Identify how much money I can manage independently. (Personal allowance/vending) Ask individual the following questions: What do you like to buy with your money? Does anyone help you with buying or saving your money? Do you earn money at your job/day program? Would you like to? Does the individual have a Trust Fund? Document Response. (Finance Department will oversee all communications regarding Trust Funds). Identify and document Representative Payee. |

**RISK SUMMARY:** I May Be At Risk of (Medical, Behavioral, etc.)

Include diet texture needs, important steps for positive communication, positive and proactive procedures supporting behavioral needs, etc.

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| **What it is?** | **What I need from you to keep me safe?** |
|  | If applicable, include: endangering behaviors, aggressive behaviors, stereotypic behavior, threatening behavior, self injurious behavior, destructive behavior, disruptive behaviors, withdrawn behavior, suicidal behavior. See Ohio ICF/IDD assessment. |
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**IMPORTANT PROCEDURES TO KEEP ME SAFE**

List important procedures related to risk management. Include any important meal time procedures, procedures related to mobility to reduce falls, medical procedures (such as seizures), and/or restrictive measure approved by the Human Rights Committee, etc.

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| If and/or when the team recommends the limitation of any right for an individual, due process procedures must be followed, which include: 1) the development of Behavior Support Strategies specifying the right(s) to be modified; 2) clear, time-sensitive and measurable objectives to be met which will result in the reinstatement of those rights; 3) review and approval by the Human Rights Committee.  Include risks and benefits of the action, treatment or service AND risks and benefits of the alternatives to the action, treatment or service. |

**MY ENVIRONMENT**

List any modifications made to the environment that has created a more supportive, positive and safer environment. Include any risk of rights that have been approved by the Human Rights Committee if necessary.

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**MY HOME:** (My Future Plan)

Identify the individual’s desires for future living arrangements.

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| Document if it is likely that this Individual will continue to require the supports and services of an ICF/DD or would like to pursue other options. (Waiver, Shared Living, etc.) Document how we have educated on alternative services and supports that are available to them. Identify where individual lives, how many roommates and if they share a bedroom. Also ask individual if they feel comfortable and safe in their home and if they are happy living with their roommates. Do they have ownership and control over their own possessions? |

**MY PLAN FOR SUCCESS:** (Home)

I need assistance in the following areas so that I can be successful with my future living arrangement. I need the following support (skill development) to foster my success wherever I choose to live.

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| List current skill developments for home. |

I along with my team agree current residential needs are appropriate at this time. YES: \_\_\_\_\_\_\_\_\_ NO: \_\_\_\_\_\_\_\_\_\_\_

I would like to explore other options at this time. YES: \_\_\_\_\_\_\_\_\_ NO: \_\_\_\_\_\_\_\_\_\_\_

**MY PATH TO EMPLOYMENT/DAY SERVICES**

Identify current day programming/employment placement. What are the individual’s desired employment outcomes?

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| Have we offered the individual an opportunity to seek employment? Have we provided opportunities for individual to make an informed choice? Include information about the individual’s desired employment outcome (i.e. would like to work at McDonald’s, sell jewelry, work with animals, retire soon, etc.)  Individual is on level \_\_\_ on their Path to Employment. Individual receives supervision at a 1: \_\_ ratio while at their day program.   * Level 4 – I don’t think I want to work, but I may not know enough about it. * Level 3 – I’m not sure about work. I need help to learn more. * Level 2 – I want a job! I need help to find one. * Level 1 – I have a job but would like a better one or to move up. |

**MY PLAN FOR SUCCESS:** (Employment/Day Services)

I need assistance in the following areas so that I can be successful with my future employment/day service. I need support (skill development) in the following areas to foster my success wherever I choose to work and/or attend day services.

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| List current skill developments for work/day program. |

I along with my team agree current Employment/Day Services is appropriate at this time. YES: \_\_\_\_\_\_\_\_\_\_\_\_ NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I would like to explore other options at this time. YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MY TRANSPORTATION**

Identify transportation needs. Individual will receive transportation to and from (NAME OF EMPLOYMENT SITE/DAY SITE) by (NAME OF PERSON PROVIDING TRANSPORTATION) as scheduled.

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| List any needs/wants during transportation. |

**MY HEALTH**

I take certain medication to keep me healthy and safe. See my current med list. My staff helps me understand what my meds are for and the things I need to do to stay healthy.

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| (Include: Diagnosis, exercise activities, wellness activities, stress reduction, counseling, health risks, etc.)  **Psych Meds:**   |  |  |  |  | | --- | --- | --- | --- | | Medication (Dosage and Frequency) | Purpose/DSM Diagnosis | Related at Risk Actions | Side Effects | |  |  |  |  | |  |  |  |  | |  |  |  |  |   **Titration Plan:**  At least annually, physician will review psychotropic medications and determine if they are safe and appropriate.  Team will approach psychiatrist regarding a decrease in medication when the following goals is met: |

See physician’s orders for current medication list.

**STRENGTHS, NEEDS, PRIORITIES AND CORRESPONDING SKILL DEVELOPMENT GOALS AND/OR SERVICE SUPPORTS**

This IP follows the functional skill areas of the CFA, identifying the individual’s strengths and prioritizing the needs, resulting in the team’s determination of Skill Development goals and/or Service Supports.

Goals will be stated in behavioral terms, time-sensitive and with clear measurable objectives denoting frequency/duration along with whom is responsible for implementation.

* **“A” - High Priority:** Priority to be addressed with a formal goal.
* **“B” - Medium Priority:** Priority to be addressed informally with a procedure, intervention or service support.
* **“C” - Low Priority**: Not a priority at this time, to be reassessed annually.

Include program area, goal, and frequency. Frequency is written as a span (1-5X weekly) and DSP is responsible for providing the services.

**TOILETING:**

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| Description of Support Needed:  “*Ability to complete activities necessary to eliminate and dispose of bodily waste; involves bowel/bladder control-task includes using a commode, bedpan or urinal, cleaning self (including wiping, changing incontinence supplies or feminine hygiene products, managing colostomy, ileostomy, or urinary catheter. Does not include set up and/or transferring to and from commode”.* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**EATING AND DINING**

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| Description of Support Needed:  **“***Ability to feed oneself; Tasks include processes of getting food into one’s mouth, chewing and swallowing, and/or ability to use and self-manage a feeding tube. This does not include set up of food and/or meal prep”.* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**DRESSING/UNDRESSING**

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| Description of Support Needed:  “*Ability to complete activities necessary to dress self. Tasks include selecting and putting on and taking off a regular or modified article of clothing or prosthesis. Fastening/unfastening an item of clothing or prosthesis. Does not include braces or ability to match colors or choose clothing that is appropriate for weather or tasks of clothing care”.* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**ORAL HYGIENE:**

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| Description of Support Needed:  *“Ability of an individual to keep mouth and teeth clean to prevent dental problems. Tasks include brushing teeth, caring for/cleansing dentures, and cleansing mouth”.* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**BATHING/SHOWERING:**

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| Description of Support Needed:  *“Include shaving/hair care/nail care) Ability of an individual to cleanse one’s body. Tasks include showering, bathing or sponge bath, or any generally accepted method. This does not include the act of transferring in and out of shower or tub. Does not include set up”.* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**PERSONAL HYGIENE:**

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| --- | --- | --- |
| Description of Support Needed: | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**MOTOR SKILLS:**

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| Description of Support Needed:  *Turning and Positioning: Include turning, positioning, range of motion, postural drainage. Enter how frequently the individual must be turned or positioned by the staff in a twenty four hour period”.*  *Mobility:* “*Ability of an individual to use fine and gross motor skills to move oneself safely from place to place within a reasonable amount of time by ambulation or by other means and ability of an individual to move between surfaces (process of moving between positions.”*  *Transfer: means the ability of an individual to move between surfaces (process of moving between positions) including but not limited to, to and from a bed, chair, toilet, bath, wheelchair or standing position.* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**RECEPTIVE COMMUNICATION:**

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| --- | --- | --- |
| Description of Support Needed:  “*Involves understanding directions, simple and complex verbal, nonverbal, written, signed, electronic, or mechanical means”.* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**EXPRESSIVE COMMUNICATION:**

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| --- | --- | --- |
| Description of Support Needed:  *“Communicates thoughts with words, sounds, gestures, personal language (i.e. understanding by staff close to the individual) or other means. (written, signed, electronic, mechanical) The act of signaling for assistance referred to 2/3/4, (Ohio IAF Assessment) means that the individual is able to gain the attention of staff and is able to communicate basic needs. (E.g. a drink, help with toileting etc.)”* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**ADAPTIVE EQUIPMENT**

**List items and purpose of adaptive equipment. Include use of technology.**

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| Description of Support Needed: | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**HOUSEHOLD MAINTENANCE:**

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| Description of Support Needed:  *“Ability to clean and use chemicals. Ability to lock and unlock doors etc. Ability to recognize safety hazards in the home.* ***This category can fall into the Endangering Behavior if individual places self or others in dangerous situations.***  *(Does not follow rules regarding hazardous household materials”.* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**CLOTHING CARE:**

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| --- | --- | --- |
| Description of Support Needed:  *“Ability to complete all steps of laundry care”.* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**FOOD PREPARATION:**

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| --- | --- | --- |
| Description of Support Needed:  **“***Ability to prepare meals”.* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**PHONE USE:**

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| Description of Support Needed:  *“Ability to complete all steps for phone use.”* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**COMMUNITY SAFETY:**

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| Description of Support Needed:  *Include Community Mobility:* “Defined as the *ability of an individual to independently travel/move around and navigate the neighborhood and community. Tasks include abilities for pedestrian safety skills; accessing buildings, stores, and restaurants; utilizing modes of transportation (e.g., walking, wheelchair, cars, buses, taxis, bicycles, etc.). Note: for “without staff”, rater should take into consideration an individual’s assessed capabilities to have unsupervised time and required level of supervision (e.g., audible, visual, and physical proximity to staff) to ensure the provision of health and welfare. Does not include movement to and from scheduled day activities (e.g.,* *school, work, or day program centers)”.* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**HOME SAFETY:**

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| --- | --- | --- |
| Description of Support Needed:  *“Ability to evacuate or otherwise remove themselves from dangerous situations. What assistance is needed to recognize fire hazards? Can they evacuate within 3 minutes? “***“***Ability to adjust water temperature when bathing, washing hands, etc.”* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**HEALTH CARE/WELLNESS:**

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| --- | --- | --- |
| Description of Support Needed:  *“Ability to understand how to stay health, my health risks, my meds. (Include, Diagnosis, exercise activities, wellness activities, stress reduction, counseling, health risks, etc.)* | Priority | Identify Support  *Skill Development*  *Service Support*  *I am Independent*  *N/A* |

**MEDICATIONS:**

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| Description of Support Needed:  *“Ability to understand what medications are for and/or ability to administer own medication”.* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**RECREATION/LEISURE ACTIVITIES AT HOME:**

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| --- | --- | --- |
| Description of Support Needed:  *“Defined as activities**the individual enjoys while in the comfort of home.* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**SOCIAL SKILLS:**

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| Description of Support Needed:  *“Ability to get along with others.* ***This category can fall into Endangering if they do not avoid vulnerable situations and/or does not follow rules regarding interaction with strangers. Can also fall into a withdrawn behavior.”*** | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**RESPONSIBILITY:**

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| Description of Support Needed:  *“Ability to take care of personal items and items of others.* ***Recognizes ownership and respects others belongings. This category can also fall into Disruptive Behavior if individual interferes with activities of others including staff.”*** | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**READING/TELLING TIME/NUMBERS/MATH**:

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| --- | --- | --- |
| Description of Support Needed:  “*Ability to read, tell time, count, and understand basic concepts of reading and math.”* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**MONEY AND PURCHASING SKILLS:**

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| --- | --- | --- |
| Description of Support Needed:  “*The ability of an individual to become oriented to the setting, deciding what to purchase, obtaining the item, waiting a turn, and paying for the purchase”.* (include ability to manage money) | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**CIVIC RESPONSIBILITY:**

|  |  |  |
| --- | --- | --- |
| Description of Support Needed:  **“***Ability to participate as a citizen and use freedom of speech for voting etc.”* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**HUMAN SEXUALITY**:

|  |  |  |
| --- | --- | --- |
| Description of Support Needed:  *“Ability to maintain intimate relations safely.**(Has this person participated in Human Sexuality Education program? Should he/she participate? Does he/she need ongoing counseling pertaining to sexuality? Has he/she had a history of inappropriate sexual behavior? Or desire to participate in intimate relations?)”* | Priority | Identify Support  *Skill Development (PIP)*  *Service Support*  *I am Independent*  *N/A* |

**My Schedule**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Sunday** | **Monday** | **Tuesday** | **Wednesday** | **Thursday** | **Friday** | **Saturday** |
| **12 a.m. – 5 a.m.** |  |  |  |  |  |  |  |
| **6 a.m.** |  |  |  |  |  |  |  |
| **7 a.m.** |  |  |  |  |  |  |  |
| **8 a.m.** |  |  |  |  |  |  |  |
| **9 a.m.** |  |  |  |  |  |  |  |
| **10 a.m.** |  |  |  |  |  |  |  |
| **11 a.m.** |  |  |  |  |  |  |  |
| **12 p.m.** |  |  |  |  |  |  |  |
| **1 p.m.** |  |  |  |  |  |  |  |
| **2 p.m.** |  |  |  |  |  |  |  |
| **3 p.m.** |  |  |  |  |  |  |  |
| **4 p.m.** |  |  |  |  |  |  |  |
| **5 p.m.** |  |  |  |  |  |  |  |
| **6 p.m.** |  |  |  |  |  |  |  |
| **7 p.m.** |  |  |  |  |  |  |  |
| **8 p.m.** |  |  |  |  |  |  |  |
| **9 p.m.** |  |  |  |  |  |  |  |
| **10 p.m. – 12 a.m.** |  |  |  |  |  |  |  |

\*All times are subject to change, depending upon individual preferences and choices.

**Meeting Minutes:**

Individual/Guardian:

Nursing:

Employment/Day Program:

QIDP:

UI/MUI trends and patterns:

Risks and Benefits of any restrictive procedures:

Team Recommendations:

**Assessments:** (Document applicable assessments)

*CFA*  *Dietary Assessment* *Falls Risk Assessment*

*Bowel Assessment*  *Nursing Assessment*

*Self-Med Assessment*  *Functional Behavioral Analysis*

**Attachments:**

*Employment/ADS Goals and Progress*  *Social History* *Consents*

IP completed by QIDP

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**Signature of QIDP Date**