

WEST VIRGINIA I/DD WAIVER INDIVIDUALIZED PROGRAM PLAN (IPP)		
IPP SERVICE YEAR: <i>mm/dd/yr – mm/dd/yr</i>	MONTH THIS PLAN WILL BE REVIEWED: Click here to enter a date.	
DEMOGRAPHICS		
TYPE OF IDT MEETING: <input type="checkbox"/> ANNUAL <input type="checkbox"/> 3-MONTH <input type="checkbox"/> 6-MONTH <input type="checkbox"/> 9-MONTH <input type="checkbox"/> CRITICAL JUNCTURE <input type="checkbox"/> TRANSFER <input type="checkbox"/> DISCHARGE <input type="checkbox"/> 7-DAY <input type="checkbox"/> 30-DAY		
Participant Name: Address: Phone Number: Date of Birth:	Additional Insurance (if applicable): Date of Financial Eligibility: Date of Medical Eligibility: Anchor Date:	
Legal Representative: Yes <input type="checkbox"/> No <input type="checkbox"/> If "Yes" Full <input type="checkbox"/> Limited <input type="checkbox"/> Name: Mailing Address: Phone:	Health Care Surrogate: Yes <input type="checkbox"/> No <input type="checkbox"/> Name: Mailing Address: Phone:	Medical Power of Attorney: Yes <input type="checkbox"/> No <input type="checkbox"/> Name: Address: Phone:
Payee: Yes <input type="checkbox"/> No <input type="checkbox"/> Name: Address: Phone:	Conservator: Yes <input type="checkbox"/> No <input type="checkbox"/> Name: Address: Phone:	Case Management: CM Name: CM Provider Agency: CM Telephone #, ext.: CM e-mail:
Attachment Requirements: <input type="checkbox"/> Crisis Plan <i>(required for Annual & 6-Month IPPs)</i> <input type="checkbox"/> Positive Behavior Support Plan/Protocol <i>(required, if applicable, for Annual & 6-Month IPP)</i> <input type="checkbox"/> Tentative Schedule <i>(required)</i> <input type="checkbox"/> Task Analysis/IHP <i>(required, if applicable)</i> <input type="checkbox"/> Participant-Directed Spending Plan® <i>(required, if applicable)</i> <input type="checkbox"/> Other: _____		

<p>I/DD Waiver Budget Information:</p> <p>Assigned Individualized Budget Amount: \$</p> <p>Cost of I/DD Waiver Services Annually: \$</p>	<p>Service Delivery Option:</p> <p><input type="checkbox"/> Traditional</p> <p><input type="checkbox"/> Traditional and Personal Options</p>	<p>Non-I/DD Waiver State Plan (Medicaid) Services:</p> <p><input type="checkbox"/> Personal Care</p> <p><input type="checkbox"/> Private Duty Nursing</p> <p><input type="checkbox"/> Other (describe in ISP section)</p>
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Coordination of Healthcare Needs:

Name of Primary Care Physician:

Date of Last Annual Physical Exam:

Are there any outstanding medical issues? Yes No

Does the person who receives services need assistance in scheduling any medical appointments?
Yes No

For any "yes" answers, describe in Health & Safety Issues area of Evaluation and Assessments Section, below

SERVICE EVALUATION (to be completed for all IPP Meetings)

In this section, indicate services both under and over-budget (when applicable) necessary to meet the member's needs. In order to obtain initial authorizations, the request must be under-budget and meet all requirements for purchasing order and service limits. If, at any point during the service year, the team is requesting an Exception – fill out the over-budget column indicating services necessary to meet the member's needs.

When requesting modifications at any IPP juncture, just replace the current unit number with the amount the team has agreed upon for modification.

Under-Budget Services (for entire service year)						
Code	Service	Units (Annual IPP)	Units (6M IPP)	Units (Insert Juncture)	Units (Insert Juncture)	Units (Insert Juncture)
Cost of Services Requested		\$	\$	\$	\$	\$

MEETING MINUTES

Who attended this meeting? Did any team members attend by phone, and why? *(Required attendees, when applicable: the member (if own guardian, must remain present for duration of meeting), legal representative, Health Care Surrogate, a representative from each provider, and/or Medley Advocate (Annual and 6M).*

Summary of what was discussed during this meeting *(describe specific details including, but not limited to, person-centered items, current events, concerns, anticipated/upcoming changes, unmet needs, budget discussion details, IDT input/recommendations, etc.)*

Review of Utilization *(list each service authorized and include: total number of units authorized, how many units used to date, and how many units remain for the remainder of the service year. E.g. BSP1: 300 units authorized - 100 used, 200 remaining)*

Incident Reports *(List any incidents which have occurred since the last IPP meeting; include any trends identified and measures that are being taken to address trends. Ensure that corresponding incident reports are on file and that each incident has been entered into the WVIMS.)*

Meeting Minutes Completed By

CIRCLE OF SUPPORT

Intimacy: Who can I count on?

Friendship: Who is a good friend?

Participation: What people, organizations, or networks am I involved with?

Exchange: Who are the people paid to be in my life (i.e. staff)?

Who would I like to participate in developing my plan? (May include anyone I want: professionals, direct care providers, family members, friends, etc.; however, it must include my legal representative - if applicable and a representative of any agency that provides services for me.)

GOALS AND DREAMS

Goals and dreams should be carried through the rest of this plan and incorporated into the Service and Habilitation Plans including responsible persons and/or provider and timelines for making plans happen.

What are my short-term and long-term goals and dreams? My dreams should be positive and possible. (Where do I want to live? Ideal job? Who do I want to live with? Dream vacation? What do I want to learn?) Who is going to help me achieve these goals/dreams?

Short-term goals:

Long-term goals:

What do I expect to be different as a result of receiving services and supports? What outcomes do I expect to accomplish with the help of supports?

What are the things that I like and dislike? What things do I consider pleasant and important? What do I like to do during my leisure time? What community activities do I enjoy?

What are my strengths? What am I good at?

Evaluation	Date of Evaluation	Summary of Assessments/Evaluations Results and Recommendations (List all assessments used to develop the service and habilitation plan):
Person-Centered Assessment		<p>SUMMARY OF CURRENT CIRCLE OF SUPPORTS AND GOALS AND DREAMS</p> <p>Based on my dreams and goals, my IDT has determined that the following services, supports and/or resources are needed:</p>
ICAP		<p>SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS</p> <p>***ANY MALADAPTIVE BEHAVIORS IDENTIFIED MUST BE ADDRESSED IN THE BSP ISP SECTION – if no BSP on the team, need for the service should be discussed and interventions identified in the appropriate PCS ISP section***</p> <p>Based on these findings, my IDT recommends the following training goals/ programs and/or support activities to be implemented:</p> <ul style="list-style-type: none"> • <p>Based on these findings, my IDT recommends the following behavioral objectives to be implemented: (delete if n/a)</p> <ul style="list-style-type: none"> • <p>Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:</p>

Evaluation	Date of Evaluation	Summary of Assessments/Evaluations Results and Recommendations (List all assessments used to develop the service and habilitation plan):
ABAS: II		<p>SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS</p> <p>Based on these findings, my IDT recommends the following training goals/ programs and/or support activities to be implemented:</p> <ul style="list-style-type: none"> • <p>Based on these findings, my IDT recommends the following behavioral objectives to be implemented: (delete if n/a)</p> <ul style="list-style-type: none"> • <p>Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:</p>
Extraordinary Care Assessment		<p>SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS</p> <p>Based on these findings, my IDT recommends the following training goals/ programs and/or support activities to be implemented:</p> <ul style="list-style-type: none"> • <p>Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:</p>

Evaluation	Date of Evaluation	Summary of Assessments/Evaluations Results and Recommendations (List all assessments used to develop the service and habilitation plan):
Health & Safety Issues Identified	Ongoing	<p>SUMMARY OF MOST CURRENT HEALTH AND SAFETY ISSUES AS IDENTIFIED BY KEPRO AND THE IDT.</p> <p>Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:</p>
Medical	Ongoing	<p>LIST ALL PHYSICIANS, DATES OF LAST APPOINTMENTS, AND RECOMMENDATIONS.</p> <p>Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:</p>
Psychological/ Psychiatric (if applicable)		<p>SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS</p> <p>Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:</p>
Therapy (PT, OT, ST, etc. – if applicable)		<p>SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS</p> <p>Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:</p>
Diagnosis	N/A	

Evaluation	Date of Evaluation	Summary of Assessments/Evaluations Results and Recommendations (List all assessments used to develop the service and habilitation plan):
CM Assessment		<p>SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS</p> <p>Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:</p>
BSP Assessment (if applicable)		<p>SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS</p> <p>Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:</p>
RN Assessment (if applicable)		<p>SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS</p> <p>Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:</p>
IEP (if applicable)		<p>SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS</p> <p>Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:</p>
IDT Meetings	N/A	<p>CHOOSE ONE:</p> <p>My IDT agrees that my needs do not warrant quarterly meetings; therefore, only Annual and 6 Month IPP IDT meetings will be held. If I have a need that must be addressed by my IDT before my next scheduled IPP review, I may request a Critical Juncture IDT meeting.</p> <p>My IDT agrees that my needs warrant quarterly meetings; therefore, my team will meet every 90 days.</p>

Living Arrangement Evaluation		
<p>Member's Currently Assessed Living Setting (found in demographics on CareConnection©)</p> <p><input type="checkbox"/> Natural Family/SFCP</p> <p><input type="checkbox"/> Unlicensed Residential x 1</p> <p><input type="checkbox"/> Unlicensed Residential x 2</p> <p><input type="checkbox"/> Unlicensed Residential x 3</p> <p><input type="checkbox"/> Licensed Group Home 4+</p>	<p>In what setting is the member currently residing?</p> <p><input type="checkbox"/> Natural Family/SFCP</p> <p><input type="checkbox"/> Unlicensed Residential x 1</p> <p><input type="checkbox"/> Unlicensed Residential x 2</p> <p><input type="checkbox"/> Unlicensed Residential x 3</p> <p><input type="checkbox"/> Licensed Group Home 4+</p>	<p>Is the team pursuing a change in living arrangement? (if yes - indicate below the arrangement being explored, discuss in meeting minutes, and complete a DSSLA)</p> <p><input type="checkbox"/> Natural Family/SFCP</p> <p><input type="checkbox"/> Unlicensed Residential x 1</p> <p><input type="checkbox"/> Unlicensed Residential x 2</p> <p><input type="checkbox"/> Unlicensed Residential x 3</p> <p><input type="checkbox"/> Licensed Group Home 4+</p>

PARTICIPANT NAME / RECORD ID #

DATE OF MEETING: MM/DD/YYYY

Medications that I take	Dosage	Frequency	Reason for taking this medication (applicable diagnosis)	Who will administer? (agency name and staff title or natural support)

IF PSYCHOTROPIC MEDICATIONS ARE ADMINISTERED, PLEASE INCLUDE A RATIONALE FOR CHANGES OR CONTINUATION OF EACH MEDICATION:

I/DD Waiver Services Needed to Support Me Individual Service Plan		
Service Description	Provider Agency	Provider Name <i>(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)</i>
Duration of Service: This service should begin on _____ and end on _____.		
Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs in addition to duties outlined in the IDDW Provider Manual? What has changed since my last IDT meeting? Progression/Regression/Achievement of actionable goals since previous juncture? ADD ROWS AS NECESSARY FOR SUBSEQUENT JUNCTURES		
Annual IPP		
6M IPP		

I/DD Waiver Services Needed to Support Me Individual Service Plan		
Service Description	Provider Agency	Provider Name <i>(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)</i>
Behavior Support Professional I <i>N/A if BSP services are not accessed</i>		
Duration of Service: This service should begin on _____ and end on _____.		
Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs in addition to duties outlined in the IDDW Provider Manual? What has changed since my last IDT meeting? Progression/Regression/Achievement of actionable goals since previous juncture? ADD ROWS AS NECESSARY FOR SUBSEQUENT JUNCTURES		
Annual IPP		
6M IPP		

Maladaptive Behavior Intervention: *For any maladaptive behaviors identified on the ICAP, identify the behavior and explain the intervention agreed upon by the IDT.*

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**I/DD Waiver Services Needed to Support Me
Individual Service Plan**

Service Description	Provider Agency	Provider Name <i>(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)</i>

Duration of Service: This service should begin on _____ and end on _____.

Plan of Action/Scope of Work to be done to support me.
What, specifically, will the provider do to support my needs in addition to duties outlined in the IDDW Provider Manual? What has changed since my last IDT meeting? Progression/Regression/Achievement of actionable goals since previous juncture? ADD ROWS AS NECESSARY FOR SUBSEQUENT JUNCTURES

Annual IPP	
6M IPP	

I/DD Waiver Services Needed to Support Me Individual Service Plan		
Service Description	Provider Agency	Provider Name <i>(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)</i>
Duration of Service: This service should begin on _____ and end on _____.		
Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs in addition to duties outlined in the IDDW Provider Manual? What has changed since my last IDT meeting? Progression/Regression/Achievement of actionable goals since previous juncture? ADD ROWS AS NECESSARY FOR SUBSEQUENT JUNCTURES		
Annual IPP		
6M IPP		

I/DD Waiver Services Needed to Support Me Individual Service Plan		
Service Description	Provider Agency	Provider Name <i>(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)</i>
Duration of Service: This service should begin on _____ and end on _____.		
Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs in addition to duties outlined in the IDDW Provider Manual? What has changed since my last IDT meeting? Progression/Regression/Achievement of actionable goals since previous juncture? ADD ROWS AS NECESSARY FOR SUBSEQUENT JUNCTURES		
Annual IPP		
6M IPP		

I/DD Waiver Services Needed to Support Me Individual Service Plan		
Service Description	Provider Agency	Provider Name <i>(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)</i>
Duration of Service: This service should begin on _____ and end on _____.		
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Annual IPP		
6M IPP		

I/DD Waiver Services Needed to Support Me Individual Service Plan		
Service Description	Provider Agency	Provider Name <i>(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)</i>
Duration of Service: This service should begin on _____ and end on _____.		
Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs in addition to duties outlined in the IDDW Provider Manual? What has changed since my last IDT meeting? Progression/Regression/Achievement of actionable goals since previous juncture? ADD ROWS AS NECESSARY FOR SUBSEQUENT JUNCTURES		
Annual IPP		
6M IPP		

I/DD Waiver Services Needed to Support Me Individual Service Plan		
Service Description	Provider Agency	Provider Name <i>(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)</i>
Duration of Service: This service should begin on _____ and end on _____.		
Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs in addition to duties outlined in the IDDW Provider Manual? What has changed since my last IDT meeting? Progression/Regression/Achievement of actionable goals since previous juncture? ADD ROWS AS NECESSARY FOR SUBSEQUENT JUNCTURES		
Annual IPP		
6M IPP		

I/DD Waiver Services Needed to Support Me Individual Service Plan		
Service Description	Provider Agency	Provider Name <i>(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)</i>
Duration of Service: This service should begin on _____ and end on _____.		
Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs in addition to duties outlined in the IDDW Provider Manual? What has changed since my last IDT meeting? Progression/Regression/Achievement of actionable goals since previous juncture? ADD ROWS AS NECESSARY FOR SUBSEQUENT JUNCTURES		
Annual IPP		
6M IPP		

Non-I/DD Waiver Services and Natural Supports (Volunteer groups, clubs, churches, schools, etc.)	
Support:	Who provides this support (name)?
Plan of Action/Scope of Work to be done to support me. How does this service benefit the member? What planned activities/services/responsibilities are upcoming during each subsequent juncture? Do any of the activities/services/responsibilities correspond to actionable goals?	
Annual IPP	
6M IPP	

Non-I/DD Waiver Services and Natural Supports (Volunteer groups, clubs, churches, schools, etc.)	
Support:	Who provides this support (name)?
Plan of Action/Scope of Work to be done to support me. How does this service benefit the member? What planned activities/services/responsibilities are upcoming during each subsequent juncture? Do any of the activities/services/responsibilities correspond to actionable goals?	
Annual IPP	
6M IPP	

Non-I/DD Waiver Services and Natural Supports (Volunteer groups, clubs, churches, schools, etc.)	
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Annual IPP	
6M IPP	

Non-I/DD Waiver Services and Natural Supports (Volunteer groups, clubs, churches, schools, etc.)	
Support:	Who provides this support (name)?
Plan of Action/Scope of Work to be done to support me. How does this service benefit the member? What planned activities/services/responsibilities are upcoming during each subsequent juncture? Do any of the activities/services/responsibilities correspond to actionable goals?	
Annual IPP	
6M IPP	

Non-I/DD Waiver Services and Natural Supports (Volunteer groups, clubs, churches, schools, etc.)	
Support:	Who provides this support (name)?
Plan of Action/Scope of Work to be done to support me. How does this service benefit the member? What planned activities/services/responsibilities are upcoming during each subsequent juncture? Do any of the activities/services/responsibilities correspond to actionable goals?	
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Non-I/DD Waiver Services and Natural Supports (Volunteer groups, clubs, churches, schools, etc.)	
Support:	Who provides this support (name)?
Plan of Action/Scope of Work to be done to support me. How does this service benefit the member? What planned activities/services/responsibilities are upcoming during each subsequent juncture? Do any of the activities/services/responsibilities correspond to actionable goals?	
Annual IPP	
6M IPP	

I/DD Waiver Individual Habilitation Plan and Task Analysis							
Participant Name:		Program #		Date Established		Target Date	
Responsible Agency and Staff:					Date Revised/Discontinued:		
My Skill or Goal Area:							
My Instructional Objective:							
Instructional Methods/Special Instructions to staff (include possible prompting levels)							
What materials are needed?							
In what setting will this take place?			How frequently will activity occur?		Miles needed to achieve goal?		
How often will data be collected?			What type of reinforcement will I receive?				
What criteria are needed to move on to the next step?							
Prompt Levels (specific to my needs):							

Task Analysis

Month/Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1																															
2																															
3																															
4																															
5																															
6																															
Staff Initials																															

Developed by:
BSP Signature and Credentials: _____

My Tentative Schedule Is:

Be certain to include **all** important person-centered details including;

- Sleep/leisure/school times (as applicable)
- Service times (ex. FBDH/PCS-A/PCS-F/PCS-PO/Respite/SE/Pre-Voc/Job Dev/PT/OT/ST)
- Natural support times
- Travel

Be specific about the anticipated times spent on activities/services throughout a typical week, as well as who/what type of staff are providing the service(s). Goals/Objectives (whether formal or informal) should also be noted and ensure the person has voiced their choice of activities when developing and/or making updates to their schedule. Note: If the person receives an average of 2 or more hours of LPN services per day, then the schedule will need to reflect all activities performed by LPN in 15-minute increments.

Projected Time Range	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7am-10am							
10am-11:30am							
11:30am-12:30pm							
12:30pm-4pm							
4pm-7pm							
7pm-9pm							
9pm-10:30pm							
10:30am-7am							

Interdisciplinary Team Signature Sheet

Participant Name:	DATE UPLOADED TO CARECONNECTION®: Click here to enter a date.
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TYPE OF IDT MEETING:

ANNUAL
 3-MONTH
 6-MONTH
 9-MONTH
 CRITICAL JUNCTURE
 TRANSFER
 DISCHARGE
 7-DAY
 30-DAY

Relationship	Signature and Credentials	Time Spent in Meeting <i>*(start/stop times)</i>	Agree	*Disagree	Date this IPP was sent out
Waiver Participant					
Parent/Legal Representative					
Case Manager					
Other Relationship:					
Other Relationship:					
Other Relationship:					

***Rationale for Disagreement with the Plan (if applicable)**

Signature: _____ Date: _____