PARTICIPANT NAME / RECORD ID # MM/DD/YYYY

WEST VIRGINIA I/DD WAIVER INDIVIDUALIZED PROGRAM PLAN (IPP)		
IPP SERVICE YEAR: *mm/dd/yr – mm/dd/yr*	**DATE OF MEETING:** Click here to enter a date.	**MONTH THIS PLAN WILL BE REVIEWED:** Click here to enter a date.

TYPE OF IDT MEETING:

☐ **ANNUAL** ☐ **3-MONTH** ☐ **6-MONTH** ☐ **9-MONTH** ☐ **CRITICAL JUNCTURE**

☐ **TRANSFER** ☐ **DISCHARGE** ☐ **7-DAY** ☐ **30-DAY**

DEMOGRAPHICS

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 ☐ No ☐ If "Yes" Full ☐ Limited ☐ Name: Address: Phone:	**Health Care Surrogate:** Yes ☐ No ☐ Name: Address: Phone:	**Medical Power of Attorney:** Yes ☐ No ☐ Name: Address: Phone:
Payee: Yes ☐ No ☐ Name: Address: Phone:	**Conservator:** Yes ☐ No ☐ Name: Address: Phone:	**Interventions for Maladaptive Behavior (if applicable):** Date of Functional Assessment: Date of Positive Behavior Support Plan: Date of HRC Approval:
Service Coordination: SC Name: SC Provider Agency: SC Telephone #, ext.: SC e-mail:		**Attachments:** ☐ Crisis Plan *(required for Annual & 6-Month IPPs)* ☐ Positive Behavior Support Plan *(required, if applicable, for Annual & 6-Month IPP)* ☐ Positive Behavior Support Protocol/Guideline *(if applicable)* ☐ Budget from CareConnection® *(required)* ☐ Task Analysis/IHP *(required, if applicable)* ☐ Participant-Directed Spending Plan® *(if applicable)* ☐ Other: _____

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I/DD Waiver Budget Information: Assigned Individualized Budget Amount: $ Cost of I/DD Waiver Services Annually: $	**Service Delivery Option:** ☐ Traditional ☐ Traditional and Personal Options	**Non-I/DD Waiver State Plan (Medicaid) Services:** ☐ Personal Care ☐ Private Duty Nursing ☐ Other (describe in ISP section)

Coordination of Healthcare Needs:

Name of Primary Care Physician:

Date of Last Annual Physical Exam:

Are there any outstanding medical issue? 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

ANNUAL SERVICE EVALUATION *(to be completed for the member's Annual IPP Meeting)*

In this section, indicate all services the team has identified for request in the under-budget column to obtain an initial authorization. If the person and/or team believes the person requires services in excess of the individualized budget, indicate all services the team has identified for request in the over-budget column. In order for the person to begin receiving any services under the IPP, the service coordinator must submit a list of services that can be purchased within the person's individualized budget, making sure all direct care service needs are purchased first. If the team is requesting services in excess of the budget, document the rationale and number of units for the request in the meeting minutes and submit a completed exceptions request, including all supporting documentation.

Under-Budget Services (for entire service year)			**Over-Budget Services (use this section only if an exception is being requested)**		
Code	**Service**	**Units Needed**	**Code**	**Service**	**Units Needed**
Cost of Services Requested		**$**	**Cost of Services Requested**		**$**
Amount Remaining in Budget		**$**	**Amount Over-Budget**		**$**

MEETING MINUTES
Who attended this meeting? Did any team members attend by phone, and why?
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 Services *(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		SUMMARY OF CURRENT CIRCLE OF SUPPORTS AND GOALS AND DREAMS Based on my dreams and goals, my IDT has determined that the following services, supports and/or resources are needed:
ICAP		SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS ***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*** Based on these findings, my IDT recommends the following training goals/ programs and/or support activities to be implemented: • Based on these findings, my IDT recommends the following behavioral objectives to be implemented: (delete if n/a) • Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:

Evaluation	Date of Evaluation	Summary of Assessments/Evaluations Results and Recommendations (List all assessments used to develop the service and habilitation plan):
ABAS: II		SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS Based on these findings, my IDT recommends the following training goals/ programs and/or support activities to be implemented: • Based on these findings, my IDT recommends the following behavioral objectives to be implemented: (delete if n/a) • Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:
Extraordinary Care Assessment		SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS Based on these findings, my IDT recommends the following training goals/ programs and/or support activities to be implemented: • Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:

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	SUMMARY OF MOST CURRENT HEALTH AND SAFETY ISSUES AS IDENTIFIED BY KEPRO AND THE IDT. Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:
Medical	Ongoing	LIST ALL PHYSICIANS, DATES OF LAST APPOINTMENTS, AND RECOMMENDATIONS. Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:
Psychological/ Psychiatric (if applicable)		SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:
Therapy (PT, OT, ST, etc. – if applicable)		SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:
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):
SC Assessment		SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:
BSP Assessment (if applicable)		SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:
RN Assessment (if applicable)		SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:
IEP (if applicable)		SUMMARY OF MOST CURRENT ASSESSMENT/EVALUATION AND RECOMMENDATIONS Based on my needs as stated above, my IDT has determined that the following services, supports and/or resources are needed:
IDT Meetings	N/A	CHOOSE ONE: 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. My IDT agrees that my needs warrant quarterly meetings; therefore, my team will meet every 90 days.

Living Arrangement Evaluation		
Member's Currently Assessed Living Setting *(found in demographics on CareConnection©)*	**In what setting is the member currently residing?**	**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)*
☐ Natural Family/SFCP ☐ Unlicensed Residential x 1 ☐ Unlicensed Residential x 2 ☐ Unlicensed Residential x 3 ☐ Licensed Group Home 4+	☐ Natural Family/SFCP ☐ Unlicensed Residential x 1 ☐ Unlicensed Residential x 2 ☐ Unlicensed Residential x 3 ☐ Licensed Group Home 4+	☐ Natural Family/SFCP ☐ Unlicensed Residential x 1 ☐ Unlicensed Residential x 2 ☐ Unlicensed Residential x 3 ☐ Licensed Group Home 4+

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 Code	**Service Description**	**Provider (include *name* of staff person)**	**Is this service available/accessible?**
			☐ Yes ☐ No
Amount/Frequency: Service should average _____ units per month & should not exceed ____ units per year.			
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? What has changed since my last IDT meeting?			

I/DD Waiver Services Needed to Support Me Individual Service Plan			
Service Description	**Service Description**	**Provider (include *name* of staff person)**	**Is this service available/accessible?**
			☐ Yes ☐ No
Amount/Frequency: Service should average _____ units per month & should not exceed ____ units per year.			
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? What has changed since my last IDT meeting?			

I/DD Waiver Services Needed to Support Me Individual Service Plan			
Service Code	**Service Description**	**Provider (include *name* of staff person)**	**Is this service available/accessible?**
			☐ Yes ☐ No
Amount/Frequency: Service should average _____ units per month & should not exceed ____ units per year.			
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? What has changed since my last IDT meeting?**			

I/DD Waiver Services Needed to Support Me Individual Service Plan			
Service Code	**Service Description**	**Provider (include *name* of staff person)**	**Is this service available/accessible?**
	Behavior Support Professional *N/A if BSP services are not accessed*		☐ Yes ☐ No
Amount/Frequency: Service should average _____ units per month & should not exceed ____ units per year.			
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? What has changed since my last IDT meeting?**			

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

I/DD Waiver Services Needed to Support Me **Individual Service Plan**			
Service Code	**Service Description**	**Provider (include *name* of staff person)**	**Is this service available/accessible?**
			☐ Yes ☐ No
Amount/Frequency: Service should average _____ units per month & should not exceed ____ units per year.			
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? What has changed since my last IDT meeting?**			

I/DD Waiver Services Needed to Support Me **Individual Service Plan**			
Service Code	**Service Description**	**Provider (include *name* of staff person)**	**Is this service available/accessible?**
			☐ Yes ☐ No
Amount/Frequency: Service should average _____ units per month & should not exceed ____ units per year.			
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? What has changed since my last IDT meeting?**			

Non-I/DD Waiver State Plan (Medicaid) Services (Personal Care, Private Duty Nursing, Other)		
Support:	**Who provides this support (name)?**	**Is this service available/accessible:** ☐ **Yes** ☐ **No** *If no, indicate what steps will be taken for the service to become available/accessible in Plan of Action.*
Frequency of Support:		
Duration of Support: This support should begin on _____ and end on _____.		
Plan of Action/Scope of Work to be done to support me.		

Participant-Directed Services (if applicable)			
Service Code(s)	**Participant-Directed Services**	**Provider(s) Name(s) for each PD Service**	**Is this service available/accessible?**
			☐ Yes ☐ No
Amount/Frequency: Service should average _____ units per month & should not exceed ____ units per year.			
Duration of Service: This service should begin on _____ and end on _____.			
			☐ Yes ☐ No
Amount/Frequency: Service should average _____ units per month & should not exceed ____ units per year.			
Duration of Service: This service should begin on _____ and end on _____.			

			☐ Yes ☐ No
Amount/Frequency: Service should average _____ units per month & should not exceed ____ units per year.			
Duration of Service: This service should begin on _____ and end on _____.			
			☐ Yes ☐ No
Amount/Frequency: Service should average _____ units per month & should not exceed ____ units per year.			
Duration of Service: This service should begin on _____ and end on _____.			
I have $ _____ available to spend for my Participant-Directed Services			
On average, I need _____ hours of direct support services per week			
☐ **The Spending Plan (outline of services and amounts of services I have chosen is attached to this IPP).**			
Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider(s) do to support my needs? Where do I need to go (transportation)? What has changed since my last IDT meeting?			

Non-I/DD Waiver Services and Natural Supports (Volunteer groups, clubs, churches, schools, etc.)		
Support:	**Who provides this support (name)?**	**Is this service available/accessible:** ☐ **Yes** ☐ **No** *If no, indicate what steps will be taken for the service to become available/accessible in Plan of Action.*
Frequency of Support:		
Duration of Support: This support should begin on _____ and end on _____.		
Plan of Action/Scope of Work to be done to support me.		

Non-I/DD Waiver Services and Natural Supports (Volunteer groups, clubs, churches, schools, etc.)		
Support:	**Who provides this support (name)?**	**Is this service available/accessible:** ☐ **Yes** ☐ **No** *If no, indicate what steps will be taken for the service to become available/accessible in Plan of Action.*
Frequency of Support:		
Duration of Support: This support should begin on _____ and end on _____.		
Plan of Action/Scope of Work to be done to support me.		

Non-I/DD Waiver Services and Natural Supports (Volunteer groups, clubs, churches, schools, etc.)		
Support:	**Who provides this support (name)?**	**Is this service available/accessible:** ☐ **Yes** ☐ **No** *If no, indicate what steps will be taken for the service to become available/accessible in Plan of Action.*
Frequency of Support:		
Duration of Support: This support should begin on _____ and end on _____.		
Plan of Action/Scope of Work to be done to support me.		

Non-I/DD Waiver Services and Natural Supports (Volunteer groups, clubs, churches, schools, etc.)		
Support:	**Who provides this support (name)?**	**Is this service available/accessible:** ☐ **Yes** ☐ **No** *If no, indicate what steps will be taken for the service to become available/accessible in Plan of Action.*
Frequency of Support:		
Duration of Support: This support should begin on _____ and end on _____.		
Plan of Action/Scope of Work to be done to support me.		

PARTICIPANT NAME / RECORD ID # MM/DD/YYYY

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																																
7																																
	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	Morning Routine- Formal and Informal Support provided by PCS-F: Shaving, Breakfast prep, Brushing teeth, Getting dressed	Morning Routine- Formal and Informal Support provided by PCS-F: Breakfast prep, Brushing teeth, Getting dressed	Morning Routine- Formal and Informal Support provided by PCS-F: Shaving, Breakfast prep, Brushing teeth, Getting dressed	Morning Routine- Formal and Informal Support provided by PCS-F: Breakfast prep, Brushing teeth, Getting dressed, Prep for/Travel to Day Hab	Morning Routine- Formal and Informal Support provided by PCS-F: Shaving, Breakfast prep, Brushing teeth, Getting dressed	Morning Routine- Formal and Informal Support provided by PCS-F: Shaving, Breakfast prep, Brushing teeth, Getting dressed	Morning Routine- Formal and Informal Support provided by PCS-F: Shaving, Breakfast prep, Brushing teeth, Getting dressed
10am-11:30am	Leisure Time/Natural Support: Preferred activities	Leisure Time/Natural Support: Preferred activities	Leisure Time/Natural Support: Preferred activities	Day Hab- Formal and Informal support provided by FBDH: Hand Washing, Identify Money, Social Skills, Preferred activities, Travel in comm., Bowling, Park, Mall, Exercise	Leisure Time/Natural Support: Preferred activities	Leisure Time/Natural Support: Visit with Grandma	Travel time to Church and Lunch in Comm. Formal support provided by PCS-F
11:30am-12:30pm	Lunch/Prep for outing with PCS-A	Lunch/Prep for outing with PCS-F	Lunch/Prep for outing with PCS-A		Lunch/Prep for outing with PCS-A	Lunch/Prep for outing with Respite	Lunch/Prep for outing with Respite
12:30pm-4pm	Travel time to outing of choice and formal support with PCS-A:	Travel time to therapies with PCS-F: ST (1pm-2pm) OT	Travel time to outing of choice and formal support with PCS-A: Library, YMCA,		Travel time to outing of choice and formal support with PCS-A: Library, YMCA,	Travel time to outing of choice and informal support with Respite:	Travel time to outing of choice and informal support with Respite:

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	Library, YMCA, Safety skills, Purchasing	(2pm-3pm) Travel time home with PCS-F	Safety skills, Purchasing		Safety skills, Purchasing	Shopping, Community Center	Shopping, Community Center
4pm-7pm	Travel time home with PCS: A. Formal and Informal support with PCS-F: Laundry, Prep dinner, Talk about today	Formal and Informal support with PCS-F: Chores, Prep dinner, Talk about today	Travel time home with PCS: A. Formal and Informal support with PCS-F: Laundry, Prep dinner, Talk about today	Leisure Time/Natural Support: Dinner, Talk about today	Travel time home with PCS: A. Formal and Informal support with PCS-F: Laundry, Prep dinner, Talk about today	Travel time home with Respite. Formal and Informal support with PCS-F: Laundry, Prep dinner, Talk about today	Travel time home with Respite. Formal and Informal support with PCS-F: Laundry, Prep dinner, Talk about today
7pm-9pm	Leisure Time/Natural Support: Preferred activities	Leisure Time/Natural Support: Preferred activities	Leisure Time/Natural Support: Preferred activities	Leisure Time/Natural Support: Preferred activities	Leisure Time/Natural Support: Preferred activities	Leisure Time/Natural Support: Preferred activities	Leisure Time/Natural Support: Preferred activities
9pm-10:30pm	Evening Routine-Formal and Informal Support provided by PCS-F: Shower, Snack prep, Brushing teeth, Dress for bed	Evening Routine-Formal and Informal Support provided by PCS-F: Shower, Snack prep, Brushing teeth, Dress for bed	Evening Routine-Formal and Informal Support provided by PCS-F: Shower, Snack prep, Brushing teeth, Dress for bed	Evening Routine-Formal and Informal Support provided by PCS-F: Shower, Snack prep, Brushing teeth, Dress for bed	Evening Routine-Formal and Informal Support provided by PCS-F: Shower, Snack prep, Brushing teeth, Dress for bed	Evening Routine-Formal and Informal Support provided by PCS-F: Shower, Snack prep, Brushing teeth, Dress for bed	Evening Routine-Formal and Informal Support provided by PCS-F: Shower, Snack prep, Brushing teeth, Dress for bed
10:30am-7am	Sleep Time/Natural Support	Sleep Time/Natural Support	Sleep Time/Natural Support	Sleep Time/Natural Support	Sleep Time/Natural Support	Sleep Time/Natural Support	Sleep Time/Natural Support

Interdisciplinary Team Signature Sheet		
Participant Name:	**Date of Meeting:** Click here to enter a date.	**DATE UPLOADED TO CARECONNECTION©:** Click here to enter a date.

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 *(start/stop times)*	Agree	*Disagree	Date this IPP was sent out
Waiver Participant					
Parent/Legal Representative					
Service Coordinator					
Other Relationship:					
Other Relationship:					
Other Relationship:					

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

_____

_____

_____

_____

Signature: _____ Date: _____