PARTICIPANT NAME / RECORD ID #

DATE OF MEETING:

West Virginia I/DD Waiver
Individualized Program Plan - (IPP)

IPP Service Year: *mm/dd/yy – mm/dd/yy*	**Meeting Type:** ☐ Annual ☐ 3-Month ☐ 6-Month ☐ 9-Month ☐ Critical Juncture ☐ Transfer ☐ Discharge ☐ 7-Day ☐ 30-Day

Cover/Demographics

Participant Name/Date of Birth	**Physical Address**	**Mailing Address**	**Phone Number**
DOB:			
Legal Guardian/Representative	**Name**	**Mailing Address**	**Phone Number**
☐ Yes ☐ No			
Other Authorized Rep	**Name**	**Mailing Address**	**Phone Number**
☐ Yes ☐ No ☐ HealthCare Surrogate ☐ Medical Power of Attorney ☐ Other:			
Financial Representative	**Name**	**Address**	**Phone Number**
☐ Yes ☐ No ☐ Payee ☐ Conservator ☐ Other:			
Advocate	**Name**	**Address**	**Phone Number**
☐ Yes ☐ No			
Action Item: Who is responsible for monitoring the member's service plan to ensure services are authorized and delivered?			

Action Item: Provide contact email and phone number(s) for all agencies providing services.	**Email Address**	**Phone Number**

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Meeting Minutes

This section is completed for all IPP meetings. A summarization of what was discussed during the meeting (i.e., person-centered items, current needs, concerns, anticipated and/or upcoming changes, unmet needs, new service needs, and IDT input/recommendations, etc.). Providers must come prepared with current utilization to report to the team to discuss and agree upon any necessary changes. ***Note****: Required attachments include Crisis Plan, Positive Behavior Support Plan/Protocol/Guideline, Tentative Schedule, Task Analysis/Individual Habilitation Plan, current Budget from UMCs web portal, and any DD-12s since the last meeting juncture.*

Meeting Attendees

Attendance Details

Did any attendees participate via electronic means? *(*Note, physical or acceptable electronic signatures are required regardless of electronic participation.)*	☐ Yes ☐ No
Action Item: If "**yes**" list the name(s) of those who attended electronically.	
Did all IDT members attend the full meeting?	☐ Yes ☐ No
Action Item(s): If "**no**" list the name(s) of those who did not attend the full meeting.	

Summary of what was discussed during the meeting

Conflict Resolution

The team must identify strategies for solving conflict or disagreement within the IPP process. Include discussion about what the IDT will do in the event of non-compliance, non-agreement, concerns with plan implementation, errors in utilization, or other inter-agency/family concerns.

Utilization Review

Provider Agency	Service Name	Units Authorized	Units Used	Units Remaining

Action Item: Discussion of Service Utilization/Modification Requests:	
Action Item: Is the member receiving services, including staffing ratios, as identified and agreed upon by the IDT? If '**no'**, explain.	☐ Yes ☐ No If '**no'**, explain:

Minutes completed by: *(include credentials, as applicable)*		**Meeting Start / Stop Time:**	

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Supports/Goals and Dreams

This section addresses the member's goals and dreams as well as identifies potential barriers which may impact obtainment. Assessment information may be prepared prior to IDT's discussion; however, the team needs to review all responses and work towards ensuring information is utilized to meet member's person-specific goals/dreams/outcomes.

There are personal goals/dreams in the following area(s):	☐ Community ☐ Family ☐ Physical ☐ Social ☐ Creativity ☐ Financial ☐ Relationships ☐ Spiritual ☐ Educational ☐ Home Environment ☐ Self-Esteem ☐ Recreational ☐ Emotional ☐ Occupational
Action Item: Describe the member's strengths and preferences.	
Identify one or more immediate goals: Include desired outcomes. Definition of Timeframe: *0 – 1 year	
Identify one or more short-term goals: Include desired outcomes. Definition of Timeframe: *1 – 5 years	
Identify one or more long-term goals: Include desired outcomes. Definition of Timeframe: *6-10+ years	
Action Item: Based upon outcomes, what specific service(s), and/or support(s) does the member need to help achieve their goals?	
Did the member provide their own responses to their goals/dreams?	☐ Yes – Actively ☐ Yes – With the assistance of a Legal Representative ☐ No – Legal Representative provided answers. ☐ No – IDT provided answers
Action Item: If "**no**," describe the barriers to goal setting, and how the team plans to address those and/or provide support to the member for future participation. ☐ n/a	

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Service Evaluation Needs/Individual Service Plan/Scope of Service

This section is completed for all IPP meetings to address service needs, identify the member's budget and include any additional Medicaid services.

IDDW services must be purchased in the following order so that the health and safety of the member receiving services is ensured: Case management services must be purchased first, followed by direct-care services in the following order, if the IDT wishes to purchase any of these services: person-centered support services, day services, electronic monitoring, direct-LPN services, and respite. Professional services may be purchased next in the following order if the IDT wishes to purchase any of these services: RN, BSP, Indirect LPN, any of the specialty therapies (speech therapy (ST), physical therapy (PT), occupational therapy (OT) dietary therapy (DT), and Transportation.

Services	
I/DD Waiver Budget	$

Under-Budget Services

Outline all service needs under budget including the agency/staff providing the service.

*For Licensed Group Home PCS, Unlicensed Residential PCS, or Day Services, it is acceptable to indicate only the name of the agency that will supply the staff. This is also acceptable if Out-of-Home Respite is provided through a licensed facility-based day habilitation site. For all other services, it is required to include the provider agency **and** the name of staff. If BMS grants an amount over the assigned budget through a DSSLA, Exceptions Request, or for other reasons, these services must be outlined in the Under-Budget Services box.*

Service Name	Service Code	Provider Agency and Name of staff	Units Requested	Duration of Service Start Date/End Date
Cost of Services Requested	$			

Over-Budget Services

For any member requiring services above budget, complete the over-budget table which must correspond with an Exception request. Include the TOTAL amount requested for the service year for ALL services.

Leave this box blank if it is not applicable.

Service Name	Service Code	Provider Agency and Name of staff	Units Requested	Duration of Service Start Date/End Date
Cost of Services Requested	$			
Amount Over-Budget	$			

Scope of Service

Complete for all purchases

Action Item: Describe the purpose of **each** service the team is purchasing/attempting to purchase **and** include the types of activities they will be responsible for. The scope of service should be more than what the service *can*

provide, per policy, but instead, identify how it will be used over the course of the current service year to assist in obtaining/progressing with, meeting the member's goals, dreams, skills, etc.

Service Name	Scope of Service

Non-I/DD Waiver Services and Natural Supports/Scope of Service (Volunteer groups, clubs, churches, schools, etc.)

Include State Plan, WV ABLE, Personal Care, School, NEMT, and/or other Medicaid Services. How do these services benefit the member? What planned activities/services/responsibilities are upcoming? Do any of the activities/services/responsibilities correspond to actionable goals? If so, which ones? Include discussion of ongoing progressions/regressions/etc. Add rows as needed.

Identified Support	Description of Support
Non-I/DD Services/Natural Supports Received:	☐ Personal Care ☐ Private Duty Nursing ☐ State Plan Therapies ☐ NEMT ☐ WV ABLE Account ☐ School Services ☐ Other: _____
	Scope of Service
1.	
2.	
3.	

Living Arrangement Evaluation

Member's Currently Assessed Living Setting *(found in demographics on UMC's web portal)*	**In what setting is the member currently residing?**	**Is the team pursuing a change in living arrangements?** *(if yes – indicate the arrangement being explored, discuss in meeting minutes, and complete a DSSLA, as applicable)*
☐ 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+

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Service Availability and Member Participation

Members should be provided with an opportunity to participate in and choose their service delivery and have any barriers/concerns addressed. If any changes to the treatment plan are desired, the member/legal representative has the right to request a formal meeting and/or for the CM to complete an addendum.

Are all needed services available?	☐ Yes ☐ No
List any unavailable services due to: ☐ n/a	☐ Unavailable provider ☐ Environmental limitations ☐ Limited funding ☐ Other: Click or tap here to enter text.
Action Item: If "**no**," how will the IDT attempt to obtain needed services for the member? Include IDT's discussion about how the team plans to assist in securing services. ☐ n/a	
Did the member participate in choosing/requesting their services, including the people on their IDT? (***Note*: *People may be defined as the agency professional or the chosen provider(s); not individual person(s).*	☐ Yes – Actively ☐ Yes – With the assistance of a Legal Representative ☐ No – Legal Representative and/or IDT chose services.
Action Item: For "**no**," describe why the member did not/was unable to choose either their services or the members** of their IDT and discuss how the team plans to address those for future participation. ☐ n/a	
Action Item: Did the meeting occur at a time/place convenient for the member? Identify the location.	☐ Yes ☐ No Location: _____
Action Item: If "**no**," why? How will the team address this moving forward? ☐ n/a	
Action Item: Discuss what the member/family considers convenient for time/place and outline any compromises which have been agreed to by both the providers and/or participant/legal representative. ☐ n/a	
Indicate the member's primary method of communication.	☐ Nonverbal ☐ Communication device ☐ Verbal – English ☐ Signs/Gestures

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	☐ Verbal – Other language: ☐ Other:		
Does the member's method/level of communication inhibit their participation in/understanding of their person-centered planning?	☐ Yes ☐ No		
Action Item: If "**yes**," how will the team address communication barriers to ensure the member is able to participate in/understand their person-centered planning? ☐ n/a			
Have the member's cultural preferences been taken into consideration?	☐ Yes ☐ No		
Action Item: If "**no**," how will the team ensure cultural considerations are reflected? ☐ n/a			
My current level of need warrants regular meetings at the following intervals:	☐ Each quarter ☐ Every six months		
Action Item: List/describe any rights restrictions currently in place. Briefly describe and discuss efforts agreed upon by the IDT to work towards eliminating and/or reducing these restrictions.			
Rights Restriction ☐ n/a	**Efforts to Reduce/Eliminate Restriction**	**Initial HRC/IDT Approval Date** *Approximate date will suffice if unknown	**Current HRC Approval Date**
Action Item: Document timelines for periodic reviews which will be used to determine if modifications or restrictions are still necessary, and when/if they may be modified or terminated.			

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SUMMARY OF ASSESSMENT & EVALUATION RESULTS

Coordination of Healthcare

For any areas of need selected below, indicate what each need looks like for the member, how are they impacted, what the limitation looks like, etc. Also indicate which service(s) and/or support(s) will be utilized to help the member address each noted area of need.

Medical/Assessment information may be prepared prior to IDT's discussion; however, the team needs to review all responses and work towards ensuring information is utilized to meet member's person-specific needs and create actionable plans based on outcome results.

General Medical

Complete for all members.

There are needs in the following areas:	☐ Ambulation ☐ Continence ☐ Hand/Arm Movements ☐ Hearing ☐ Health	☐ Hygiene ☐ Medications ☐ Feeding ☐ Scheduling/Attending Medical Appointments	☐ Therapy ☐ Vision ☐ Other: _____

Does the IDT believe Licensed Practical Nursing services are required to address health/medical needs:	☐ Yes ☐ No
Action Item: If "**yes**," indicate whether direct and/or indirect services are being requested.	☐ Direct LPN ☐ Indirect LPN ☐ N/A

Physician Appointments

☐ n/a - none *Include appointment information since the last juncture.*

Physician Appointments General appointments	**Appointment Outcomes**
Action Item(s): Based on outcomes how will service(s) and/or support(s) change?	

Medical Evaluations

☐ n/a - none *Include medical evaluation information since the last juncture.*

Medical Evaluations Completed by a Licensed Medical Professional	**Evaluation Findings/Outcomes**

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Action Item(s): Identify all medically necessary assessments being recommended for this upcoming service year. Explain the clinical rationale for each. ☐ n/a	
Action Item(s): Based upon outcomes, what service(s) and/or support(s) does the member need?	

Medications

☐ n/a - none *Include all current medications, including PRNs.*

Medications are taken for:	☐ Health Problems	☐ Seizures	☐ Health Maintenance
	☐ Mood/Behavior	☐ Sleep	☐ Other *(indicate below)*

Medication Name	Dose/Frequency	Diagnosis/Purpose of Prescription	Who will be responsible for administration

Who is the back-up if primary support is unable to administer medications?	
Psychotropic medications used:	☐ Yes ☐ No

Action Item: If "**yes**," describe rationale for why medications changed and/or why they were continued: ☐ n/a	**Psychotropic Medication**	**Rationale for Change/Continuation**

Medical Condition(s)/Diagnosis

☐ ***N/A*** *for those completing a DD9 - Request for Nursing Services. If no DD9 is needed, complete all information.*

Describe member's conditions and/or limitations and what this specifically looks like for the member. Ensure all conditions requiring treatment, medication, and/or routine care are included.	**Approx. Date of Diagnosis**	**Temp**	**Ongoing**
		☐	☐
		☐	☐
		☐	☐

Action Item(s): Describe Any Changes in the Past Year.	

Hospitalizations and Surgeries

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☐ ***N/A*** *for those completing a DD9 - Request for Nursing Services. If no DD9 is needed, complete all information.*

Hospitalizations/Surgeries Within the Past Year	**Dates**	**Temp**	**Ongoing**
		☐	☐
		☐	☐
		☐	☐

Action Item(s): Describe Outcomes, How Treatment Changed as a Result and How Long Changes are Anticipated to Last (as applicable),	
Action Item(s): Based on outcomes how will service(s) and/or support(s) change? ☐ n/a	

Psychological/Psychiatric

Complete for all members.

Action Item(s): List all diagnosis:	
Action Item(s): Based upon outcomes, what service(s) and/or support(s) does the member need?	
Has the member had a psychological/psychiatric evaluation within the past two years?	☐ Yes ☐ No
Action Item: If "**yes**" summarize the evaluation results and recommendations: ☐ n/a	

Therapy

☐ n/a - none

Complete for all members.

I/DD Waiver	**State Plan** (includes school)	**Private Insur.**	**N/A**	**Therapy Type**	**Assessment Findings/Outcomes**
☐	☐	☐	☐	Speech	
☐	☐	☐	☐	Physical	
☐	☐	☐	☐	Occupational	
☐	☐	☐	☐	Dietician	
☐	☐	☐	☐	Other: _____	

PARTICIPANT NAME / RECORD ID # _____ DATE OF MEETING: _____

Action Item(s): Describe Any Changes within the Past Year.	
Action Item(s): Based upon outcomes, what service(s) and/or support(s) does the member need?	

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Annual Functional Assessments

The annual functional assessments help to identify areas of need across a variety of categories. The IDT may choose to address one or more needs, formally or informally, depending upon the member's wishes. Identify the member's needs and outline what is most important to the member to work on for the current year, along with necessary support needed to assist the member. Assessment information may be prepared prior to IDT's discussion; however, the team needs to review all responses and work towards ensuring information is utilized to meet member's person-specific needs and create actionable plans based on outcome results.

The following people have been identified to act respondents:	

ICAP

The team should single out the needs <u>most important to the member</u> as areas of focus for the year and fill out the chart below. Indicate what each area of need looks like for the member, how are they impacted, what does the limitation look like, etc. Indicate which service(s) and/or support(s) will be utilized to help the member address each noted area of need.

There are needs in the following area(s):	☐ Motor Skills ☐ Community Living ☐ Personal Living ☐ Social and Communication ☐ Broad Independence

Focus for the Year	**Describe conditions for achievement**

Member has participated in the following behaviors within the past year:		**This behavior looks like:**	**This behavior is considered a moderate, severe, or critical problem:**	**Action Item:** Help is needed to manage this behavior:
Hurtful to self	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
Hurtful to others	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
Destructive	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
Disruptive	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
Unusual Habits	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
Socially Offensive	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
Withdrawn	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No
Uncooperative	☐ Yes ☐ No		☐ Yes ☐ No	☐ Yes ☐ No

Action Item(s): Maladaptive Behavior Intervention: *For any maladaptive behaviors described above, identify, and briefly explain the intervention(s) agreed upon by the IDT.*

Action Item(s): Based upon outcomes, what service(s) and/or support(s) does the member need?	

ABAS III

PARTICIPANT NAME / RECORD ID # _____ DATE OF MEETING: _____

The team should single out the needs <u>most important to the member</u> as areas of focus for the year and fill out the chart below. Indicate what each area of need looks like for the member, how are they impacted, what does the limitation look like, etc. Indicate which service(s) and/or support(s) will be utilized to help the member address each noted area of need.				
There are needs in the following area(s):	☐ Communication ☐ Community Use ☐ Functional Academics	☐ Home Living ☐ Health and Safety ☐ Functional Pre-Academics	☐ Self-Direction ☐ Self-Care ☐ Leisure	☐ Social ☐ Work
Focus for the year	**Describe conditions for achievement**			
Action Item(s): Based upon outcomes, what service(s) and/or support(s) does the member need?				

Extraordinary Care Needs Assessment

The team should single out the needs <u>most important to the member</u> as areas of focus for the year and fill out the chart below. Indicate what each area of need looks like for the member, how are they impacted, what does the limitation look like, etc. Indicate which service(s) and/or support(s) will be utilized to help the member address each noted area of need.

There are needs in the following area(s): ☐ n/a	☐ Social/Communication Skills ☐ Personal Living Skills ☐ Specialized Physical, Medical, and Therapeutic Needs	☐ Motor Skills ☐ Community Living Skills ☐ Maladaptive Issues
Focus for the year	**Describe conditions for achievement**	
Action Item(s): Based upon outcomes, what service(s) and/or support(s) does the member need?		

Behavior Support Needs

*For **any** behavior category scored as moderate, severe, or critical, respond to the following applicable prompts. If applicable, a copy of the Functional Assessment, Positive Behavior Support Plan/Protocol/Guideline must be attached to the plan for Annual and 6-month IPPs.*

☐ ***N/A** - if no behavior category is scored as moderate, severe, or critical.*

A Functional Behavior Assessment (FBA) has been completed/will be completed:	☐ Yes - **Action Item** ☐ No – describe why: _____ Date of completion or planned completion: _____
The FBA indicates a Positive Behavior Support Plan (PBSP) is needed:	☐ Yes - **Action Item** ☐ No – describe why: _____ ☐ Pending FBA completion
If "**yes,**" a PBSP has been completed/will be completed:	☐ Yes - **Action Item** ☐ No – describe why: _____ ☐ Pending FBA completion

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	Date of completion or planned completion:

☐ n/a **Other BSP Assessments**	
Other Assessments Completed by a BSP	**Assessment Findings/Outcomes**
Action Item(s): Identify all person-centered assessments being recommended for the upcoming service year. Explain the clinical rationale for each. ☐ n/a	
Action Item(s): Based upon outcomes, what service(s) and/or support(s) does the member need?	

Accessibility Adaptations, Goods and Services *Includes Environmental Accessibility Adaptations for Home and Vehicle (Traditional and Personal Options) and Participant Directed Goods and Services.* ☐ ***N/A** - if IDT will not pursue these services*	
Action Item(s): Identify what specific item(s) and/or service(s) will be accessed using these services:	
Action Item(s): Identify what need(s) will be met using these services:	

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Safety and Crisis/Emergency Disaster Planning

This section addresses the member's health and safety, as well as the team's plan of action in the event of a crisis. The Crisis Plan section should discuss the person who receives services and include detailed information relevant to the individual. Plans should not be readily transferrable to another, but instead, be personalized and address any foreseeable issues which might put the person's health, safety, and/or well-being in jeopardy. Crisis plans should be immediately useful for anyone not familiar with the person. Assessment information may be prepared prior to IDT's discussion; however, the team needs to review all responses and work towards ensuring information is utilized to meet member's person-specific needs and create actionable plans.

Incident Management

Since the last juncture, there have been incidents related to: ☐ n/a	☐ Abuse ☐ Neglect ☐ Exploitation ☐ Accident/Injury w/o Additional Treatment ☐ Accident/Injury w/ Additional Treatment ☐ Falls	☐ Treatment/Medication Error ☐ Seizures ☐ Self-Injury ☐ Behavioral ☐ Other - _____

Action Item: Which provider(s) has the IDT identified for each setting to enter incident reports into the IMS? Who will serve as the back-up?

Date	Simple	Critical	A/N/E	Incident Description	Action Item(s): Changes to services/supports
	☐	☐	☐		☐ Yes ☐ No
	☐	☐	☐		☐ Yes ☐ No
	☐	☐	☐		☐ Yes ☐ No

Action Item(s): Based upon outcomes, discuss identified risk factors, patterns/trends, and indicate how the IDT will address these moving forward.

Crisis Planning

Type of Support	Name	Phone Number	Primary Method
Primary Support			☐ Call ☐ Text
Secondary Support			☐ Call ☐ Text
Emergency Contact			☐ Call ☐ Text
Emergency Contact- Secondary			☐ Call ☐ Text
Emergency Contact- Additional			☐ Call ☐ Text
Primary Care Physician			

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Preferred Hospital of Choice		Address:	

Action Item: Address no call/no show of staff or supports. *(Note: Include both paid and unpaid support. Describe back-up contingencies, and what is needed to end crisis/return to routine for both).*	
Paid Supports	
Unpaid Supports	

Action Item: Address loss of primary caregiver(s) – unavailable/unable to provide continued support. *(Note: should include detailed plans for both temporary and permanent unavailability as well as information for temporary or replacement caregiver. Describe back-up contingencies, and what is needed to end crisis/return to routine).*	
Temporary Unavailability	
Permanent Unavailability	

Action Item: Address weather-related/environmental issues such as the inability to get to scheduled location(s) such as work, school, power outages, etc. *(Note: Should include instructions specific to the individual and/or their geographical location. Describe back-up contingencies, and what is needed to end crisis/return to routine). Topics below may be altered to better represent member-specific categories, as necessary.*	
Transportation Issues (work/school/other)	
Power Outages	
Additional Member Specific Information	
Additional Member Specific Information	

Action Item: Address disaster-related issues such as flood, fire, etc. *(Note: Should include instructions specific to the individual and/or their geographical location. Describe what steps person(s) will take, any back-up contingencies, and what is needed to end crisis/return to routine). Topics below may be altered to better represent member-specific categories, as necessary.*	
Flood	
Fire	
Tornado	
Blizzard	
Chemical Spill	
Additional Member Specific Information	
Additional Member Specific Information	

Action Item: Address health/medical issues *(Note: medication administration, serious allergies, seizure protocol; all if applicable. Considerations should be given to both current and previous medical conditions. Describe what steps person(s) will take, any back-up contingencies, and what is needed to end crisis/return to routine). Topics below may be altered to better represent member-specific categories, as necessary.*	
Medication Administration	

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Allergies	
Seizures	
Other Medical Concerns	
Additional Member Specific Information	
Additional Member Specific Information	

Action Item: Address termination from and/or reduction of I/DD Waiver services. *(Note: Identifies services that may be available to the person in place of reduced or terminated I/DD Waiver services. Describe who will be responsible for completion of follow-up, what steps they will take, any back-up contingencies, and what is needed to end crisis/return to routine).*	
Termination of Services	
Reduced Services	
Additional Member Specific Information	

Action Item: Address bed bug infestations, including relocation plan, and financially responsible party(s). *(Note: Plan should address what specific actions will be taken to address bed bug infestations. In the event the person receiving services needs to be relocated, a specific location should be identified, and if there is a cost to action or relocation, the plan must identify who will be financially responsible. Describe what steps person(s) will take, any back-up contingencies, and what is needed to end crisis/return to routine).*	
Infestation	
Relocation Plan	
Financially Responsible	
Additional Member Specific Information	

Action Item: Address other person-specific health and safety issues. *(Note: This should include additional medical information, environmental adaptations/modifications needed when responding to a crisis, identified behavioral/psychiatric needs, as well as any other pertinent information responding individuals may need to know. Describe what steps person(s) will take, any back-up contingencies, and what is needed to end individual crisis/return to routine).*	
Additional Member Specific Information	
Additional Member Specific Information	
Additional Member Specific Information	

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HCBS Information

This section addresses the IPP requirements as specified in the State-wide Transition Plan intended to capture the member's training needs, as well as the details of their living arrangement evaluation and assessment.

Training

Trainer/Agency	Responsible for Training on:	
Primary:	☐ Crisis Plan ☐ Medical Needs/Medication ☐ IHP/TA	☐ Member Specific Needs ☐ Formal Behavior Interventions ☐ Other:
Secondary:	☐ Crisis Plan ☐ Medical Needs/Medication ☐ IHP/TA	☐ Member Specific Needs ☐ Formal Behavior Interventions ☐ Other:
Back-Up:	☐ Crisis Plan ☐ Medical Needs/Medication ☐ IHP/TA	☐ Member Specific Needs ☐ Formal Behavior Interventions ☐ Other:

	HCBS Integrated Settings Rule Questionnaire: Natural Family Assessment *To be completed by the IDT at the Annual IPP or as the living arrangement changes; including, if the member moves or changes are made to the existing home resulting in obvious issues with the setting requirements.*	**Yes**	**No**
1	Do you or a family member own, rent, or lease this home/apartment? *(If the answer is **no**, do not use this assessment, use the Specialized Family Care and ISS/GH Assessment.)*	☐	☐
2	If you rent or lease this home/apartment, does your rental agreement or lease have, at a minimum, the same responsibilities, and protections from eviction that tenants have under the landlord/tenant law of West Virginia? *(Do not answer if the member or their family owns the home; leave blank.)* https://www.wvlegislature.gov/wvcode/code.cfm?chap=37&art=6	☐	☐
3	If you rent or lease this home/apartment, does your rental agreement or lease provide protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law? *(Do not answer if the member or their family owns the home; leave blank.)*	☐	☐
4	Were you able to choose this setting from among non-disability specific settings? *(Do not answer if the member or their family **owns** the home; leave blank.)*	☐	☐
5	Were you offered a private room in this setting? *(Do not answer if the member is under the age of **13;** leave blank.)*	☐	☐
6	If you have a roommate, did you choose to live with that roommate? *(Do not answer if the member does not have a roommate or if the member is under the age of **13**; leave blank.)*	☐	☐
7	Do you get meals and snacks that you choose when you want to eat them?	☐	☐
8	Are/were you able to decorate and furnish your room the way you chose? *(Do not answer if the member is under the age of **13**; leave blank.)*	☐	☐
9	Do you choose what you do during the day including what activities you do, when you want to do them, where you do them and who you do them with?	☐	☐
10	May you have visitors of your choice in your home any time you want? (It is appropriate to be respectful of others living in the home when having visitors.)	☐	☐
11	Do you have locks on your bedroom and bathroom doors? *(Do not answer if the member is under the age of **13;** leave blank.)*	☐	☐
12	Do you feel safe in your home?	☐	☐
13	Do you feel your dignity is respected? (i.e., You are treated with courtesy and kindness, given choices, and listened to by others.)	☐	☐

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14	Do you feel free from coercion and/or restraint? (i.e., You are not bullied or forced to do things that you do not want to do. You are not prevented from saying things or doing things that you want to do.)	☐	☐
15	Are you able to receive mail?	☐	☐
16	Are you able to make phone calls in private? *(Do not answer if the member is under the age of **10;** leave blank.)*	☐	☐
17	Are you able to get into and out of your home and into all areas of your home like the kitchen, living room and all communal living areas?	☐	☐
18	If your home is not accessible in any way, is this noted on your Person-Centered Plan so that appropriate modifications can be made?	☐	☐
19	Do you consider your home to be integrated in the community and does it support full access to the greater community, including opportunities to: a. Seek employment *(Do not answer if the member is under the age of **14**.)* b. Work in competitive integrated settings; *(Do not answer if the member is under the age of **14**.)* c. Engage in community life (Attending community activities, visiting with friends and family, shopping, going to restaurants, etc.) d. Control personal resources and possessions *(Do not answer if the member is under the age of **13**.)* e. Receive services in the community to the same degree as individuals not receiving Medicaid?	☐	☐
20	Did you choose what services you are receiving?	☐	☐
21	Did you choose who provides these services to you?	☐	☐
22	Have your staff been trained to meet your needs and is there documentation of that training?	☐	☐

Natural Family Assessment Expansion Questions

Action Item: Document what other alternative home and community-based settings were considered by the IDT**.** Discussion should include what types of settings or service options were provided and indicate the options where the member could receive services such as community settings, types of residential settings, available day settings, etc.	
Action Item: Identify any additional services/supports needed to achieve full integration into the community.	

Action Item: If any answer on the above survey is "**no**," describe what modifications/restrictions are needed:	**Action Item:** Identify the assessed need/rationale which supports the implementation of this modification:

Action Item: For **"no"** responses which are *NOT* supported by an assessed need, please provide a remediation plan for each:

Question #: _____ Remediation Plan:	
Question #: _____ Remediation Plan:	

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HCBS Integrated Settings Rule Questionnaire: Provider-Controlled Assessment: Specialized Family Care and ISS/GH Assessment *To be completed by the IDT at the Annual IPP or as the living arrangement changes including if the member moves or changes are made to the existing home resulting in obvious issues with the setting requirements. While the UMC will complete full questionnaires for SFC/ISS/GH to ensure accuracy, agencies are required to answer the following question(s) for members who live in these settings:*		**Yes**	**No**
1	Were you able to choose the place where you are now living from among non-disability specific settings?	☐	☐

Provider-Controlled Assessment Expansion Questions	
Action Item: Document what other alternative home and community-based settings were considered by the IDT**.** Discussion should include what types of settings or service options were provided and indicate the options where the member could receive services such as community settings, types of residential settings, available day settings, etc.	
Action Item: Identify any additional services/supports needed to achieve full integration into the community.	

Action Item: For any modifications/restrictions to community access, personal resources, privacy, freedom from restraint, individual choice, control over schedule/activities, access to food, opportunities to choose visitors/interactions, environmental access/freedoms, etc., describe why these restrictions are needed:	**Action Item:** Identify the assessed need/rationale which supports the implementation of this modification:

PARTICIPANT NAME / RECORD ID # _____ DATE OF MEETING: _____

I/DD Waiver Individual Habilitation Plan

Member Name:		**Program #:**	
Date Established:		**Target Completion Date:**	
Date(s) Revised:		**Responsible Agency:**	

Goal Area

☐Motor Skills	☐Functional Pre-Academics	☐Self-Direction	☐Occupational
☐Communication	☐Home Living	☐Social	☐Self-Esteem
☐Personal Living	☐Health	☐Creativity	☐Spiritual
☐Community Living/Use	☐Safety	☐Educational	☐Other:
☐Broad Independence	☐Leisure	☐Emotional	
☐Functional Academics	☐Self-Care	☐Financial	

Objective: *(Program name or skill)*	
Implementation Frequency:	
Target Accuracy: *(What is expected for mastery or goal completion?)*	

Current Abilities and Needs

Things that may limit participation:	
Things that may encourage participation:	
Resources needed to complete goal; include any needed mileage:	

General Task Flow

Currently working on the following step(s):		
General task flow: Document ALL program steps.	1	
	2	
	3	
	4	
	5	

How to Teach Me Based on My Current Step

#	**Methodology for teaching:** Discuss how staff should teach each step. Indicate what to do when barriers are present and provide specific information about how/when staff should provide either more or less support.
1	
2	
3	
4	
5	

PARTICIPANT NAME / RECORD ID # _____ DATE OF MEETING: _____

Participant Name:		Program #		Month/Year:	
Objective:					

Task Analysis

Program Step 1	
Program Step 2	
Program Step 3	
Program Step 4	
Program Step 5	

	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
Step 1																															
Step 2																															
Step 3																															
Step 4																															
Step 5																															
Staff Initials																															

Print Provider/Staff Name:	Provider/Staff Signature:	Print Provider/Staff Name:	Provider/Staff Signature:

PARTICIPANT NAME / RECORD ID # _____ DATE OF MEETING: _____

Tentative Schedule:

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

- Sleep/leisure/school times (as applicable)
- Service times (ex. Day services / PCS / Direct Support services / Therapies, Other Medicaid services (non-I/DD), etc.)
- Natural support times
- Travel

Action Item: 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 communicated 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 the 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							

PARTICIPANT NAME / RECORD ID # _____ DATE OF MEETING: _____

Interdisciplinary Team Signature Sheet

Meeting Type: ☐ Annual ☐ 3-Month ☐ 6-Month ☐ 9-Month ☐ Critical Juncture ☐ Transfer ☐ Discharge ☐ 7-Day ☐ 30-Day	**Date IPP Disseminated to IDT:** Click or tap here to enter text.

Meeting Attendance

By signing below, I am indicating that I participated in the meeting and that I agree/disagree with the plan that was verbally discussed. Teams are still required to adhere to all policy requirements/clarifications outlined in the Chapter 513 policy manual. If, after this plan has been received and reviewed, any attendee who wishes to address content concerns, should request another meeting (or an addendum) to address any outstanding issues.

Relationship	**Attendee Name - PRINT**	**Signature and Credentials**	**Agency Represented** *(Can be 'n/a' if individual is not representing an I/DD Waiver provider)*	**Agree**	***Disagree**
Waiver Participant			**N/A**		
Parent/Legal Representative					
Case Manager					
Other:					
Other:					
Other:					
Other:					
Other: Advocate					

***Rationale for Disagreement**

If any team member disagreed with the IPP, indicate the reasoning below. If the member and/or their legal representative disagree with the IPP, the IDT must reconvene to obtain satisfactory results. The IPP cannot be considered valid without the member and/or legal representative's agreement. Proration of services may be required when annual meetings are late.