PARTICIPANT NAME / RECORD ID # DATE OF MEETING: MM/DD/YYYY

WEST VIRGINIA I/DD WAIVER INDIVIDUALIZED PROGRAM PLAN (IPP)	
IPP SERVICE YEAR: *mm/dd/yr – mm/dd/yr*	**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: Mailing Address: Phone:	**Health Care Surrogate:** Yes ☐ No ☐ Name: Mailing Address: Phone:	**Medical Power of Attorney:** Yes ☐ No ☐ Name: Address: Phone:
Payee: Yes ☐ No ☐ Name: Address: Phone:	**Conservator:** Yes ☐ No ☐ Name: Address: Phone:	**Service Coordination:** SC Name: SC Provider Agency: SC Telephone #, ext.: SC e-mail:

Attachment Requirements:

☐ Crisis Plan *(required for Annual & 6-Month IPPs)*
☐ Positive Behavior Support Plan/Protocol *(required, if applicable, for Annual & 6-Month IPP)*
☐ Tentative Schedule *(required)*
☐ Task Analysis/IHP *(required, if applicable)*
☐ Participant-Directed Spending Plan® *(required, if applicable)*
☐ Other: _____

PARTICIPANT NAME / RECORD ID # DATE OF MEETING: MM/DD/YYYY

I/DD Waiver Budget Information:	**Service Delivery Option:**	**Non-I/DD Waiver State Plan (Medicaid) Services:**
Assigned Individualized Budget Amount: $ Cost of I/DD Waiver Services Annually: $	☐ Traditional ☐ Traditional and Personal Options	☐ 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 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		**$**	**$**	**$**	**$**	**$**

Over-Budget Services (Use this section only if an Exception is being requested. Indicate TOTAL over-budget units in appropriate juncture column.)						
Code	**Service**	**Total Units (Annual IPP)**	**Total Units (6M IPP)**	**Total Units (Insert Juncture)**	**Total Units (Insert Juncture)**	**Total Units (Insert Juncture)**
Cost of Services Requested		**$**	**$**	**$**	**$**	**$**
Amount Over-Budget		**$**	**$**	**$**	**$**	**$**

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		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 Description	**Provider Agency**	**Provider Name** *(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)*
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** *(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)*
Behavior Support Professional I *N/A if BSP services are not accessed*		
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.*

I/DD Waiver Services Needed to Support Me **Individual Service Plan**		
Service Description	**Provider Agency**	**Provider Name** *(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)*
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** *(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)*
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** *(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)*
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** *(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)*
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** *(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)*
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** *(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)*
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** *(applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)*
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.)	
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.)	
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	

PARTICIPANT NAME / RECORD ID # DATE OF MEETING: 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							
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: MM/DD/YYYY

Interdisciplinary Team Signature Sheet	
Participant Name:	**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: _____