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:	**Additional Insurance (if applicable):**
Address:	**Date of Financial Eligibility:**
Phone Number:	**Date of Medical Eligibility:**
Date of Birth:	**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:	**Case Management:** CM Name: CM Provider Agency: CM Telephone #, ext.: CM 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: ______________________________

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 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?

<table>
<tr><th>Evaluation</th><th>Date of Evaluation</th><th>Summary of Assessments/Evaluations Results and Recommendations (List all assessments used to develop the service and habilitation plan):</th></tr>
<tr><td>HCBS Integrated Settings Rule Questionnaire: Natural Family Assessment</td><td></td><td>
This survey is to be completed for members who live in natural family settings only.

The State must assess all members annually to assure that they are integrated into their community and have full access to the benefits of community living.

If any questions are answered “no”, a copy of the IPP must be emailed to WVIDDWaiver@kepro.com. Please include the Record ID in the subject line of email in order to allow for accurate reporting.
<table>
<tr><th></th><th>Yes</th><th>No</th></tr>
<tr><td>1. Do you or a family member own, rent, or lease this home/apartment? (If the answer is no, then don’t use this assessment, use the Specialized Family Care and ISS/GH Assessment.)</td><td></td><td></td></tr>
<tr><td>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.) https://www.wvlegislature.gov/wvcode/code.cfm?chap=37&art=6</td><td></td><td></td></tr>
<tr><td>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.)</td><td></td><td></td></tr>
<tr><td>4. Were you able to choose this setting from among non-disability specific settings and is this documented on your person-centered plan? (Do not answer if the member or their family owns the home.)</td><td></td><td></td></tr>
<tr><td>5. Were you offered a private room in this setting? (Do not answer if the member is under the age of 13.)</td><td></td><td></td></tr>
<tr><td>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.)</td><td></td><td></td></tr>
<tr><td>7. Do you get meals and snacks that you choose when you want to eat them?</td><td></td><td></td></tr>
<tr><td>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.)</td><td></td><td></td></tr>
</table>
</td></tr>
</table>

		Question		
		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 them to come? (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.)*		
		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.)		
		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**.*		
		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 common 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?		

<table>
<tr><td></td><td></td><td>
<table>
<tr><td>22. Have your staff been trained to meet your needs and is there documentation of that training?</td><td></td><td></td></tr>
<tr><td>23. If any answer on this survey is no, are there reasons why these modifications are needed and are these modifications supported by an assessed need and documented on your person-centered plan?</td><td></td><td></td></tr>
</table>
</td></tr>
<tr><td>HCBS Integrated Settings Rule Questionnaire: Specialized Family Care and ISS/GH Assessment</td><td></td><td>While the UMC will complete questionnaires for SFC/ISS/GH, to ensure accuracy agencies are required to answer the following questions for members who live in these settings. Completed only for members who live in SFC/ISS/GH and it is not required to email IPPs that contain responses of “no” to the IDDW inbox.

1. Have all staff working with me have been fully trained, per policy requirements?
☐Yes ☐ No
2. Was the member/LR was able to choose their current residence from among non-disability specific settings?
☐Yes ☐ No
3. Are the credentials and qualifications of the current Case Manager included in the IPP and updated as necessary?
☐Yes ☐ No
4. Are there strategies for solving conflict or disagreement within the IPP process that are specific to the IDT and the member’s need?
☐Yes ☐ No
5. Were any alternative home and community-based settings considered by the member and the IDT?
☐Yes ☐ No
6. Does the IPP identify who will monitor the member’s service plan in order to ensure services are authorized and delivered?
☐Yes ☐ No</td></tr>
</table>

<table>
<tr><td>ICAP</td><td></td><td>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:</td></tr>
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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:</td></tr>
<tr><td>Extraordinary Care Assessment</td><td></td><td>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:

•</td></tr>
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		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):
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:

<table>
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Individual Service Plan</th></tr>
<tr><td>Service Description</td><td>Provider Agency</td><td>Provider Name (applicable for FPCS, HBPCS, and Respite Services when not accessed at a FBDH site)</td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td colspan="3">Duration of Service: This service should begin on _________ and end on _________.</td></tr>
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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</td></tr>
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<tr><td>Behavior Support Professional I
N/A if BSP services are not accessed</td><td></td><td></td></tr>
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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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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	

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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.

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					
Case Manager					
Other Relationship:					
Other Relationship:					
Other Relationship:					

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

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Signature: ____ Date: __________