DEPARTMENT OF DEVELOPMENTAL SERVICES

Individual Plan-Short Form

***e*CAMRIS Codes:**
☐ **IPS – Ongoing (replaces FAP)**
☐ **IPT– 90 Day Transition to Waiver**

Date: **Region:** **Completed by:**

PERSONAL INFORMATION

Name: _____ **DDS #:** _____ **Gender:** _____ **DOB:** _____
Address: _____
Phone: _____ **SS #:** _____ **Physician:** _____
Admission Status: _____ **Legal Status:** _____
Contact Person: _____ **Relationship:** _____
Address: _____ **Phone:** _____
Entitlements: _____ **Involved Agencies:** _____
(ID# and $ amount)

PERSONAL PROFILE:

Home: (*Describe the person's living situation, activities, abilities and supports provided.)*

Relationships/Family: (*Describe the person's significant relationships including those with family members, friends, neighbors and advocates.)*

Health: *(Provide a summary of the person's health including any health concerns, allergies, medications, adaptive devices or therapies.)*

School/Work/Day Service: *(Provide a summary of the person's day including the type of employment, day service,or school, location, hours and activities.)*

Leisure: *(Describe the person's leisure activities.)*
Finances: *(Provide a summary of the person's financial status including entitlements, benefits, insurance, income and the person's responsibility for managing finances.)*
Vision for the Future: (*Describe where the person will live and how he/she will spend their day and leisure time beyond the coming year.)*
Relevant Issues: *(Identify issues that are relevant for the person for the coming year.* ***Identify any risk issues identified on the LON Risk Summary and how they will be addressed.)***
Service Plan: *(Identify the services that will be pursued during the year to address the relevant issues for the person. Plans should include a description of the activities, supports and services that would benefit the person or his or her family. Descriptions should include the person responsible and time frames.)*
Case Management: *(Describe the nature and frequency of case manager contact with the person and his/her family, guardian or advocate as appropriate.)*

Attach IP.6 when applying for HCBS Waiver enrollment.

Should service needs change during the period of the plan, please contact your DDS Case Manager.
My signature represents my agreement with this plan:

Individual:	Family Member/Guardian:
Service Provider:	Case Manager:
Service Provider:	Service Provider: