

# *A Guide to Individual Planning*



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## **Introduction**

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The individual planning process results in the development of a comprehensive DDS Individual Plan, which is the document to guide all supports and services provided to the individual. It is a way to discover the kind of life a person desires, map out a plan for how it may be achieved, and ensure access to needed supports and services. Individual planning is driven by a respect for the individual, a belief in their capacities and gifts, and the conviction that everyone deserves the right to create their own future.

Individual planning supports people to achieve the outcomes of the mission and vision of the Department of Developmental Services, which states:

### ***Mission***

The mission of the Department of Developmental Services is to partner with the individuals we support and their families, to support lifelong planning and to join with others to create and promote meaningful opportunities for individuals to fully participate as valued members of their communities.

### ***Vision***

All citizens supported by the Department of Developmental Services are valued contributors to their communities as family members, friends, neighbors, students, employees, volunteers, members of civic and religious associations, voters and advocates. These individuals:

- Live, learn, work and enjoy community life in places where they can use their personal strengths, talents and passions.
- Have safe, meaningful and empowering relationships.
- Have families who feel supported from the earliest years and throughout their lifetimes.
- Have lifelong opportunities and the assistance to learn things that matter to them.
- Make informed choices and take responsibility for their lives and experience the dignity of risk.
- Earn money to facilitate personal choices.
- Know their rights and responsibilities and pursue opportunities to live the life they choose.

The individual planning process promotes and encourages the person to take the lead in directing this process and in planning, choosing, managing, and evaluating supports and services with the

help and support of those people who know and care about him or her. It puts the person at the “center” of the plan. Individual planning offers people the opportunity to lead self-determined lifestyles and exercise greater control in their lives.

Individual planning values listening to the person. During the process, the person and their Personal Support Team (PST) develop a holistic plan of supports and services that is meaningful to him or her. The resulting plan identifies services and supports to meet the person’s unique desires and needs, regardless of funding source and may include utilizing a person’s personal strengths and assets, relationships, community supports, assistive technology and eligibility specific services. The plan is not the outcome. The life the person wants is the outcome. Through the implementation of ongoing action steps, the planning and support team help the person move towards the life that he or she desires.

The new IP is written in Person First language. All entries to direct questions for the individual must come from the individual, as much as possible. PSTs may need to assist some individuals in expressing their thoughts or understanding the questions. Any information or answer entered for direct questions that is not an individual’s response must be identified as to whom is speaking. For example: “The Team feels...” or “Mrs. Jones said...” Teams need to avoid speaking for the person. This may be challenging for those individuals who have difficulties with communicating, but is a key part of person centered planning.

Case managers may share information with individuals about different types of person-centered planning processes and encourage them to choose the planning process that works best. However, any information obtained from other types of person-centered planning processes must be incorporated into the DDS Individual Plan form.

## **Who Is Required to Have an Individual Plan?**

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All individuals assigned a case manager shall have an Individual Plan (IP) or Individual Plan – Short (IPS) Form commensurate with the supports and services received.

### **The following individuals shall have an Individual Plan:**

- All individuals who receive DDS HCBS Waiver services
- All children in Behavior Supports Program
- All individuals served by the department who pay directly for Residential Habilitation services.

### *Exceptions to an Individual Plan*

Individuals served by the department are **not** required to have a comprehensive Individual Plan under the following circumstances:

- Individuals who are enrolling in a HCBS waiver will use the **Individual Plan – Short Form**, along with a **Summary of Supports and Services**, for the first 90 days of receipt of new HCBS Waiver services, 45 days in licensed settings, after which time an Individual Plan must be in place. This process will also be used for any individuals in the MFP program.
- Individuals who live in private ICF/IID settings may plan use the private agency's plan form.
- Individuals who live at home with their family or in their own homes and who do not receive DDS funded residential supports, including Individualized Home Supports or any Home and Community Based Services (HCBS) Waiver supports, including day support shall have an **Individual Plan – Short Form**.
- Individuals who are appropriately placed in Long Term Care/Skilled Nursing facilities including those receiving **Specialized Supports** shall have an **Individual Plan – Short Form**.
- Individuals who pay directly for employment supports or day services and have no other paid supports provided by DDS shall have an **Individual Plan – Short Form**.
- Individuals in Out of State placements do **not** require a DDS Individual Plan or IPS but must have a plan in place provided by the school or agency they reside with. The DDS Case Manager must have a copy of this plan in the person's master record.

## **Individual Planning Timeframes**

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The Individual Plan is the document that guides the supports and services provided to the individual. The Individual Plan should accurately reflect the individual's vision for their future, current life situation and address their specific desired outcomes and supports and services. At a minimum, Individual Plans and Individual Plan Shorts will be reviewed and updated on a yearly basis. For HCBS Waiver recipients, the plan must be renewed within the same month of the prior year's plan date. If a plan cannot be completed within the required time frame the case manager must follow the procedure "To Extend an IP or IPS". For individuals newly determined eligible for DDS services, the case manager should ensure that an initial Individual Plan or Individual Plan – Short Form is developed within 60 days of the initial visit.



## **Roles and Responsibilities**

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### *Role of the Individual*

The individual is at the center of the planning process. Individuals and their family members should participate in the planning process to the greatest degree possible and effectively communicate their needs, desires and preferences to other team members. Individuals and their families have an important role in selecting participants to be invited to the planning meeting and helping to expand and enhance team membership. Ways that this can be done include identifying, recruiting and welcoming new team members and showing appreciation and support for the contributions of existing team members.

Before the meeting, the individual should complete the One Page Profile and the Trajectory pages of the IP and prepare to discuss at the upcoming meeting. Individuals and their families should provide information to the case manager to help him or her complete the Level of Need Assessment and Screening Tool (LON). Along with the case manager, individuals and their families should review the assessments, reports, and evaluations and determine how information is to be presented.

Some individuals may have difficulty expressing their thoughts and feelings about their future vision or how they want supports to look like for them. Families, case managers and support providers should be ready to assist the person to share their thoughts and to present this information in any way possible. It is important that teams take the time to get the person's view of what they want for their vision of their future and not impart too much of what they, as families or providers think the person's life should be like. There will be a time and place for the person's PST to discuss and present ideas on service and support needs, but the One Page Profile and the Trajectory pages should include as much of the individual's thoughts as possible. If the individual does not provide input to these sections of the plan the team shouldn't just write in their own thoughts, they should document the efforts they made to obtain the individual's thoughts within this area. Teams could include pictures or narrative of how the person reacted to the questions or options that the team presented them in areas of home life, work, activities, etc. While teams may feel a need to add their own thoughts on these subjects it is important not to speak for the individual. If a team does add some ideas or statements they should show how they arrived at their conclusion. For example, if they feel the person thinks baseball is important to them they could attach a picture of the person enjoying a game. This will not only back up what they are saying but it can involve the individual with what's in their plan more than just written words the person may not be able to read. Family members who feel they must add their own thoughts or information on these subjects could use other copies of these pages to be added to the IP.

(For additional information see the section on the One Page Profile and Trajectory page.)

During the meeting, the individual should share his or her vision for a Good Life, what they don't want their life to look like, preferences for what their home should be like and work or activities to be pursued, types of supports to be provided, support providers, and objectives for the coming year. After the meeting, the individual and his or her family should review the completed plan for accuracy. The individual, parent, guardian, advocate or provider should contact the case manager within two weeks of receipt of the written plan if they do not agree with the plan as written.

Throughout the development of the Individual Plan, the individual should share information with the case manager and other team members about his or her satisfaction with the supports and services received. The individual should participate in ongoing monitoring and quality service reviews of supports and services and in periodic reviews of the plan.

### *Role of the Case Manager*

The role of the DDS case manager in individual planning is to support the person and other team members to develop and implement a plan that addresses the individual's vision, needs and preferences. The case manager will support the individual to be actively involved in the planning process and to assume greater responsibility over time for directing and facilitating their meeting if they choose.

The case manager should assist the individual to identify members of his or her planning and support team and to invite them to the meeting. The case manager will support the individual and family to review assessments and reports before the meeting and to provide them with the One Page Profile and Trajectory pages. The case manager will complete a Level Of Need prior to the meeting based upon the information provided them by team members. Prior to the meeting, the case manager will also ensure that any individuals who express interest in self-directing supports are made aware of the opportunity to hire an independent support broker to assist with planning.

The case manager is responsible to ensure the individual planning meeting is scheduled at a time when the person, his or her family and other team members can attend. The case manager will help to ensure that the person is in their planning meeting to the fullest extent they desire. He or she is responsible to facilitate the annual individual planning meeting unless the individual requests another team member facilitate the meeting. The case manager should ensure the meeting is facilitated in line with the individual planning process and encompasses input across services settings.

Annually, the case manager will notify the individual and their family or guardian about their human/civil rights, department's guidelines for reporting incidents or abuse to family members, the ADA, their Wait List status as applicable, LON score, Medicaid Fair Hearing rights and Regional Advisory Councils.

At the time of the individual's planning meeting, the case manager is responsible for ensuring the individual, and his or her family, guardian, advocate or other legal representative, if applicable, is informed of the rights extended to them by DDS, including the right to appeal any decision that is made at the meeting through the Programmatic Administrative Review (PAR) process. The case manager will also notify individuals who are age 18 or older of their right to vote and to offer assistance with registering to vote if they so desire. The case manager will document the individual's response to this notification on an ED-682 form.

The case manager shall ensure the individual has been offered a choice of supports, service options, and providers and that the plan represents the individual's preferences and vision for a good life. The case manager will transcribe and document the plan on the Individual Plan forms. The case manager will review the documented plan for accuracy and share with the individual and

his or her family or guardian and service providers for review. At the planning meeting, the case manager will document who participated in the planning process and obtain signatures of those present on the Signature Sheet. The case manager will ensure the plan is distributed to all team members within 30 calendar days of plan development. If the team cannot meet to conduct the IP within the required annual timeframe, the case manager will complete all steps required to extend the IP for a specific period of time as needed, usually within 30 days. In incidences where the IP is not written and/or distributed in the required time period, the case manager or provider will follow the “Procedure to ensure Timely documentation”.

During the first year of DDS’ roll out and implementation of this new IP format, case managers will have up to 45 days to complete and distribute the plan to all team members.

Through contacts and quality service reviews the case manager is responsible to monitor implementation of the plan to ensure supports and services are provided as outlined in the plan and that progress is being made that results in improvements in the individual’s quality of life. He or she will ensure the plan is periodically reviewed and updated based on individual circumstances and regulatory requirements. The case manager will document details about the IP meeting as well as any other contacts in the Electronic Case Notes system.

### *Support Provider Roles*

The role of support providers is to provide assistance to the individual with working on their vision for their life and to ensure that quality, effective and timely supports are provided by qualified, trained staff. Providers should be active participants in the individual planning meeting and are responsible for developing specific plans including teaching strategies, programs, protocols, and guidelines that are in line with the person’s desires and needs and include how, when, where, and what supports will be provided and how these supports will help the individual to achieve their vision.

Providers will assist in scheduling of meetings to be at a time and place convenient to the individual and their guardian/family. Providers should make accommodations to assist the guardian/family to attend the IP meeting as necessary. Providers should be ready to assist the person to share their thoughts, help them to complete the One Page Profile and Trajectory pages and to present this information in any way possible. Providers will complete any assessments, evaluations, or reports for which they are responsible and will submit them to the other team members at least 14 days before the Individual Planning meeting and at other required deadlines. They shall provide information to the case manager to assist with the completion of the LON. Support providers will maintain documentation of progress on specific plans, including teaching strategies, programs, protocols, and guidelines. All providers of services are responsible to complete an Individual Progress Review on the goals they are responsible for and distribute to team members at the 6 month mark of the IP meeting and 14 days prior to the next IP. Nursing and Behavioral reports are still required on a quarterly basis. Providers will notify the case manager at any time there are any significant changes in the individual’s life that warrant a revision of the individual plan.

**Individual Planning**  
**Planning and Support Team Member Roles and Responsibilities**

<b>Individual Planning Activities</b>	<b><u>Individual</u></b>	<b><u>Case Manager</u></b>	<b><u>Support Providers</u></b> (includes residential, day, & other providers)
Before the meeting select participants to be invited	✓	✓	
Schedule meeting at time and place convenient for individual/family, CM, and other team members and invite participants	✓	✓	✓
Submit current Assessments, Reports, Evaluations and LON information to all team members 14 days prior to IP meeting			✓
Review Assessments, Reports, and Evaluations with individual and family as needed.		✓	
Provide Individuals with the One Page Profile and Trajectory pages.		✓	
Ensure copies of Assessments, Reports, Evaluations are shared with team members.		✓	✓
Assist individuals with completion of the One Page Profile and Trajectory page as needed.	✓	✓	✓
Complete LON with input from individual, family, and other team members		✓	
Share LON and LON Summary Report with individual/family and provider(s)		✓	
Facilitate the meeting unless individual requests another facilitator		✓	
Review IP for accuracy and completeness	✓	✓	✓
Complete document and Distribute the Plan Within 30 days of IP meeting. (45 days in the first year of DDS' roll out of new IP process)		✓	
Notify CM within 2 weeks of receipt if the individual or PST member does not agree with plan as written	✓		✓
Develop and Implement Specific Plans in line with the IP, including teaching strategies, protocols, guidelines, and program plans			✓
Document Progress on Goals and Specific Plans			✓
Provide 6 month Individual Progress Reviews to team members			✓

Convene team meeting during the plan year if needed		✓	
Update CAMRIS information		✓	
Document IP meeting and contacts in Electronic Case Note system		✓	

## **Steps of the Individual Planning Process**

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### *Prepare to Plan*

- Identify the individuals to be involved in the planning process
- Schedule the planning meeting
- Provide the One Page Profile and Trajectory pages to the individual and support them to prepare for the planning meeting
- Gather information from other team members and develop the Level of Need Assessment and Screening Tool

### *Gather a Good Understanding of the Individual*

- Review recent assessments, screenings, evaluations and reports
- Review the completed LON and the LON Summary Report

### *Develop a Plan to Achieve Desired Outcomes*

- Identify the person's Vision for a Good Life and how they want supports provided
- Assist the individual and their team to identify how they want their services to look like and what supports are necessary.
- Develop a plan for emergency back-up supports, if applicable
- Develop action steps that are specific and measurable
- Identify supports needed to assist the person to make choices and participate in planning
- Identify how progress on the individual's plan will be monitored
- Complete the Aquatic Activity Screening - Addendum to the plan
- Complete the Fall Risk screening as needed
- Review the Financial Assessment; identify recommendations to include in the plan.

### *Summarize the Plan of Supports and Services*

- Identify types and amounts of services and supports to address the person's desired outcomes
- Document who will provide the support and in what time frame

### *Document the Plan and Obtain Agreements*

- Document the Plan and disseminate to team members
- Individuals/families/team members notify case manager within 2 weeks if do not agree with written plan

### *Put the Plan Into Action*

- Submit requests and arrange for needed supports and implement the plan
- Providers implement specific plans including teaching strategies, programs, protocols, etc.

### *Monitor and Revise the Plan as Needed*

- Monitor plan implementation
- Conduct annual Quality Service review
- Providers submit 6 month IPRs, quarterly nursing & behavioral report to all team members
- The team convenes to make changes to the plan as needs and circumstances change.
- Document any steps taken in the overall IP process in the person's electronic case notes

## **Prepare to Plan**

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### *Identify the Participants to be involved in the Planning Process*

The individual and his or her family members should be comfortable with the people who help to develop the Individual Plan and should consider inviting a balance of people who can contribute to planning, including friends, family, support providers, professional staff. The individual should be supported to include people in the planning and support team who:

- Care about the individual and see him or her in a positive light.
- Recognize the individual's strengths and take the time to listen to him or her
- Can make a commitment of time and energy to help the individual to develop, carry out, review and update the plan.

At the very minimum, all planning and support teams shall include the individual who is receiving supports, his or her guardian if applicable, his or her case manager, and persons whom the individual requests to be involved in the individual planning process. The case manager should contact the individual prior to scheduling the meeting to identify the people the individual requests to have present at his or her planning meeting.

Individuals who are interested in self-directing their supports shall be made aware of the opportunity to hire an independent support broker. If selected, the independent support broker would become a member of the person's planning and support team.

Planning and support teams for individuals who receive residential, employment, or day support should include support staff chosen by the individual and who know the person best. Depending upon the individual's specific needs, health providers, allied health providers, and professionals who provide supports and services to the individual should be involved in the individual planning process and may be in attendance at the individual planning meeting.

Individuals who are interested and would benefit from the support of additional members of their team should be encouraged to invite friends, co-workers, IP buddies, advocates and interested community members to their planning meetings. These community members should be supported to participate in the planning process in a meaningful and constructive ways.

### *Schedule the Planning Meeting*

Every effort will be made to schedule the planning meeting at times and locations that will facilitate participation by the individual and his or her family, guardian, advocate or other legal representative as applicable. The case manager will ensure that the individual and/or the person's family are contacted to schedule a meeting at their convenience.

If the person, family, or guardian refuses to participate in the Individual Plan meeting, the case manager will document his or her attempt(s) to invite participation and the responses to those

attempts in the electronic case note system and in the Summary of Representation, Participation, and Plan Monitoring section of the IP. In these situations, the case manager and the team members shall pursue other ways to involve the individual, family, or guardian in the planning process outside of the meeting. Any steps to increase participation of the individual for next year's IP should be noted in the Action Plan of this year's IP. ***It is important that we clearly document all efforts to include the individual and their representatives in the planning process and the level of participation that occurred.***

### ***Support the Individual to Prepare for the Planning Meeting***

The case manager and other team members should assist the person and his or her family to be actively involved in the planning process. This includes inviting the individual and team members to participate in the planning process, determining the content of the meeting and deciding how the meeting will be run and organized. The case manager and other team members shall assemble as much information as possible before the meeting to assist the individual and his or her family to prepare for the meeting. This helps the meeting to be shorter, more focused on planning and decision making, and more run more efficiently. Supporting the individual to prepare for the meeting offers an opportunity to express his or her desires or concerns to the case manager or another team member with whom he or she is comfortable and who can assist the individual to share these issues with the larger group.

If the person and his or her family are interested in self-directing their supports, the case manager shall explain the supports an independent support broker can provide and offer an opportunity to invite an independent support broker to be involved in the planning process.

Before the meeting, the case manager will distribute the One Page Profile and Trajectory pages to the individual and their guardian. Some individuals may have difficulty expressing their thoughts and feelings about their future vision or how they want supports to look like for them. Families, case managers and support providers should be ready to assist the person to share their thoughts, complete these two pages as best they can and to present this information in any way possible.

The case manager will complete the Level of Need Assessment and Screening Tool (LON) with information from the individual, the family, providers and/or the master file prior to the planning meeting. Providers of supports and services must share current assessments, Individual Progress Reviews, reports and evaluations with the case manager and other team members at least 14 days prior to the scheduled meeting. The case manager will share the updated LON and LON Summary Report with team members prior to the planning meeting, if possible. The case manager shall provide an opportunity for the person and his or her family to review the information contained in current assessments, reports, and evaluations that will be discussed at the meeting.

The individual has the option of having the case manager facilitate the planning meeting or selecting another person to facilitate the meeting. If the person selects an independent support broker, he or she may also choose to have the broker facilitate the meeting.

### **Accommodations**



The case manager and the PST shall ensure individuals have needed accommodations for the meeting. Individual plans should be developed and provided to individuals and families in their native language when requested. Should an individual or family member require a language or sign language interpreter to effectively participate in the planning process, case managers may submit requests for translation or interpreter services to their supervisor for approval.

Some individuals may have communication devices, adaptive equipment or technology, or other types of required accommodations that must be available in order to successfully participate in the planning meeting. The case manager will help to make sure that these devices, equipment, or accommodation supports are available and in good working order at the time of the meeting, so that there are no barriers to participation.

There may be circumstances when the individual does not want to discuss something in a meeting. This preference should be respected whenever possible. However, personal information that affects supports or impacts the individual's health or safety should be addressed. In these circumstances, the topic should be acknowledged and dealt with respectfully and privately outside of the meeting with the person and with others who need to know this information to provide appropriate supports.

### **Informed Choice**

An important part of pre-meeting planning is helping the individual understand the choices that are available. The case manager will help the individual to understand the waiver service options and hiring options that DDS provides to all consumers and will explain the DDS portability process. A review of support options is especially important during periods of transition, such as during the transition from school-to-work, when funding resources become available to the individual, when major life changes occur, or when aging issues become apparent.

### *Develop the Level of Need Assessment and Screening Tool*

Prior to the individual plan meeting, the case manager will develop or update the Level of Need Assessment and Screening Tool (LON) with input from the individual, the family, and providers and with information from the master record. Support providers have input into the LON and should share current information about the person, including their skills and abilities, behaviors, health care needs, and medications. The case manager is responsible to reviewing the information for accuracy and ensuring it aligns with his or her own knowledge of the individual, information from the family, and assessments and reports that are on file.

The LON will be completed before the initial plan and updated annually or more often as needed to reflect significant changes in the person's life or to identify and document concerns or issues that may pose a health or safety risk to the individual. The completed LON and the LON Summary Report, along with other assessments, will be shared with the individual's team members in preparation for the planning meeting.

## **Gather a Good Understanding of the Individual**

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During the planning meeting, the individual and his or her planning and support team will review or assist the individual to complete the One Page Profile and the Trajectory page, assess the person's current home, work/day, financial, health and wellness and relationships status. The team should complete an analysis of the person's preferences, desired outcomes, and support needs. They shall analyze current assessments, reports, and evaluations, including the Level of Need Assessment and Screening Tool (LON) and the LON Summary Report, to identify what is important to include in the plan and to identify any additional assessments needed. The informational sections of the plan that are completed and reviewed during this stage of plan development include the:

- One Page Profile
- Trajectory Page
- Home Life
- Work, Day, Retirement or School
- Health and Wellness
- Friendships, Relationships and Activities
- Integrated Support Star

### *One Page Profile*

The first two pages of the Individual Plan (IP) are for the individual to provide their thoughts about what's important to them and desires for the future as a start to gathering information on how to support the person. The 'One Page Profile' begins with "What People Like and Admire about Me". It is important that this information come from the individual themselves and not a combination of the team's thoughts. There will be an area within the Integrated Support Star to put similar information from team members. In this spot it should be exclusively the individual's view as much as possible. These first two pages need to be sent to the person before the meeting to give them time to think about the questions and complete them. Families, providers and the case manager can assist the person with these pages but it's important for them to not lead the person with their support but try to solicit their view in any way possible. This may mean making use of alternative methods of communication, assistive technology, taking pictures of the person's expressions, videos, etc. Whatever helps the person to express their desires for their future or the things they like. 'What's Important to Me?' should focus on the things a person feels they need to improve their quality of life. It is their opinion and should not be qualified or edited in any way. In the 'How Best to Support Me?' box, what does the person feel are the best ways to support or

interact with them? How would they like to see their supports provided? Teams could include pictures or narrative of how the person reacted to the questions or options that the team presented them in areas of home life, work, activities, etc. This may take some time, but it is an important part of the support that a team can provide the person. If the team does add some ideas or statements they should show how they arrived at their conclusion. If pictures are difficult to insert in the IP document they can go on separate pages and attached to the IP. It can be noted in the sections they relate to that they are attached.

### *Trajectory Page*

The Trajectory page is where the person identifies their vision for the future. What they want their life to look like and the things they don't want in their life. People should be encouraged to dream BIG. While not all dreams are attainable, the pursuit of them is what's important. It is in the pursuit that a person can gain improvements in their quality of life. Teams should help the person to see beyond their present circumstances and think towards the future. Their 'Vision for a Good Life' should be what they consider to be ideal. Would they like to own a home, get married, get their driver's license, own their own business, etc.? Some of the individuals we support may not have been asked questions like this in the past and may require help to comprehend them and come up with answers. It is important to note whatever they do come up with. For some it may be easier to identify what they DON'T want their life to look like. Those items would be recorded in the box with that title and the teams should refer to them when developing support plans. The 'Actions Steps That Will Lead to a Good Life' should list some things that the individual would identify as stepping stones toward their goals. These are not fully written out action steps like what will be developed in the Action Plan section later in the IP. It is what the individual suggests should go there. These should be just a short list of items that the person identifies as their way to measure progress towards their goals noted in their 'Vision for a Good Life'.

The information in these two pages should be short, simple listings of information. There is no need for long narratives or detailed sentences. It is best to get to the heart of what the person is describing, as it will make it easier when developing action plans later. The space within the boxes for these graphics won't support an unlimited amount of information. While lists may pass the visual section of the text boxes, it will remain within the electronic copy of the document. The printed version will only show what is visible in the box. A scroll icon will appear when text goes beyond the box boundaries. If the individual does not provide input to these sections of the plan the team shouldn't speak for the person, but they should document the efforts they made to obtain the individual's thoughts within this area. Teams could include pictures of how the person reacted to the questions or options that the team presented them in areas of home life, work, activities, etc. While teams may feel a need to add their own thoughts on these subjects it is important not to speak for the individual. If the team does add some ideas or statements they should show how they arrived at their conclusion. For example, if they feel the person thinks baseball is important to them they could attach a picture of the person enjoying a game. This will not only back up what they are saying but it can involve the individual with what's in their plan more than just written words the person may not be able to read. Family members who feel they must add their own thoughts or information on these subjects could use other copies of these pages to be added to the IP.

## Home Life

The Home Life section starts with the person's **Current Status**. This is where all team members can provide brief summaries and concise information on how the person is doing in their current residential situation. Important points from reports, progress or accomplishments made this year can be provided. This may be a place to note how specific LON risk areas are being addressed. This is not an area to rewrite or insert large amounts from other reports. Reports should be sent to the team members prior to, and be reviewed before, the meeting. Those documents can be discussed at the meeting and attached to the IP. Things to include in this area would be the individual's schedule, the supports they receive and supervision needs.

In all these informational sections the questions are directed to the individual and are geared to help get as much from the person themselves as possible. Teams can and should assist the person to answer the questions and may need to find accommodations to the manner in which the person is questioned or in how they answer. This may involve using picture boards, communication technology or the assistance of the people who know the person well and how they communicate. Any process that can help the person answer or understand the question should be considered, but of most importance, is for the team to provide the time to the individual to answer as best they can.

1. **What do I want my Home to be like?** This question focuses on the person's present living situation. What the person would like to see happen at home to improve their satisfaction there. Teams can help the person identify things they like about their home, how they like to spend their time there and how to increase or improve those things.
2. **Would you like to live anywhere else, what's your vision?** This question should refer back to what the person identified in their 'Vision for a Good Life'. What was their vision for their home on the Trajectory page? Are there any more details the individual can add? How can the team help the person identify those things?
3. **What supports do you need to help with this?** What does the individual feel they need for supports to move to their most desired setting? Do they need training in certain areas? Ongoing or intermittent supports? Teams can assist the individual to identify these supports but they must be sure to include the individual in that discussion.
4. **Do you need support with your finances?** Residential providers are required to submit annual financial assessments. These reports can identify some of the support the person needs and referred to in the IP rather than re-written here. All teams should help the individual to identify their supports needs here. Does the person have a representative payee? Do they need one?
5. **You are required to obtain and maintain Medicaid benefits. Do you require help maintaining Medicaid?** Individuals receiving supports funded by DDS are required to keep and maintain their Medicaid status. This requires annual re-applications. Teams need to identify the people supporting the individual in this area. Be specific. The individual and his or her family, legal representative or residential provider shall maintain Medicaid eligibility and submit required documents to the Department of Social Services (DSS).
6. **Financial Information.** The intent here is to enter as much information as needed to assist the person in understanding their financial situation. If the information is listed in a report

prepared by a provider it does not have to be replicated here but referred to. It should be discussed at the meeting. The case manager is responsible for verifying a person's continuing eligibility for Medicaid. This information is important for that verification.

7. **Are you satisfied with the supports you are receiving at home?** All areas of support listed in the informational sections will have this question. It is an important one and needs to come from the individual themselves. This is required information for the individual plan. If family or guardians have a different perspective that can be included too but the person's response must be here. Some individuals may not feel comfortable answering this question at the meeting. Case managers should be considerate of this issue and follow up with the person as needed either before or after the meeting.
8. **Emergency Contact.** Very simply, who is the first person to contact in case of an emergency for the individual?
9. **Emergency Back-up Plan.** This must be completed for those individuals who receive waiver services and live in settings where staff might not be continuously available, and who receive personal care and /or supervision and the failure of those supports to be available would lead to an IMMEDIATE risk to the individual's health and safety. It can be used for other reasons if the team feels it is important but it must be used when the conditions noted previously apply. For individuals who hire their own employees, the back-up plan shall include a list of staff, family, friends, and neighbors who have agreed to provide backup support, their contact information, and their availability. Qualified providers and Agency with Choice providers are responsible for providing back up for the services they provide. If a person does not require a backup plan the team will check the "NO" box.

### *Work, Day, Retirement or School*

The Work, Day, Retirement or School section is the place to review and discuss the person's progress and desires for their activities during the day or their work/career vision. Like in Home Life it starts with the **Current Status** which should provide a brief description and summary of what the individual is doing in this area. Supports that are needed, accomplishments, how specific LON risk areas are being addressed, etc. Highlights of reports previously submitted can be included here. The follow up questions are devised to help produce information to include in a person's action plan.

1. **Do you like the job you have or the activities you do during the day?** This is a direct yes or no question for the individual to answer. If the individual has anything else to add they can, but most of that info would probably be part of the next question.
2. **What do you like about it, what would you like to change?** While this should be primarily the individual's opinion only, teams may need to assist the person if they are having difficulty in identifying specific items.
3. **What new skills, education or activities would you like to learn or take part in this year?** Were there items from the Trajectory page that can go here? Can the team help the person be more specific? Is there a first step toward a dream job that the person can begin in the next year? This area can help provide information for action steps in the Action Plan.

4. **What are your career goals? Vision for the future?** Were there any items related to work or daily activities in the person's 'Vision for a Good Life'? There should be. Teams should be encouraging and assisting those who want to work to think about careers. Do they have a career objective? What's their dream job? For those who no longer want to work, what activities do they enjoy and what do they want to do in the years ahead? Can any of those items be included in this year's Action Plan?
5. **What supports do you need during work or activities?** What does the individual feel they need to progress to their most desired setting or activity? Do they need training in certain areas? Teams can assist the individual to be clear on what they feel they need. It is important not to lose the person's opinion in team discussions and recommendations.
6. **Do you have transportation to get you to and from work on time?** What are the transportation arrangements for the person? Is it working? Are they satisfied? Is the person frequently late to work due to transportation problems? Day providers and teams have steps to follow for those situations. It needs to be discussed and addressed here as needed.
7. **Do you make minimum wage or better?** Many of the people we serve may not be aware of minimum wage requirements or what they earn. This question can be used to give the person a perspective on their earnings.
8. **Are you satisfied with your wages?** While this seems like an easy question it may open up discussion on what the person really thinks of what they earn. It is a start of the discussion that can more clearly be documented in the following two questions.
9. **Do you make enough money to do the things you want?** Can the person pay their bills on time? Could they afford to live on their own or would they require living with other people? Can they take part in desired recreational activities?
10. **What can you do this year to make more money?** If the person desires to make more the team can discuss with them what they may need to do to accomplish this. Examples include; increasing hours at their job, seeking a higher paying job or finding an additional job. Ideas that come from this question will help generate action steps for this year.
11. **Are you satisfied with the supports you are receiving?** As in all areas of support it is required that we document a person's level of satisfaction with the supports they receive. While it can be answered with a yes or no, if there is any additional information the person wants to add that is important as well. As in the Home Life section case managers need to be sensitive to those who may not feel comfortable answering this question with the support providers or family members present.

## *Health and Wellness*

While health and safety is an important part of all our lives, teams need to make sure it is not the singular focus of a person's planning meeting. Reports should come to team members before the meeting so they can take the time needed to read and process the information outside of the meeting. Time at the meeting should be spent on specific questions about the reported information or the summaries of the key points. The person's opinion on what they feel is important to them about their health and safety must be considered. All citizens have the right to make choices about our health and safety and the individuals we serve have the same rights. While some of the people we serve have a guardian or conservator over medical or programmatic decisions their opinions on

how they want to be served in this area must still be solicited. As in the previous two sections, Health and Wellness starts with the **Current Status**. Team members will submit information on current doctor's order, medications, known allergies, brief overview of health or behavior history unless noted in submitted reports. All reports can be referred to, attached to the IP and only key points noted in this section.

1. **What's Important to me about my health and safety?** What areas does the person want to work on? What parts of their health care or other supports do they find working well? What would they like to see improved? This is entirely the person's point of view in this area. Teams may or may not agree with the person but it is important to hear what the person thinks about their health and safety. Some individuals may require assistance with this question to express themselves.
2. **Are you up to date on routine medical tests and visits?** For those individuals with nursing supports this should be answered in the nursing report. Nursing support providers utilize the DDS Health Standard 09-1 Attachment A, Minimal Preventative Care Guidelines for Persons with Intellectual/Developmental Disabilities. For individuals who live with families and do not have nursing supports or health care coordinators, teams need to refer to this document as well. Is the person able to follow these recommended guidelines? If the person has any Deferrals for recommended tests or assessments these should be listed in this section.
3. **What supports do you need to improve your health and safety?** Individuals and their teams should use this area to identify steps for the person's action plan. This is the area where the teams will discuss needs and develop strategies on addressing them, including any risks identified in the LON.
4. **Are you satisfied with the supports and services you are receiving?** The person may choose to answer this with a Yes/No but the team should also include any other points the individual wishes to make about their health and safety supports. If a person answers with a No and declines to explain it the case manager must follow up with the person at a later time. It may be difficult for them to express it during a team meeting.

### *Friendships, Relationships and Activities*

Loneliness is an increasing problem for many Americans and it can especially affect the people we serve who may have limited access to social situations or of developing friendships due to a variety of reasons. How can the team assist the person to increase or improve their relationships if they desire to do so? How can they help them to build friendships? Does the person have other things they enjoy in their lives besides work or home activities? Do they want to do more? Building a social network of some type should be part of everyone's plan for the future however that may look. The intent of this section is to assist the person to identify, improve or increase friendships, relationships and activities outside of their regular residential or work settings. Question 1 identifies some of the people in the individual's life while questions 2 and 3 are for helping to define some of the things that can help a person meet people with similar interests and potential friendships or fun activities.

1. **Who do you enjoy spending time with?** This should be a simple listing of people the individual enjoys being with. Friends, family, co-workers, acquaintances. Who are the people in their life?
2. **What are your interests and hobbies?** While some people may have a good many interests and hobbies, others may not. For those that do, it provides them with a chance to think about where they want to go with those activities, whether to increase the opportunities or to get more involved. It also provides them with areas to look at when trying to meet new people or increase friendships. For those folks that do not have or are not pursuing other interests, this is a good time for the team to help them look at that. Do they want to learn something new? Are there things they wish they could do? Have they heard of other people doing things that they think they would enjoy?
3. **Do you participate in any groups?** Is the person a member of a group now and do they enjoy it? Do they want to get more involved? Who are the people in those groups that they like? For those who don't take part in any groups, are they interested in looking into some? What would they find enjoyable? Being part of a group is a good way to increase your friendships, social standing and network.
4. **Would you like to increase the time you spend with family, friends or doing hobbies or favorite activities?** The team should be trying to help the person get more specific here about what they would like to do or who they would like to spend more time with. The answer to this shouldn't be a simple yes/no but should be descriptive.
5. **What help do you need to accomplish this?** This is directly related to the above question and is where the team can help the individual identify the supports they need and develop an action plan for this year and the future.

### *The Integrated Support Star*

The Integrated Support Star can help individuals and their teams to look beyond eligibility specific providers of support like DDS or DSS to other resources in the community and their social connections. The five groups identified in the star are: Relationships, Personal Strengths and Assets, Technology, Community and Eligibility Specific.

- **Relationships** - the individual and their team should ask who the important people in the person's life are. What people can assist the individual on their path toward their vision? Are there other people that can be sought out to help or for the person to meet?
- **Personal Strengths and Assets** - is similar to what the individual may have put down in their One Page Profile for how they think other see them. But here, the whole team can add their thoughts on a person's strengths and assets. How can these be used to help the person toward their vision or in devising an action plan to meet their desired outcomes?
- **Technology** - is changing at a fast pace. There have been many different assistive technology devices that have been developed in the last few years that have provided many people with a level of independence that were unavailable before. The team should be looking at ways any technology, new or older, can be used to help the person along their vision path or improving their independence and quality of life.



- **Community** – this area of the Star should contain any resources available in the individual’s home town or area. Examples are: Community centers for recreation or social activities, Literacy volunteers or library resources for learning, Meals on Wheels for increasing the person’s independence to live in their own home, Fire and Police Department auxiliaries for social groups or pursuing interests, Church or religious activity for spiritual growth or community inclusion.
- **Eligibility Specific** – this relates to entities that provide supports to people based upon their meeting specific criteria. DDS is an example of this as well as many other state agencies that help people. Individuals and teams should look to make sure this isn’t the only area marked in a person’s Integrated Support Star. If so, their opportunities are limited. There may be different agencies that can provide needed support and they should be noted. But the best way to help a person along their vision path is to include the many other areas noted within the star.

### *Review the LON and the LON Summary Report*

While not a specific section in the individual plan document, the individual and his or her planning and support team will need to ensure they address all the areas of support needed by the individual as identified in the Level of Need Assessment and Screening Tool (LON) and the LON Summary Report. Much of this information may already be incorporated in a person’s nursing, behavioral or programmatic plans.

The Assessment Summary section of the LON Summary Report will show the results in each area assessed by the tool. Those areas with higher results, relative to the maximum, are areas in which the person more likely requires an increasing level of support. Those support needs shall be considered in the development of the Individual Plan.

When areas are identified as having the potential for risk in the LON Summary Report, they must be addressed in the person’s Individual Plan. Potential risks may be addressed in a number of ways in the plan. Addressing the potential risk may include the identification of a needed assessment or evaluation and associated step in the action plan to obtain that assessment or evaluation; reference that current supports, guidelines, or a protocol are in place to address the need; specific notation of the team’s review in the information sections, or recommendations if any, for additional supports, training, or sharing of information. The strategies listed on the LON Summary Report are potential ways identified risk areas may be addressed. The case manager and planning and support team are not required to complete the check boxes on this form, but could use it as a reference in developing the plan.

The Risk Summary section of the LON Summary Report does not include every area in which a person may need support to minimize risk. The Risk Summary only identifies common potential risk areas, so should not be considered all encompassing. The team must still refer to the completed LON Assessment for specific detail about the person’s unique needs.

## **Develop an Action Plan to Achieve Desired Outcomes**

Once the team has gathered a good understanding of the individual's desires, future vision, current life situation and support needs they should begin to identify the action plan for the coming year. Some individuals may be clear with what they want or the supports they need. Others may not be as capable to articulate this information. To assist the individual to identify desired outcomes, the members of the planning and support team should work together to identify ideas or themes that surfaced during a review of the information the individual and others shared. The themes may be recurring ideas about required support needs or about a person's desires. What can be done this year to help the person make progress towards their future vision? Themes shall be identified by reviewing the One Page Profile, the Trajectory Page, reviewing the informational pages, and the Integrated Support Star. Information within the various assessments and progress reviews need to be considered as well.

The action plan will include desired outcomes, why this is important to the individual, the actions and steps that will be taken, the responsible persons, and timeframes. While developing the action plan, the team should keep the individual's vision, choices and preferences in the forefront. Any identified risks from the LON needs to be addressed in some manner within the body of the IP or in an action step. Not all LON risk needs will require a specific action step if a response to it has already been included in informational sections of the IP. As a guideline, any need that warrants a protocol, guidelines, program or paid supports needs to be reflected in some way in an action step. The case manager shall ensure the individual and his or her family or guardian have information to make informed decisions regarding the degree to which the individual may wish to self-direct services and supports.

Individuals may self-direct their supports and services, may choose an agency with choice to hire the staff they prefer, may select to have services delivered by qualified vendors, or a combination of options.

While the Action Plan, like the majority of the Individual Plan, is written in Person First language, teams can develop outcomes and steps that do not all need to be written as "I want ..." statements unless the person specifically provides that language for the Desired Outcome. Example: a Desired Outcome could be written as "Increase the hours worked at [name of company]".

While the previous pages of the plan spoke of future vision topics, desired places to live or work, etc., the action plan is where the team should get more specific with what supports will be given this year to help the person take steps toward achieving their dreams, as well as necessary health and safety needs. It is good to start with a defined Desired Outcome which will lead to more defined action steps that are easily measured and accountable. Avoid generalized statements that do not clearly state the real intent of the desired outcome. If specific plans of action or action steps are outlined in nursing or behavioral plans, or other procedural plans or teaching strategies, an action step can refer to them and the details do not have to be re-written in the action step.

## Action Plan Components

### The action plan must include:

1. **Desired Outcomes** – what do you hope to accomplish? What does the person want or need? Avoid being too generic as this will lead to generic Action Steps. Example: if it is a health outcome, what specifically is desired or needed? If it is a work or residential desire or issue, what is that you are really referring to? If, after writing a desired outcome you ask the question ‘what does it mean’ then you would be better off to just write the answer to that question as the desired outcome.
2. **Why is this important to you?** – What does this mean to the individual? Will it help them to make more money? Will it help them to develop more friendships, improve their health, or gain independence?
3. **Actions and Steps** – List the steps needed for the individual to accomplish their desired outcome. These steps must be listed and they must be measurable. This could be either as a Met/Unmet measurement or with more detailed progress or data measurement. Depending on the Desired Outcome, in some cases these steps can refer to another written plan such as a nursing or behavior plan or eating guideline. The steps included in those plans do not need to be re-written in this area but those plans need to be kept with the IP for reference.
4. **Responsible Person(s)** - Who is going to assist the person with this action step? Is the individual responsible for a part of this step? Who is providing the support? Who is accountable?
5. **Date to be Completed or the Time Frame it is to be monitored** – Does this step have a specific deadline for completion? Example: scheduling of a doctor’s appointment or completion of an application. Is it something that needs to be done or monitored daily, weekly or monthly? If so it should be listed as such and not just labeled as an ambiguous statement such as “ongoing”.

When an individual plan identifies the use of behavior modifying medication or aversive programming including restraints, PRC (Programmatic Review Committee) and/or HRC (Human Rights Committee) policies and procedures must be followed, unless there is a valid waiver from such review in accordance with applicable policies and procedures.

When a PRC exemption is in place, the individual’s case manager shall review the exemption annually or sooner if indicated by changes in the individual’s health or cognitive status. The case manager will document whether the exemption status remains appropriate during the individual’s annual planning meeting. If exemption status remains appropriate, the case manager will document and date such on the original exempt approval form. If exemption status does not remain appropriate, the case manager shall notify the PRC Liaison and the PRC Exemption Committee chairperson.

## **Summarize the Plan of Supports and Services**

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Once the individual and team have completed the action plan, they must identify the type of services and supports that will address and implement the action plan. The Summary of Supports and Services form will be completed to document services the individual will receive.

Individuals shall be offered choices of qualified providers and be fully informed of their right to freely select among qualified providers. The case manager or support broker shall ensure that the individual and his or her family or guardian have sufficient information available to make informed selections of support providers. Case managers shall provide individuals and families information about self-directing, agency with choice, and qualified provider options. When individuals request supports and services from agencies, case managers will refer them to the directory of qualified providers within that region. The directory is located in the case manager Table of Contents and on the Intranet under Qualified Providers.

Case managers or support brokers may accompany individuals to interviews, tours, and initial visits with providers. Case managers shall also assist individuals and their families or legal representatives to evaluate several different options and providers to ensure the best selection. If the person has chosen an independent support broker, the independent support broker will assist the person with this step in the process.

Once the individual has selected providers, the Summary of Supports and Services will identify specific agencies and/or individuals who will provide supports or services. This section must include DDS funded supports (waiver services and state funded), Medicaid state plan services, generic resources, and natural supports provided to address the needs identified in the action plan. The information documented in the plan must include the agency or individual who will provide support, the type of service or support, and the amount of service or support. Individual plans that include waiver services will specify which waiver service(s) are to be provided (ex. Personal Support, Individualized Home Support, Supported Employment - Individual, Health Care Coordination, Respite, Clinical, and Behavioral Support Services).

For Waiver services which are inclusive, such as Residential Habilitation (CLA), the Summary of Support and Services does not have to list on separate lines each support included within that Waiver service, such as Occupational Therapy or Nursing Services. If the team wants to note services specific to the person that are part of a comprehensive service, these inclusive supports may be shown in parentheses following the Waiver service. But different major services need to have their own separate line even if provided by the same agency. Example: Residential, Day and Transportation. For individuals who self-direct, the Summary of Supports and Services does not have to include specific costs associated with hiring staff such as workers compensation or background checks.

The Summary of Supports and Services will automatically list the DDS Case Management service and the frequency of contact which is entered as “quarterly contact and as needed”.

If a provider of a particular support or service has not been identified at the time of the meeting, the plan may indicate that a provider will be selected. In these situations the team should indicate the type of provider to furnish the service and describe the activities to support that selection. Once

a selection is made the case manager shall ensure the information is incorporated into the final Individual Plan.

It is of upmost importance that the information on the provider, supports/services and amount of supports/services for funded supports listed on the Summary of Supports and Services page match the DDS authorization for those supports. Case managers and providers may need to confer with Resource Managers to make sure these details (including the information on the Placement screen in CAMRIS) match.

### *Identify Additional Supports Needed to Assist the Individual to Make Choices and Participate in Planning*

#### **Summary of Representation, Participation & Plan Monitoring**

***The individuals' and their representatives' participation in the planning process is a key element in Individual/Person Centered Planning. Our actions to assist with participation must be documented clearly so that we can assure that this is occurring for all individuals and can report this information to our funding sources.***

The Summary of Representation, Participation & Plan Monitoring summarizes four areas:

**Choice and Decision Making** – this area documents the person's desire for assistance of a guardian or decision maker and the team's evaluation of the individual's understanding and capacity to make important decisions/choices, accept assistance from others, and possible need for guardian/advocate/legal or personal representative. This should be an area that is discussed every year. Is the current guardianship status (or lack of guardian) appropriate for the needs of the individual? Have there been any changes in the person's ability to make decisions? Does the person no longer need a guardian? The team shall consider ways that greater involvement in self-advocacy may be of benefit to the person and they can review whether the individual would like or could benefit from the assistance of a self-advocate Individual Plan (IP) Buddy, advocate, or legal or personal representative. Teams should note steps to be taken based upon the decisions that are made in this area.

**Individual's Participation in Planning Process** – this area documents the person's actual participation in the planning process, the team's efforts to involve the person in planning, and planned efforts to enhance the person's future participation in planning. All individuals should take part in their planning to the full extent that they desire and are capable of. It is the team's responsibility to modify their time of meeting, place of meeting, mode or language to increase the individual's participation in their planning. What steps are needed to assist the person with participation? Consider the time of the meeting. Is it a good time for the individual? Does the location need to be more accommodating for the person for physical or psychological reasons? Are there behavior challenges that need to be considered? Are there things to be worked on throughout the upcoming year? Teams should not assume that because a person has not participated in the past that they shouldn't participate in the future. Teams should develop a plan with the individual as needed to enhance their participation and include it in the action plan for this year. This is an

important, critical part of the plan, as the information in this section is reviewed to ensure teams are doing their best to get the individual involved. This is not only a right of the individual to be a part of their planning but also a requirement of CMS waived services.

**Representative's Participation in Planning Process** – this area documents the person's family, guardian, advocate, legal or personal representative participation in the planning process, the team's efforts to involve the person's family, guardian, advocate, or legal or personal representative participation in the planning process and efforts to enhance that participation in the future. Any steps taken to get optimal participation from the person's guardian or family member must be noted here. Were there scheduling problems? Was the location difficult for the guardian or family member to attend? Could teleconferencing or video conferencing be considered?

**Monitoring and Evaluation of the Plan** - this area documents the team's plans to ensure that the Individual Plan will be implemented and that progress is made toward achieving desired outcomes. Providers are required to complete and distribute an Individual Progress Review every six months and 2 weeks before the next IP. Nursing and behavioral reports are still required on a quarterly basis. Case managers are required to complete an annual Quality Service Review once a year according to the QSR procedure. Teams can note any additional steps for monitoring and evaluation here as well.

## **Complete the Addendums to the Individual Plan**

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### *Completing the Aquatic Activity Screening*

The Planning and Support Team shall complete the Aquatic Activity Screening form, as an attached addendum to the plan annually at the time of the Individual Plan meeting. The Aquatic Activity Screening is also to be completed at the time of the Individual Plan – Short Form for those individuals who do not have comprehensive plans. The purpose of the Aquatic Activity Screening form is to have accurate information about an individual's abilities and safety needs around water activities. Refer to the Aquatic Activity Code Guidelines for guidance on completing the Aquatic Activity Screening.

The information on the Aquatic Activity Screening promotes team member awareness of an individual's supervision needs during aquatic activities, including activities proximal to water. The completed Aquatic Activity Screening form shall be distributed to all team members along with the plan. All staff who provide supports to the individual shall refer to the individual's Aquatic Activity Screening before participation in activities that are in or proximal to water.

### *Complete the Fall Risk Screening Form*

Though not currently attached to the plan, the team needs to complete a Fall Risk Screening form. This screening will help to decide whether the individual requires a Fall Risk assessment and prevention plan. If a plan is necessary it would be included in the list of supports needed in some manner within the person's action plan.

## **The Individual Progress Review (IPR)**

An Individual Progress Review form is attached to the IP *as a prompt and tool* to remind providers of supports of the action steps that require six month updates to the team. The Desired Outcomes and their Action Steps will automatically populate the IPR upon completion of the IP by the case manager. While the Desired Outcomes and Action Steps are identified there is more information that needs to be filled out by the provider on the IPR. **Providers should cut and paste the Desired Outcomes and the Action Steps for which they are responsible unto a separate IPR to complete and distribute to team members.**

Case Managers will review all IPRs and document that review in the electronic case note system. They will contact individuals and teams as needed concerning any changes noted in the IPR.

An IPR can stand as a part of an Individual Plan as it will note and update any changes to the Desired Outcomes or Action Plan.

## **The Signature Sheet**

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The Signature Sheet is a separate document from the main body of the IP. It is the only part of the IP that requires a handwritten signature. Much of the information on the Signature Sheet is generated automatically from different data sources when the case manager prints out the form prior to the IP. This form is generated from a data system maintained by CT BEST. There have been occasions when CT BEST is working on that system and you cannot generate a Signature Sheet with completed information. These times happen rarely and usually do not last long. If at all possible, you can wait a bit and try again. If this doesn't work and you need a Signature Sheet or your meeting you can use a handwritten one located in the Table of Contents under individual Plan.

An important step for the case manager and the team is to make sure the information on this page is correct and up to date. If it is not, the case manager will correct the information in the specific data source and reprint the Signature Sheet prior to the IP or, if the error is found at the IP, the case manager will note what area needs correction in the section of the Signature Sheet "Is this Accurate?" and make that correction in the appropriate data source as soon as possible. If the correction needs to be made in any the areas of the Waiting List (WL) this may require a request to be made to the regional Planning Resource and Allocation Team (PRAT). That action should be noted in the action plan of the IP.

The Level of Need information on the signature page will be the latest information that the case manager has put into the LON system prior to printing out a Signature Sheet. If additional information concerning the LON is presented during the meeting the CM will make note in the "Is this accurate?" section that the LON will have additional information added. They do not need to write that specific information into this section but only note there will be changes made to the LON. The case manager will enter that information into the LON as soon as possible after the IP and distribute the new LON to the team members. There is no revision of the IP Signature Sheet necessary if there are any score changes for LON. The score on the Signature Sheet provides the team the last LON status prior to the IP planning meeting.

There are some sections of the Signature Sheet that require both an annual review and manual check-off on the page. These include: assurance that the Annual Notifications have been sent or given to the individual or guardian; that there is a HIPPA Notification in the file; that Legal Liability Notification is completed as necessary; that the individual or guardian has received information on the Regional Advisory Council (part of the Annual Notifications) and that the Voter Registration Notification has been completed (ED-682 Declining to Register to Vote). This Voter Registration notification process is a legal requirement for all agencies that provide services to individuals in our nation. It is a requirement that we fill out the ED-682 each year and file in the individual's master record regardless of the fact the person may decline each year or is still registered to vote. This requirement is part of the Motor Voter law and we are responsible to complete this action each year or face legal repercussions.

The Signature Sheet contains the notification that the individual or any team member should contact the case manager within two weeks of receipt of the plan if they don't agree with any part of it as written. Individuals, family, guardians or advocates also have the right to request a Programmatic Administrative Review (PAR) if they disagree with any part of the plan that cannot be resolved in a team meeting.



Case managers can access a Signature Sheet by following the steps outlined in “How To Get A Signature Sheet” posted on the Table of Contents. Since this Signature Sheet is a separate PDF document, case managers must scan it to be able to electronically send it to other team members. **Case Managers must file and retain the *original* Signature Sheet in the person’s master record.** Other team members will receive a copy.

## **Put the Plan into Action**

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The individual's plan describes his or her services for the coming year. Every effort should be made to arrange for needed supports and to implement the plan as soon as possible after the meeting. Support providers should be taking whatever notes necessary to provide or continue required supports to the individual from the time of the meeting forward. Overall, supports and services shall be implemented within 60 days of plan development, or within 30 days in licensed settings, and should be provided as described in the Individual Plan. Only approved supports and services identified in the Individual Plan may be purchased with DDS funding. If supports and services cannot be promptly implemented, the case manager, individual and planning and support team must consider the need to revise the Individual Plan to meet the person's needs.

The case manager has overall responsibility for ensuring that Waiver services are coordinated with other services, resources, and supports available to the person, including state plan, generic, and informal services and supports. Case managers shall assist individuals to coordinate the services identified in the individual plan and promote cooperative communication among support providers.

The Individual Plan is the individual's plan and he or she should be included in all aspects of implementation of the plan. Moving towards a person's desired outcomes will be accomplished with everybody on the team working together and communicating their progress.

The individual and his or her planning and support team, including his or her family or legal representative and support providers, also have roles in assuring that services are delivered as described in the plan to meet the person's needs. The individual and the planning and support team members will inform the case manager of any changes in the person's life situation or needs which require the planning and support team members to meet and modify the plan. The individual and team members shall provide access to locations and information that will enable the case manager to monitor supports and services.

## **Monitor and Review the Individual Plan as Needed**

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### *Monitoring Plan Implementation*

The case manager has responsibility to ensure approved waiver services are delivered according to the Individual Plan and to routinely review and monitor all aspects of service delivery. Case managers will engage in activities to evaluate whether supports and services are meeting the desired outcomes for the individual and will work with the individual and his or her family or legal representative to make adaptations to plans and service arrangements as needed.

The case manager shall monitor progress on plan goals on an ongoing basis through contacts, site visits, review of Individual Progress Reviews; review of provider documentation, and Quality Service Reviews (QSRs). Through ongoing monitoring and review the case manager is able to:

- Determine that needed supports and services in the Individual Plan have been provided
- Review implementation of strategies, guidelines, and action plans to ensure specific needs, preferences and desired outcomes are being addressed.
- Review the individual's progress and accomplishments
- Review the individual's satisfaction with supports and with service providers
- Identify any changes in the individual's needs, preferences and desired outcomes
- Identify the need to change the amount or type of supports and services
- Identify the need to revise and update the individual's plan of services.

Case managers shall have contact with individuals on a frequency based on the services the individual receives. For specific minimum requirements for case management contact, case managers should refer to the Case Manager Tasks chart or the Frequency of Case Management Contact Procedure as references.

On an ongoing basis, service providers will review and document progress on the specific personal outcomes and actions for which they are responsible. Providers of residential and day services are required to submit a written six month Individual Progress Review to the case manager and other team members six months after the IP and two weeks prior to the next annual plan. At a minimum, other team members who should receive the six month reviews are the individual's family and the residential or day providers. (i.e. the day provider shall submit their review to the case manager, family, and residential provider and the residential provider will submit their review to the case manager, family and day provider).

Case managers will review all service provider Individual Progress Reviews, and file them in the Individual Plan section of the Master File. Case managers and support brokers will also review regular reports from Fiscal Intermediaries (FIs) as applicable. Case managers shall document all their activities related to development, monitoring or review of the plan in the electronic case note system. At a minimum, case management running notes should include a description of the Case Management services provided.

Case manager monitoring and review of supports and services includes implementation of Case Manager Quality Service Reviews (QSR). The case manager will visit the individual at locations where the Waiver supports and services are provided to conduct the Case Manager Quality Service

Reviews. The Quality Service Reviews include an interview with the individual, observation of support providers, and a review of provider documentation. Case managers must document their quality reviews and ensure the data is entered into the QSR data system.

When a case manager identifies or is notified that an individual may be in need of additional support, is at risk, or may be entering a crisis, the case manager shall take steps to notify appropriate parties, convene the planning and support team to make needed support changes, make referrals to the region's Planning and Resource Allocation Team (PRAT), implement appropriate practices or procedures, or manage the crisis as appropriate to respond to the situation. If the issue is related to the individual's program or plan the case manager will bring the issue to the planning and support team and may schedule a meeting to update the plan.

### *Community Companion Homes Reviews*

Prior to 9/1/2017, teams supporting people residing in Community Companion Homes (CCH) were required to hold quarterly meetings. This requirement is no longer needed and CCH teams can follow the same requirements for reviews as other licensed settings which includes completion of a 6 month Individual Progress Review and an IPR two week prior to the annual IP. The determination of the frequency of reviews will be made by the Planning and Support Team (PST) and documented in the Monitoring section of the IP. The PST will modify the IP, using an IPR or revisions to the IP document, anytime the individual's needs change. The case manager will provide quarterly contact and the CCH Support Professional (Tech) will provide monthly monitoring.

### *Monitoring Plans for Individuals Who Self-Direct*

Support providers who are hired directly by the person or family will document supports or activities provided onto their time sheets. They shall also utilize the 6 month IPR to note progress on specific personal outcomes and goals for which they are responsible. The support broker or case manager will contact the support provider or Employer of Record if the IPR is not provided and document this progress in a case note for the individual.

For individuals who are hiring their own staff, the case manager will review the fiscal intermediary reports that indicate the supports that have been provided and billed as a method to monitor the actual delivery of services and supports as prescribed in the Individual Plan. Line items that are being overspent or under spent shall be reviewed and corresponding adjustments or amendments made to the budget, as needed.

### *Changes to the Individual Plan*

The Individual Planning process is an ongoing process that should change as the needs and circumstances of the individual change. The individual or his or her legal representative may request a meeting to revise the Individual Plan at any time. The individual plan should accurately reflect the individual's current life situation and specific supports and services. The individual plan

shall be updated and revised within 90 days when an individual receives new residential or day supports and services or experiences a major change in one or both of these services. Individuals who live in licensed settings must have their plans updated within 45 days of a change in services, and individuals in ICF/IID settings must have their individual plans updated within 30 days of a change.

The Individual Plan must be revised prior to the initiation of any new services or significant changes to services. If the planning and support team recommends changes to types of supports and services or providers within the authorized individual budget, the plan will be revised to show the changes in services including, at a minimum, a revised Action Plan, and a revised Summary of Supports and Services and a Signature Sheet. Other sections of the plan may be updated, if needed. The revised plan will be shared with all team members.

For individuals enrolled in a DDS HCBS waiver, a change in services may occur prior to an update to the Individual Plan when it is a change in the amount or duration of an already approved service type. If the change constitutes a new waiver service not previously authorized in the Individual Plan, the new service may not be initiated until the service has been approved and authorized by DDS.

If a requested change in services will exceed the dollar limit in the approved service level or Individual Budget, the case manager must submit a Request for Services to the PRAT along with the current Summary of Supports and Services, a new LON Summary Report if there are changes in the person's needs, a Residential Request Assessment, if applicable, and a description of the change in the person's circumstances. The Request for Services should detail the amount of services requested, the reasons for the requested services, and indicates if supports are self-directed. The PRAT will review increased service requests based on identified needs. Once PRAT notifies the case manager that resources have been assigned to the person, the case manager shall contact the person and his or her family within 5 days to initiate the planning process and should complete a new Individual Plan within 30 to 60 days. A new Individual Budget should also be developed within 30 to 60 days based on the new plan.

The Waiver Unit may need to be notified if increased services affect what waiver the person is on. Example: a person receiving EDS waived supports now have Individual Home Supports added requiring them to move to the IFS waiver.

If additional services are thought to be needed at the time of the annual plan, a new Individual Plan shall be developed that represents current service levels, describes the change in the person's circumstances, and includes steps within the action plan to request increased supports through the PRAT. If the PRAT approves the request, the team will update the plan to show the approved increase in services. At a minimum, the updated plan shall reflect the new action steps associated with the need for the new or additional services and include the revised Summary of Supports and Services. If the PRAT denies the request there may still be a need to revise the plan if there is a need to reorganize the service array, develop new action steps to seek supports in a different manner, or otherwise update the plan.

If the PRAT responds to a Request for Services by indicating increased funding will be assigned within 12 months, the Individual Plan that describes current service levels, remains in place until resources are assigned. If the PRAT denies the request for additional resources, the current

Individual Plan remains in place. In these situations, the case manager will inform the individual and family of the decision and they may request a meeting with the designated regional manager to discuss alternative supports or options. Based on those discussions, additional information may be provided to the PRAT sufficient to alter the decision. If the individual and the family do not accept partial or delayed funding, the case manager notifies the PRAT. When this occurs or when the PRAT recommends denial of the request, the PRAT will notify the DDS Central Office Waiver unit. If the Waiver Unit agrees with the recommendation to deny the request, they will notify the individual or personal representative of the DSS Fair Hearing Rights.

## **Transition Planning**

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For individuals who are moving to new residential settings, transition planning can help team members to ensure all the details of the move are addressed. The Transition Planning Checklist shall be completed for individuals moving between or into DDS-funded or operated residences and may be used for other individuals who change residences. For individuals moving between or into DDS funded, or operated residences, the sending case manager will ensure the individual has an updated Transition Plan, including a current Summary of Supports and Services that describes the services to be received as a result of the move. Regions shall ensure that individuals receive notification of their rights to request a transfer hearing when a move is planned from one public or private DDS supported residence to another according to transfer hearing requirements.

When an individual lives with his or her family and is moving into a DDS-funded or operated residence, and is enrolling in a DDS waiver, the case manager must complete an Individual Plan - Short Form (IPT), along with a Summary of Supports and Services, for the first 90 days of receipt of new HCBS Waiver services, 45 days in licensed settings, after which time an Individual Plan must be in place.

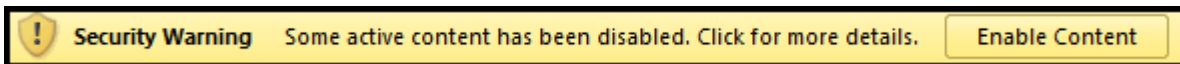
Case managers shall follow the Case Transfer Procedure, (I C 1 PR 001f: Case Transfer Procedure), when transitions result in a transfer between case managers. It is best practice, but not required, that case managers use the Transition Plan and Transition Planning Checklist for individuals who experience transitions or major changes in services or supports other than changes in residences.

## Using the Form

The Individual Plan has been developed using WORD 2010. This was the best format and option available to us and allows some details to be automatically filled out on multiple pages. Formulas within WORD 2010, combined with the fact we are now incorporating newer computers that use Windows 10, requires users to be aware of some steps needed in completing and saving this document. This guide will help illustrate those requirements and how to get the most from the new features.

### *Opening the document*

When you open the IP form in Word, you'll often see a yellow bar at the top labeled "Security Warning" Here is a picture of how it looks:



Click the 'Enable Content' button. This will bring up a window to confirm you'd like to make the form a "Trusted Document."

Click 'Yes' to activate all the features on the new form.

This action generally happens in the newer computers using Windows 10. If you do not see this "Security Warning" box when you open the IP document you do not have to do anything else to begin working.

### *Person's name, DDS # and Meeting date*

The person's name, DDS# and meeting date will be populated on all pages by the entry of this information into the box titled: **Enter the Individual's First Name and Last name, Case Manager's Name and the Meeting Date.** You will not see this information populate immediately onto the top of the first or other pages.

Here's a picture of how it looks on a blank version:

State of Connecticut  
Department of Developmental Services  
<http://ct.gov/dds>

Person Centered Plan      DDS#      Meeting Date:

Enter the Individual's First Name & Last Name, DDS#, Case Manager's Name and the Meeting Date:

Person Centered Plan      DDS #   
 Case Manager:       Meeting Date:



Start by filling out the four available text boxes. Enter the individual's entire first and last name into the first box.

Use your Backspace and Delete keys to remove any unnecessary blank space. Here's an example of how it looks when filled out:

State of Connecticut  
Department of Developmental Services  
<http://ct.gov/dds>  
Person Centered Plan      DDS#      Meeting Date:

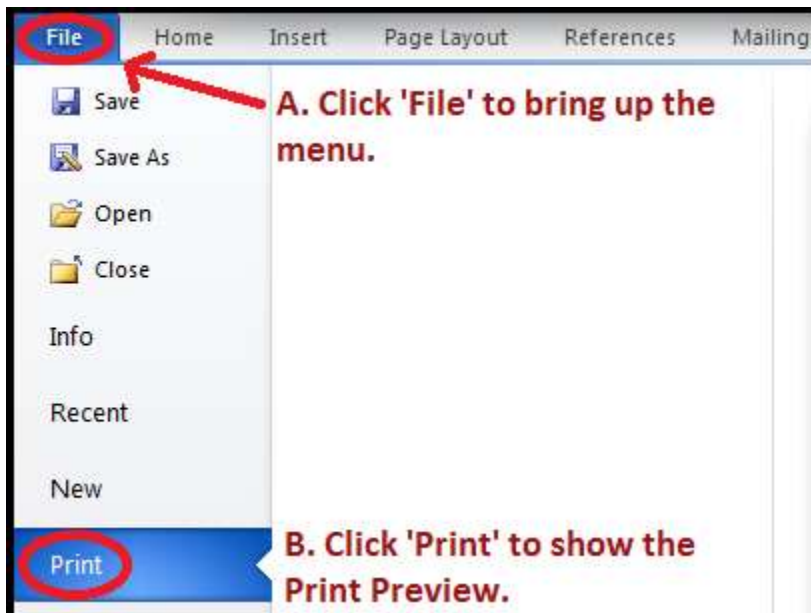
**Enter the Individual's First Name & Last Name, DDS#, Case Manager's Name and the Meeting Date:**

Yuri Lowenthal    Person Centered Plan    DDS # 40261

Case Manager: Tara Platt      Meeting Date: 4/16/2019

***How do you populate information from the name box onto all pages and from the Action Plan into the Individual Progress Review?***

You will not see the population of any information automatically and immediately happen at the top of the pages when you enter in the shaded areas. Upon completion of writing the IP, or prior to saving and closing during the composition, the case manager is required to bring the document up in the Print Preview screen. This is done by simply opening the Print menu in Microsoft Word.



Now just click “Save As” to save the document, “File” to close the menu and continue working or “Print” as needed. You’ll see the information has been automatically entered at the top:

**BEFORE**

State of Connecticut  
Department of Developmental Services  
<http://ct.gov/dds>  
Person Centered Plan      DDS#      Meeting Date:

Enter the Individual’s First Name & Last Name, DDS#, Case Manager’s Name and the Meeting Date:

Yuri Lowenthal    Person Centered Plan    DDS # 40261  
Case Manager: Tara Platt      Meeting Date: 4/16/2019




**AFTER**

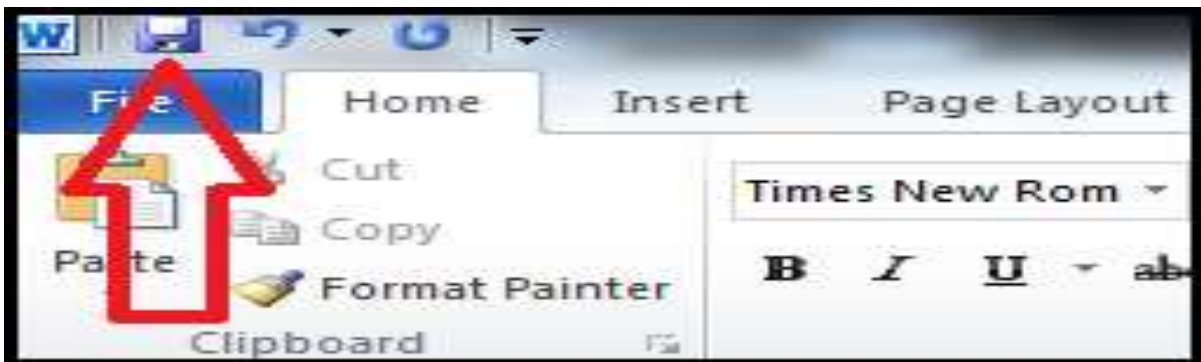
State of Connecticut  
Department of Developmental Services  
<http://ct.gov/dds>  
Yuri Lowenthal Person Centered Plan      DDS# 40261      Meeting Date: 4/16/2019

Enter the Individual’s First Name & Last Name, DDS#, Case Manager’s Name and the Meeting Date:

Yuri Lowenthal    Person Centered Plan    DDS # 40261  
Case Manager: Tara Platt      Meeting Date: 4/16/2019



When you use the ‘Save As...’ option to save your work into your H: drive be sure to give your form a unique and identifiable name. Saving periodically as you go is a good way to ensure you don’t lose any work. You can use the  button at the top-left of Microsoft Word to quickly save an IP in progress.



***Text Boxes on the One Page Profile, Trajectory and Integrated Support Star pages.***

Because the graphic pages from another format were brought into the WORD document, text boxes had to be constructed within sections to allow people to write on those pages. The size and shapes of those boxes vary according to the area they are placed in. While these areas are considered spots primarily for people to input lists or short simple sentences outlining the things that are important to them, the boxes do not expand as in other sections of the IP if that information exceeds the visible space. If the text is going to go outside of the visible area of the box a “scroll icon” will pop up on the right side of the box to let the writer know. Any information put into the document after that will still be retained and can be read by using the scroll icon. But this information is only available on the electronic copy of the plan. A printed version of the plan will only show whatever is in the box at the time of the printing. The scroll icon will remain upon printing to let readers know there is additional information. Writers of the plan should consider making different columns of lists or using whatever visible space in the text boxes to avoid this issue.

***I can't find the text box in the Integrated Support Star.***

The text boxes in the Integrated Support Star are different sizes and shapes to conform within the star sections. Just move and click your cursor in the section until you see the blinking line that denotes where you can start typing.

***I can't see anything in the Print Preview screen.***

Occasionally, if the cursor is left on a graphic page in the IP document when moving to the Print screen, no document shows in the Print Preview screen. Nothing is lost. It is only that the document doesn't show up even though it can still be printed. If this occurs it is best to look back in the document and move the cursor to another page.

***Does the IP Form support spell checking?***

No, due some of the special features designed into the IP Form, spell checking does not work in the document.

However, if you're working on long paragraphs and want them checked, you can type them into a blank Microsoft Word document, use spell check, and then instantly copy-and-paste the finished work into the IP Form.

### ***How do I Cut-and-Paste information from earlier versions of the IP form?***

This is easily done by using keyboard shortcuts.

- 1) Use your mouse to highlight the text you'd like to Copy.
- 2) Press **CTRL-C** on your keyboard. You won't see anything happen, but this tells the computer you intend to copy the text to a new location.
- 3) Click into the field where you'd like to Paste the information and press **CTRL-V** on your keyboard. All the text you highlighted in Step 1 should appear immediately.

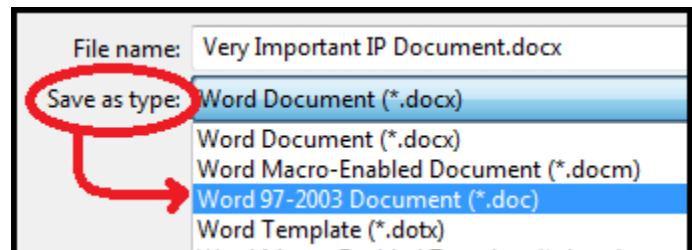
### ***Can I unprotect the IP in order to use Spell Check?***

Unprotecting this IP, as some users used to do with the older IP document, upsets the processes of the formulas built into the plan. Once upset they do not reset and the plan does not come out as it is required. For this reason this IP is protected and cannot be unprotected.

### ***What if I'm having trouble updating an older version of the IP Form?***

In most cases, you will be able to successfully save changes to older IP Forms by adjusting their file format. This is easy to do in Microsoft Word

- 1) Open the File menu and select 'Save As...' This will bring up a new window with options for where and how to save the document.
- 2) At the bottom of the window, click the "Save as type" line and change the selection to "Word 97 – 2003 Document (\*.doc)"



There are several similar options, so be sure to choose the one ending with \*.doc

### ***How do I know if I'm using the latest version of the IP Form?***

At the bottom-right of each page, there is a Revision date. This tells you when the blank version of the form was first published for use.

Versions of the IP Form released earlier than November 2018 are likely to experience problems saving or printing. You may be able to correct saving problems by following the steps above, or you may want to recreate the information on the latest IP Form by using the Copy and Paste options to quickly replicate information.

The IP Form may continue be updated from time to time. The latest official release can always be found linked in the Table Of Contents on the J: drive.

***My form looks fine on the computer, but things on Pages 1, 2, and the Star Page look all jumbled up when I print. Is there anything I can do?***

This symptom is very erratic, but occurs more frequently on older versions of the IP Form. Here are two steps you can try.

- 1) Use your Backspace and Delete keys to remove any unnecessary spaces or “blank lines” from Pages 1, 2, or the Star Page. This is especially important for the boxes at the very top of Page 1.

The screenshot shows the top portion of a form. At the top left is the DDS logo. To its right, the text reads: "State of Connecticut", "Department of Developmental Services", and a URL "http://ct.gov/dds". Below this, there are three labels: "Person Centered Plan", "DDS#", and "Meeting Date:". A horizontal line separates this header from the input area. Below the line, a prompt reads: "Enter the Individual's First Name & Last Name, DDS#, Case Manager's Name and the Meeting Date:". Underneath the prompt, there are four input fields with the following text: "Yuri Lowenthal", "Person Centered Plan", "DDS # 40261", and "Case Manager: Tara Platt". Below these, there are two more input fields: "Meeting Date: 4/16/2019".

- 2) Save your work and completely close Microsoft Word. Then open the IP Form and try printing the affected pages again. This usually resolves the issue.

***I find it difficult to insert pictures into the IP. What should I do?***

If you can't insert pictures in the IP you can put them on separate pages and attach to the IP. You can reference these picture pages in those sections you wanted them to be.

***Additional References for Individual Planning***

For additional information about Individual Planning, please refer to the respective DDS policy, procedures in the DDS Manual, and reference documents located in the Case Manager Table of Contents and on the DDS website under Individual Plan Forms and Life Course Planning.