

INDIVIDUAL'S NAME

ID # 0000000
DOB: 00/00/0000
TCM Entity

Meeting Date: 00/00/04
Start Date: 00/01/04

FAMILY/FRIENDS (who lives in the home, who is important to the person, what someone needs to know to support the person, routines):

INDEPENDENT LIVING SKILLS/SUPPORT PREFERENCES (hygiene, domestic, dressing, does person have a preference in support age, sex, favorite assistant, etc.):

HEALTH / PHYSICAL MOTOR (medications, weight, vision, hearing, allergies, physical, dental, seizures, ambulatory, who is their physician, mobility strength, endurance, fine & gross motor skills; what we need to know to keep this person healthy):

Most recent examination dates:

Physical:	Dental:
Psychological:	Vision:
Neurological:	Ob-gyn:
Speech:	Physical Therapy:
Occupational Therapy:	Other:

BEHAVIOR/SAFETY NEEDS (effective reinforcers, behaviors which put this person at risk, emergency safety, water regulation, evacuation, friendly to strangers, street crossing, etc.):

COMMUNICATION (how, writing ability, reading comprehension, type of sign, augmentative device, etc):

When this is happening	And individual does this	We think it means	And we should

Person Centered Planning Process

ISP Sample 1

SPECIAL SKILLS & INTERESTS (strengths, functional use of math, reading, writing, money, etc):

COMMUNITY INVOLVEMENT (other family members, friends, churches, libraries, shopping, recreation, clubs, etc):

LIKES	DISLIKES

RIGHTS/RESTRICTIONS:

VISION FOR THE FUTURE INDIVIDUAL (transition plans, short/long range goals, need specific period of time):

VISION FOR THE FUTURE FAMILY/GUARDIAN:

OTHER SERVICES (school IEP, Day Hab, insurance, community services, employment, adult daycare, etc):

WHAT NEEDS TO BE MAINTAINED/WHAT NEEDS TO BE CHANGED?

ACTION PLAN FOR:

OUTCOME:	
Where are they now (at the time of this plan)?	
What needs to be done?	
A.	
B.	
C.	
Who will do:	When?
A.	
B.	
C.	

OUTCOME:	
Where are they now (at the time of this plan)?	
What needs to be done?	
A.	
B.	
C.	
Who will do:	When?
A.	
B.	
C.	

ACTION PLAN FOR:

OUTCOME:	
Where are they now (at the time of this plan)?	
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OUTCOME:	
Where are they now (at the time of this plan)?	
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C.	
Who will do:	When?
A.	
B.	
C.	

Person Centered Planning Process

ISP Sample 1

QUESTION:	RESPONSE:
How often/when do you want your support coordinator (formally service coordinator) to telephone you?	
How often/where do you want your support coordinator to meet with you in person?	
How often will you call your support coordinator?	
Is there anything else your support coordinator can do for you?	

I have received the choice of remaining with _____ Service Coordination Team: Yes No

I Choose to remain with _____ Service Coordination Team: Yes No

I have received and reviewed the Service Coordination Guidebook: Yes No

This action plan explains what you want your support coordinator to do to serve you. It must be reviewed with you by your support coordinator at least every three (3) months. You may change any part of it anytime by meeting with your support coordinator and discussing the changes you want.

By signing below, you are agreeing that this is the action plan you want to implement with your support coordinator.

Consents

TITLE	SIGNATURE	DATE
CONSUMER		
PARENT/GUARDIAN		
SUPPORT COORDINATOR		
OTHER		

TEAM MEMBERS / CONTRIBUTORS TO PLAN

NAME	TITLE	AGENCY	PRESENT/BY REPORT