Plan of Services and Supports Status: Program Type: ID/DD

Overview

Active:
PSS Type: Initial/Recertification/Change
Service Type

Created Date:
Effective Date:
End Date:

Comments:

Part I - Essential Information

Contact Information

Legal First Name:
Legal Last Name:
Legal Middle Name:
Preferred Name:
Date of Birth:
Address:

Medicaid #
Initial Certification Date:
Home Phone:
Cell Phone:
Email:
Support Coordinator/TCM

Family Contact

First Name:
Last Name:
Middle Name:
Contact Type:

Phone:
Fax:
Email:
Address:

First Name:
Last Name:
Middle Name:
Contact Type:

Phone:
Fax:
Email:
Address:

First Name:
Last Name:
Middle Name:
Contact Type:

Phone:
Fax:
Email:
Address:

ID/DD Waiver Supports

Service Information

Service Type:
Frequency Type:
Hours per Month:
Minutes:
How/When Support is Used:

PSS Service:
Units per month:
Rate:
Costs:

Provider Information

Provider Name:
Contact Name:
Address:

Provider Number:
Phone:
Email address

Service Information

Service Type:
Frequency Type:
Hours per Month:
Minutes:
How/When Support is Used:

PSS Service:
Units per month:
Rate:
Costs:

Provider Information

Provider Name:
Contact Name:
Address:

Provider Number:
Phone:
Email address

PSS Costs

Annual Waiver Plan Services Total:
Annual 1915(i) Services Total:
Total PSS Budget:

Non – Waiver Agency Supports

Agency	Contact Name	Phone Number:	Non-Waiver Agency Support	How/When Support Provided

Natural Supports

Are there natural supports? Yes/No

Support Person	Relationship	Support Role	Phone Number

Medical Information

Physician	Specialty	Address	Phone

Medications

Medications required?

Medication:	Physician:	Dosage	Frequency	Reason(s) Prescribed	Psychotropic Y/N

Recent Physical and Health Conditions

Recent Physical Complaints and/or Health Conditions

Chronic health conditions?	Yes	No	Description:
History of health problems/issues?	Yes	No	Description:
Current limitations or restrictions on physical activities?	Yes	No	Description:
Any serious illnesses and/or hospitalizations in the past year including ER visits?	Yes	No	Description:
Admissions to ICF/IID, Mental Health Facilities, Rehabilitation Facilities or other inpatient care?	Yes	No	Description: *(when, where, why)*

Latest Exam Dates

Date of my last physical exam:	Date of my last dental exam:
Estimated/approximate date?	Estimated/Approximate date?
Examination Results	Examination Results

Name: _____ Medicaid #: _____ Certification Date: _____

Allergies:

Reactions:

Medical Support Needs and Mental Health Support Needs

Medical Support Needs Mental Health Support Needs

.

Communication, Adaptive Equipment, Assistive Technology and/or Modifications

Method(s) of communication:

Describe supports needed for communication (if any):

Describe any adaptive equipment or assistive technology supports used:

How is equipment maintained? Who is responsible?

What is the back-up plan for power outages if medical equipment is used?

Describe any environmental modifications necessary:

Risk Assessment

Date Created: Risk: Resolution

Back-up and Emergency Plans

Steps to take if the provider does not show up:

Steps to take if the day program/work or other activity is canceled, closes or you have to leave for some other reason:

Steps to take when a natural disaster occurs:

Plan for future living arrangements if something were to happen to the primary caregiver:

Family and Current Living Arrangements

Education

Current School — Year

Last School Attended: — Year

Type of Diploma/Certificate: — Year:

Employment History

Was {name} ever employed? Yes No

Reason why {name} isn't working:

Volunteer Activities

Did {name} ever volunteer? Yes No

Behavior Supports

Previous and Current Behavior Supports:

Serious Incidents During the Past Year

Evaluation Information

Current ICAP Date:
Current ICAP Score
Who Completed the ICAP
Current ICAP Service Level
Previous ICAP Date
Previous ICAP Score
Who Completed the ICAP?
Previous ICAP Service Level
Psychological Date:
Examiner Name:
Examiner Agency:
Primary DSM Code
Secondary DSM Code(s)

Essential Information completed by:

Person:
Legal Guardian:
Support Coordinator/Credentials:
Additional Contributors:
Date Reviewed:

Part II – Personal Profile

Great Things About {name}

Hopes and Dreams

Important To/For

Important TO	Important FOR

Working/Not Working

Perspectives

Things that work	Things That Do Not work
_____'s Perspective:	_____'s Perspective:
Family's Perspective	Family's Perspective
Family's Perspective	Family's Perspective
Provider's Perspective	Provider's Perspective
Provider's Perspective	Provider's Perspective

Name: _____ Medicaid #: _____ Certification Date: _____

Need to Know & Strengths

Things People Need to Know to Support {name} and Keep Him/Her Healthy and Safe

{Name} 's Strengths

Questions/Things to Figure Out

Question	Person Responsible

Are any referrals needed?

Yes No Explain:

Name: _____ Medicaid #: _____ Certification Date: _____

Part III – Person Centeredness

Choice, Control, Restrictions/Limitations

Were you given a choice of service(s)?	Yes	No	Please describe:
Were you given a choice of provider(s)?	Yes	No	Please describe:
Were you given a choice of living setting(s)?	Yes	No	Please describe:
Were you given a choice of roommate(s)?	Yes	No	Please describe:
Do you have control of your personal resources?	Yes	No	Please describe:
Are you given a choice of activities in your living setting? *(including where you want to go in the community)*	Yes	No	Please describe:
Are you given a choice of activities in your day program setting? *(including where you want to go in the community)*	Yes	No	Please describe:
Do you have any restrictions or limitations set by staff? *(including visitors and food)*	Yes	No	Please describe:

Contributors Not at Meeting

Support Person	Relationship	Date contributed

Signatures

Type	Name	Services	Signature Name	Signature Date

Part IV - Shared Planning

Desired Outcome	Supports	How Often	Start Date	End Date

Name: _____ Medicaid #: _____ Certification Date: _____