

**WEST VIRGINIA I/DD WAIVER
INDIVIDUALIZED PROGRAM PLAN (IPP)**

IPP Start Date: _____

Date this Plan will be Reviewed: _____

Type of IDT Meeting

Annual 3-month 6-month 9-month Critical Juncture Transfer Discharge

Demographics

Member Name: _____

Address: _____

Phone Number: _____

Date of Birth: _____

Additional Insurance (if applicable):

Date of Financial Eligibility: _____

Date of Medical Eligibility: _____

Anchor Date: _____

Legal Representative:

Yes No

If "Yes" Full Limited

Name: _____

Address: _____

Phone: _____

Health Care Surrogate:

Yes No

Name: _____

Address: _____

Phone: _____

Medical Power of Attorney:

Yes No

Name: _____

Address: _____

Phone: _____

Payee: Yes No

Name: _____

Address: _____

Phone #: _____

Conservator: Yes No

Name: _____

Address: _____

Phone#: _____

Interventions for Maladaptive Behavior Not Applicable

_____ Date of Functional Assessment

_____ Date of Positive Behavior Support Plan or Protocol

_____ Date of HRC Approval

Service Coordination

SC Name: _____

SC Provider Agency: _____

SC Telephone #, ext: _____

SC e-mail: _____

Check Attachments

Crisis Plan (required for Annual and 6-month IPPs)

Positive Behavior Support Plan/Protocol (required, if applicable, for Annual and 6-month IPPs)

Participant-Directed Spending Plan (if applicable)

Budget from CareConnection® (required)

I/DD Waiver Budget Information:

Assessed Individualized Budget Amount:

\$ _____

Cost of I/DD Waiver Services Annually:

\$ _____

Service Model Choice

Traditional

Traditional and Agency with Choice

Traditional and Personal Options

Meeting Minutes

(Use additional pages, as necessary)

Who attended this meeting? Did any team members attend by phone, and why?

Summary of what was discussed during this meeting:

Meeting Minutes Completed By

Circle of Support	
Intimacy: Who can I count on	
Friendship: Who is a good friend?	
Participation: List people, organizations, or networks you are involved with:	
Exchange: People who are paid to be in my life (staff):	
Who I would like to participate in developing my plan?	
Goals and Dreams	
Goals and dreams should be carried through the rest of this plan and incorporated into the Service and Habilitation Plans including responsible persons and/or provider and timelines for making plans happen. (Use additional space, as necessary)	
What are my short-term and long-term goals and dreams? Goals should be positive and possible. (Where do I want to live? Ideal job? Who do I want to live with? Dream vacation? What do I want to learn?) Who is going to help me achieve these goals/dreams?	
<u>Short-term goals:</u>	
<u>Long-term goals:</u>	
What do I expect to be different as a result of receiving services and supports? What outcomes do I expect to accomplish with the help of supports?	
What are things that I like and dislike? What things do I consider pleasant and important? What do I like to do during my leisure time? What community activities do I enjoy?	
What are my strengths? What am I good at?	

Evaluation	Date of Evaluation	Summary of Assessment/Evaluations Results and Recommendations (List all assessments used to develop the service and habilitation plan; use additional space/pages as necessary):
Person-Centered Assessment		
ICAP		
ABAS:II		
Health & Safety Issues Identified		
Psychological/ Psychiatric		If applicable
Medical		List all physicians, date of last appointment, and recommendations
Therapy (PT, OT, ST, etc.)		If applicable
Other		
Other		
Other		

Medications that I take (use additional rows, as necessary)	Dosage	Frequency	Reason for taking this medication (applicable diagnosis)	Who will administer? (agency name and staff title or natural support)

I/DD Waiver Services Needed to Support Me Individual Services Plan			
Service Code	Service Description	Provider	Is the service available/accessible?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Amount/Frequency: Service should average ____ units per month and should not exceed ____ units per year			
Duration of Service: This should service should begin on _____ and end on _____			
Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs? What has changed since the last time my IDT met?			
Service Code	Service Description	Provider	Is the service available/accessible?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Amount/Frequency: Service should average ____ units per month and should not exceed ____ units per year			
Duration of Service: This should service should begin on _____ and end on _____			
Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs? What has changed since the last time my IDT met?			
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Plan of Action/Scope of Work to be done to support me. What, specifically, will the provider do to support my needs? What has changed since the last time my IDT met?			

**Non-I/DD Waiver and Natural Supports
(Volunteer groups, clubs, churches, schools, etc.)**

Support	Who Provides This Support?
Frequency of Support:	
Duration of Support: This support should begin on _____ and end on _____	
<u>Plan of Action/Scope of Work to be done to support me:</u>	
Support	Who Provides This Support?
Frequency of Support:	
Duration of Support: This support should begin on _____ and end on _____	
<u>Plan of Action/Scope of Work to be done to support me:</u>	
Support	Who Provides This Support?
Frequency of Support:	
Duration of Support: This support should begin on _____ and end on _____	
<u>Plan of Action/Scope of Work to be done to support me:</u>	
Support	Who Provides This Support?
Frequency of Support:	
Duration of Support: This support should begin on _____ and end on _____	
<u>Plan of Action/Scope of Work to be done to support me:</u>	

Interdisciplinary Team Signature Sheet

Member Name: _____ Date of Meeting: _____

Type of IDT Meeting:

Annual
 3-month
 6-month
 9-month
 Critical Juncture
 Transfer
 Discharge

Relationship	Signature and Credentials	Time Spent in Meeting	Agree	*Disagree	Date this IPP was sent out
Member			<input type="checkbox"/>	<input type="checkbox"/>	
Parent/Legal Representative			<input type="checkbox"/>	<input type="checkbox"/>	
Service Coordinator			<input type="checkbox"/>	<input type="checkbox"/>	
Non-legal Rep for Participant-direction			<input type="checkbox"/>	<input type="checkbox"/>	
Other Relationship:			<input type="checkbox"/>	<input type="checkbox"/>	
Other Relationship:			<input type="checkbox"/>	<input type="checkbox"/>	
Other Relationship:			<input type="checkbox"/>	<input type="checkbox"/>	
Other Relationship:			<input type="checkbox"/>	<input type="checkbox"/>	
Other Relationship:			<input type="checkbox"/>	<input type="checkbox"/>	

**IDT member has disagreed with the plan. The rationale is attached.*

Rationale for Disagreement with the Plan

Signature: _____ Date: _____