Home and Community Based Services Assisted Living Waiver Individual Service Plan Desk Guide

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Introduction

The Assisted Living Waiver is one of several Home and Community-Based Services (HCBS) waiver programs administrated by the California Department of Health Care Services (DHCS) that offers eligible Medi-Cal members who live in (or who are at risk of being admitted to) a nursing care facility, the opportunity to receive long-term services and supports (LTSS) and the right to choose a less-restrictive and more homelike setting.

The goal of the ALW is to enable eligible Medi-Cal members who require a Nursing Facility (NF) level of care (LOC), to remain in, or relocate to, home-like community settings.

Specifically, the goals of the ALW are to:

- Facilitate safe and timely transitions of Medi-Cal-eligible seniors and persons with disabilities living in NFs, by helping them to move to a home-like community setting in which they are able to receive necessary LTSS; and,
- Offer eligible seniors and persons with disabilities who reside in the community, but who are ***at risk*** of being institutionalized, the option of utilizing ALW services to continue to meet their care needs in the community home-like setting.

The Care Coordination Agency (CCA) develops the Individualized Service Plan (ISP) to identify the participant's needs and the methodology to meet those needs. The assisted living provider is either the RCFE, ARF, or a Home Health Agency (HHA) in the Publicly Subsidized Housing setting.

The development of a person-centered plan must be an inclusive process that is directed to the maximum extent possible by the individual and/or the person legally authorized to make decisions on his/her behalf. It must therefore take into consideration the full context of the individual’s personal goals, preferences, family supports, as well as the community and personal resources that are available to the individual.

This desk guide was created to assist Care Coordinators in the development of a person-centered ISP. Failure to develop a complete and detailed person-centered ISP will result in an audit finding by DHCS.

Individual's Information

1

Individual's Information			
Individual's Name *(First MI Last)*		Tier Level	#VALUE!
Eligible for Tier 5	○ Yes ● No	Receiving Tier 5 services	○ Yes ● No
Individual's CIN	0	Medicare Number	0
Location of ISP Meeting		Date of ISP	
ISP Start Date		ISP End Date	
Individual present at ISP meeting	● Yes ○ No	This ISP is an	● Initial ○ Update
ALW Residence		CCA	

2

If this ISP is an update, complete the following:			
Date of Last ISP		Tier in Last ISP *(Drop-Down)*	
Reason for ISP Update *(Drop-Down)*		If Other, Please Specify	

3

Is the Physician's Report attached to this ISP?	● Yes ○ No	If yes, Date of Report	
Diagnosis(es)			

Instructions – 1
The *Individual's Information* section is where the pertinent demographic information for the individual is captured. It is broken down into three separate sections.
Individual's Name
Individual's name will auto-populate from Assessment in the format *First MI Last*.
Tier Level
Tier level will auto-populate from Assessment.
Please note – Individuals who do not meet the minimum level of care (tier one) but have been in an institutional setting for 60 consecutive days are grandfathered in as tier one. In this instance the ISP tier level will read "'#VALIUE".
Eligible for Tier 5
Select "Yes" or "No" based on the eligibility determination in the Tier 5 tab of the Assessment Tool.
Receiving Tier 5 services

Select “Yes” or “No.” If “Yes” is selected, the Tier Level above will automatically become blank. If “No” is selected, the Tier Level above will keep the current tier.
Individual’s CIN
Individual’s CIN will auto-populate from Assessment.
Medicare Number
Medicare number will auto-populate from Assessment.
Location of ISP Meeting
Enter where the ISP meeting took place.
Date of ISP
Enter the date the ISP meeting took place; this may be the same date as the assessment.
ISP Start Date
Enter the date the ISP will begin.
Date should be the same as 'Date of ISP'
ISP End Date
Enter the date the ISP will end.
Date should be 6 months from the ISP Start Date.
Individual present at ISP meeting
Select “Yes” or “No.”
This ISP is an
Select “Initial” or “Update.”
ALW Residence
Enter name of the ALW Residence; if this is an initial enrollment and the ALW residence is not yet known, enter TBD.
CCA
Enter name of the CCA completing the ISP.

Instructions – 2 *Only complete this section if the ISP is an Update*
Date of Last ISP

Enter the date the last ISP was completed.
Tier in Last ISP
From the dropdown, select the tier from the last ISP.
CCA should NOT hand write in a tier. Please leave tier field blank.
‘Yes' box should only be selected on reenrollments and or reassessments. For initial applications ‘No’ should be selected.
Reason for ISP Update
From the dropdown, select the reason for the ISP Update.
If Other, Please Specify
Enter the reason for the ISP Update, such as a change in service provider.

Instructions – 3	
Is the Physician’s Report attached to this ISP?	
Select “Yes” or “No.”	
If yes, Date of Report	
if “Yes” was selected, enter the date of the attached Physician’s Report.	
Diagnosis(es)	
Enter only the diagnosis(es) relevant to the individual’s long-term support needs.	
Things to Consider	• This section is not intended to serve as a comprehensive medical history — much of that information is already captured in the Assessment. • Only the diagnoses that are relevant to the development of the ISP should be entered here.
Example Documentation	• Mary’s multiple sclerosis diagnosis should be entered here but not her occasional acid reflux or that she developed shingles last year.

Legally Responsible Contact Information

Legally Responsible Contact Information			
Contact's Name			
Relationship to Individual *(Drop-Down)*		If Other, Please Specify	
If Family, Relationship to Individual *(Drop-Down)*		If Other, Please Specify	
Address		Phone Number	
Email		Preferred Method of Contact *(Drop-Down)*	

Instructions
In this section, the information for the legally responsible contact for the individual is entered. Please be sure to fill in all relevant information.
Contact's Name
Enter contact's name.
Relationship to Individual
Select the relationship of the contact to the individual from the dropdown; this does include the option to select "Self" if the individual is their own legally responsible person.
If Other, Please Specify
If "Other" is selected, enter the relationship to the individual.
If Family, Relationship to Individual
If "Family" is selected, select the relationship of the contact to the individual from the dropdown.
If Other, Please Specify
If "Other" is selected, enter the familial relationship to the individual.
Address
Enter the address of the contact.
Phone Number
Enter the phone number of the contact.
Email

Enter the email of the contact.
Preferred Method of Contact
Select the contact’s preferred method of contact from the dropdown.

Strengths

Strengths
Identify things the individual is good at. Provide responses as well as other known strengths of the individual in the space below.

Instructions	
Strengths	
In accordance with 42 CFR §441.301(c)(2)(ii), the *Strengths* section is meant to identify and record the individual's strengths. It should be completed based on the individual's responses; additional ISP meeting participants' responses; and care coordinator observations. Capturing the individual's strengths will help care coordinators identify what type of setting and services would best suit the individual, thereby providing the best care options.	
Things to Consider	• Talk with individual about what they are good at. • May be able to obtain some information from the assessment, based on what his or her needs are or aren't. • If family or others are present, they may be able to provide information.
Example Documentation	• Joe is friendly and gets along well with everyone. • Betty is great at knitting and enjoys teaching others.

Strengths
Identify things the individual is good at. Provide responses as well as other known strengths of the individual in the space below.
DT is friendly and gets along well with everyone. She enjoys socializing with others. DT does well following medical advice/directives and enjoys using a stationary bike or treadmill as part of PT/OT.

Personal Goals

Personal Goals			
Identify personal goals, including those for community participation. Provide a description of the goal in the space below.			
Goal/Desired Outcome	Description	Supports Needed	Who Provides Support

Instructions	
In accordance with 42 CFR §441.301(c)(1)(iv) and (v), this section is the portion of the person-centered plan that must include individually identified goals and desired outcomes, and it must reflect the services and supports (paid and unpaid) that will assist the individual to achieve the identified goals. Individuals must be recognized as the experts on their own interests, needs, preferences, and desires and should be supported to establish goals that are relevant and meaningful to them. Facilitate a conversation with the individual (and/or the individual's representative, as appropriate) about their personal goals and desired outcomes.	
Goal/Desired Outcome	
Briefly state the personal goal or desired outcome in first column.	
Things to Consider	• Goals are self-determined, and as such, they are often related to an individual's quality of life and may extend beyond the services and supports available under the waiver program. • Goals do not need to be elaborate or complicated and in fact, may be related to an individual's daily life or routine. • Information you learned about the individual's strengths and/or through the Assessment may help start the conversation about what their goals are. • Goals may be related to education, employment, transportation, recreation, family relationships,

	friendships, home environment, therapies, treatments, or any other topics consistent with the individual's needs and desires. Individuals should not be limited to program-specific goals and should be supported to develop non-traditional strategies for achieving them. • It should not be assumed that individuals are uninterested in having or unable to accomplish goals due to advanced age or cognitive impairment. Goals are not limited to professional or personal achievements and may be developed in coordination with family members or others who support the individual.
Example Documentation	• Jeff wants to maintain his sobriety. • Support Beverly's musical interests. • Mary wants to get out of bed every morning.

Description	
Define the goal or desired outcome by describing what achievement of the goal looks like to the individual and provide any necessary information on how the goal is relevant or meaningful to the individual.	
Things to Consider	• While some goals may seem unattainable, they should not be dismissed as impossible or unrealistic. It may be helpful to break a goal into smaller steps or component parts that assist the individual in making progress toward achieving a larger goal.
Example Documentation	• Jeff wants to attend his AA meetings in person two times each week and connect with his sponsor, at least virtually one time each week. • Beverly's daughter explained that prior to the progression of her dementia and other physical limitations, Beverly participated in dance competitions and taught dance lessons. Although she can no longer dance, she enjoys listening to music, which also helps to calm her when she feels anxious or is agitated.

Supports Needed	
Briefly summarize the assistance the individual may need to achieve their goal or desired outcome.	
Things to Consider	• Supports may be paid or unpaid. • Supports may be related to activities of daily living, instrumental activities of daily living, or some other need.

Example Documentation	• Jeff needs transportation to and from his AA meetings on Mondays and Thursdays. Jeff also needs help managing his calendar to schedule calls with his sponsor. • Beverly needs help using the MP3 player and speaker Beverly's daughter set up in her room. She also needs assistance reducing other noise and distractions when she is overstimulated.
Who Provides Support	
Document the individuals or entities that will support the individual and briefly summarize the actions they have agreed to take.	
Things to Consider	• One goal may have multiple individuals and/or entities providing support – it does not need to be limited to one.
Example Documentation	• Jeff's daughter will drive him to and from his AA meetings; the ALW will help Jeff manage his calendar. • Staff at the ALW notice when Beverly is anxious and offer to help her select from among the preloaded playlists of her favorite artists. Staff also help set the volume and reduce competing noises by turning off her television and closing her bedroom door.

Personal Goals			
Identify personal goals, including those for community participation. Provide a description of the goal in the space below.			
Goal/Desired Outcome	Description	Supports Needed	Who Provides Support
Continue vacations with her daughter.	DT enjoys going to Las Vegas with her daughter. They try to go for Christmas every year and she would like this to continue.	Oxygen 24/7, so needs help identifying how this need gets met for traveling. DT also needs support to manage her money, so she can have her own spending money.	ARF will help DT arrange for oxygen and other medical needs for travel. DT's daughter will help with money management.
Avoid ER and/or hospitalizations.	DT would like to avoid ER visits and/or hospitalizations from her falls.	PT/OT to strengthen legs, arms, hands. Review of DME to ensure DT has the best DME to support her when ambulating.	ARF will coordinate with primary care and other agencies to attain PT/OT and review DME.

Preferences

Preferences
Identify likes or dislikes includiung what a typical day looks like. Provide a description in the space below.

Instructions	
Preferences	
In accordance with 42 CFR §441.301(c)(2)(ii), the *Preferences* section is used to record the individual's likes and dislikes, including what a typical day looks like. This conversation is intended to be an open dialogue where the care coordinator asks the individual prompting questions about a range of topics. For instance, the care coordinator can ask about a typical day, what gender of staff the individual prefers for support with bathing, types of social activities the individual likes to engage in, where the individual prefers to eat, etc. Capturing these preferences creates an ISP that is more person-centered and provides information to providers that support them in providing person-centered services.	
Things to Consider	• Document what the individual likes and does not like. • Document what a typical day looks like for the individual. • Information from "Client Info" tab, "Social Life" section can be used to start this conversation.
Example Documentation	• Mary does not like waking up before 9 a.m. and likes going to bed late. She likes to listen to music when she falls asleep and while she gets ready for her day.

Preferences
Identify likes or dislikes including what a typical day looks like. Provide a description in the space below.
DT likes to have time after waking before she eats breakfast. She prefers to shower every day. DT likes to watch TV when she gets into bed. She also enjoys scary/horror movies, especially in October/around her birthday. DT really likes all the Marvel movies as well. She likes music from the 50s and 60s, especially Motown and Elvis. DT enjoys ice cream and sweets, her favorite being Haagen Dazs.

Assessed Needs and Services

Assessed Needs and Services			
For each assessed need, add additional information about the supports the individual needs, including their preferences and how the need is being met.			
Assessed Needs	Description and Preferences (narrative)	How Need is Being Met	
Cognition, Mood, & Behavior			
Memory and Use of Information	Does not have difficulty remembering and using information. Does not require directions or reminding from others	☐ ALW ☐ RCFE ☐ ARF ☐ HHA ☐ CCA ☐ Natural Supports ☐ State Plan ☐ Community Resources ☐ Other	Name of agency and/or person

Physical Functioning			
Bed Mobility	#VALUE!	☐ ALW ☐ RCFE ☐ ARF ☐ HHA ☐ CCA ☐ Natural Supports ☐ State Plan ☐ Community Resources ☐ Other	Name of agency and/or person

Additional Needs			
Communication		☐ ALW ☐ RCFE ☐ ARF ☐ HHA ☐ CCA ☐ Natural Supports ☐ State Plan ☐ Community Resources ☐ Other	Name of agency and/or person

Instructions
Pursuant to 42 CFR §441.301(c)(2), a person-centered service plan must reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional needs, as well as what is important to the individual with regard to preferences for the delivery of such services and supports. In accordance with 42 CFR §441.301(c)(2)(v), the person-centered service plan must reflect the services and supports (both paid and unpaid) that will assist the individual in achieving the identified goals and desired outcomes. While the assessment is used primarily to evaluate whether the individual meets (or continues to meet) the level of care required for waiver participation and to determine the individual's tier level, the information obtained from that assessment is crucial to the development of a person-centered ISP.

Description and Preferences	

In the space provided for each assessment item with an identified need, document the individual's preferences for how, when, or by whom support should be provided and any additional information relevant to the individual's needs. Additional information is not required for each assessment item; however, the service plan must be comprehensive and effective in communicating the individual's needs and preferences to the service and support providers responsible for its implementation.
 	
Information from the assessment will auto-populate for the following items.
• Cognition, Mood, & Behavior
  o Memory and Use of Information
  o Cognitive Skills for Daily Decision-Making
  o Wandering
  o Behavioral Demands on Others
  o Agitated, Disruptive, and/or Aggressive
  o Awareness of Needs/Judgment
  o Notes/Comments
• Physical Functioning
  o Bed Mobility
  o Transfer
  o Locomotion in Residence
  o Dressing
  o Eating
  o Toilet Use
  o Personal Hygiene
  o Bathing
  o Notes/Comments
 	
Other items in the assessment require additional analysis to identify the individual's specific support needs and other essential information. For the following items, review the information provided in the assessment and use professional judgment to summarize the individual's functional status and potential support needs.
• Physical Functioning:
  o Assistive Devices and Environmental Modification
• Additional Needs
  o Communication
  o Nutrition
  o Medication Management
  o Transportation
  o Treatments
  o Other	

Things to Consider	• Discuss the assessment results for each item and use open-ended questions to facilitate a conversation about the individual's preferences. • Pay particular attention to areas of the assessment that may relate to personal goals identified earlier in the service planning process. • Ask probing questions and offer suggestions for how addressing the needs identified by the assessment may also support the achievement of the individual's personal goals.

	• To ensure the person-centered ISP is truly representative of the individual's preferences and supportive of personal goal achievement, the functional support needs and treatment information gathered through the assessment must be supplemented by the additional information gathered from the participant at the time of ISP development/update.
Example Documentation	• **Bathing:** Harry requires extensive assistance to get in and out of the shower, as well as washing his upper and lower body. Harry has poor range of motion and is unable to reach most of his body to adequately wash. Harry prefers showering/bathing at the end of the day, before going to bed. • **Communication:** Per Harry's daughter, he has a history of Macular Degeneration and had Cataract surgery but can now see adequately with reading glasses. His daughter provides his glasses. • **Nutrition:** Ensure that Harry is eating a sufficient amount of calories/day and is swallowing safely. • **Transportation:** Harry requires transportation to medical appointments and to the Senior Center on appointed days. • **Treatments:** Harry has a habit of itching and needs assistance to apply lotion daily.

How Need is Being Met	
The ISP must reasonably assure the health and welfare of the individual and must therefore address all needs identified by the assessment. Select the service or support type(s) from the checklist and enter the name(s) of the individual(s) or agency(ies) responsible for providing that service or support in the space provided. If more than one individual or entity will be responsible for meeting that need, use the space provided in the service description box to briefly summarize their respective duties or responsibilities.	
Things to Consider	• The ISP is not limited to only those services available through the waiver. Consider the additional services and supports which may be available to the individual through the Medi-Cal; other federal, state, and local public programs; the individual's family/natural support system; and/or any other relevant community resources.

Area	Assessment	Provider	Name of agency and/or person
Cognitive Skills for Daily Decision-Making	Modified Independence - some difficulty in new situations only, judgement sometimes impaired In new situations DT would prefer support to discuss the issue/situation to fully understand it. She is able to make her own decisions, but would like supported decision making when asked for.	☑ ALW ☐ RCFE ☑ ARF ☐ HHA ☐ CCA ☑ Natural Supports ☐ State Plan ☐ Community Resources ☐ Other	ARF: ABC ARF Natural Supports: Daughter
Locomotion in Residence	Limited Assistance DT uses a 4WW for all mobility. She would benefit from a cane for small spaces and occasional supervision, especially when her hands are shaking and she feels weak.	☑ ALW ☐ RCFE ☑ ARF ☐ HHA ☐ CCA ☐ Natural Supports ☐ State Plan ☐ Community Resources ☐ Other	ARF: ABC ARF
Bathing	Limited Assistance DT is able to bathe herself, however, needs supervision for safety when getting in and out of the shower. She prefers to shower in the morning, but needs time after waking up before showering. If she has to be somewhere early in the day, she would prefer to shower at night.	☑ ALW ☐ RCFE ☑ ARF ☐ HHA ☐ CCA ☐ Natural Supports ☐ State Plan ☐ Community Resources ☐ Other	ARF: ABC ARF
Assistive Devices and Environmental Modifications	DT uses a 4WW for all mobility. She uses grab bars to help getting in and out of the shower. She also has a shower bench and a handheld shower. She occasionally uses a shoe horn and grabber. She would benefit from walk-in shower.	☑ ALW ☐ RCFE ☑ ARF ☐ HHA ☐ CCA ☐ Natural Supports ☐ State Plan ☐ Community Resources ☐ Other	ARF: ABC ARF
Transportation	DT is no longer able to drive due to her impaired vision. She needs transportation support to all medical appointments and other activities she may enjoy.	☑ ALW ☐ RCFE ☑ ARF ☐ HHA ☐ CCA ☑ Natural Supports ☐ State Plan ☑ Community Resources ☐ Other	ARF: ABC ARF Natural Supports: Daughter Community Resources: Public Transportation
Treatments	DT is on 2.5 liters of oxygen 24/7. PT and OT will help her keep strength and help to prevent falls.	☑ ALW ☐ RCFE ☑ ARF ☐ HHA ☐ CCA ☐ Natural Supports ☐ State Plan ☐ Community Resources ☐ Other	ARF: ABC ARF

Risk Management and Safeguards

Risk Management and Safeguards		
Identify risks to the individual's health/wellbeing, what creates the risk, and how the risk will be mitigated.		
Risk (*Drop-Down*)	Contributing Factors	Risk Mitigation Plan
Environmental/Home Safety/Housing Insecuri Social Isolation/Loneliness Mental/Behavioral Health Nutrition/Food Insecurity Personal Safety Health and Wellness including Medical Caregiver/Natural Support Fatigue		

Instructions
Risk Management and Safeguards

In accordance with 42 CFR §441.301(c)(2)(vi), a person-centered service plan must identify risks to the individual's health/wellbeing. This section is where those risks are recorded as well as the factors contributing to the risks and the plans to mitigate those risks.

Care coordinators should consider all aspects of the individual's health/wellbeing when determining risks, accounting for medical, physical, social, and emotional risks. It's important to inform the individual of these risks and help to identify ways to make living safer, all while keeping their preferences in mind. Risks to consider include:

- **Environmental/Home Safety/Housing Insecurity:**
    - Individual does not feel safe in home,
    - Individual is unable to maintain home,
    - Individual is unable to continue financially affording home, and/or
    - Home needs modifications for individual to continue living safely.
- **Social Isolation/Loneliness:**
    - Individual feels isolated from others,
    - Frequency individual participates in activities they enjoy,
    - Individual feels left out from family, friends, and/or the community, and/or
    - Individual lacks companionship.
- **Mental/Behavioral Health:**
    - Individual feels down/depressed and/or
    - Individual has little interest or pleasure in participating in activities.
- **Nutrition/Food Insecurity:**
    - Individual is worried about food not lasting,
    - Individual cannot afford to eat nutritious foods, and/or
    - Individual does not have enough money to buy food by the end of the month.

- **Personal Safety:**
    - Individual is not aware of poor treatment,
    - Individual does not make their needs/wants known, and/or
    - Individual is unable to recognize unsafe group or social situations.
- **Health and Wellness including Medical:**
    - Individual has an increased risk of falls,
    - Individual is disoriented due to dementia,
    - Individual has chronic pain, and/or
    - Individual has fluctuating blood glucose levels due to diabetes.
- **Caregiver/Natural Support Fatigue:**
    - Current caregiver is unable or unwilling to continue providing any support or current level of support.

Risk	
Select the risk to the individual's health and/or wellbeing from the drop-down menu.	
Things to Consider	• The risk is identified through the assessment process. Risks include health, safety, and welfare of individual. • Reminder that everyone has the right to take reasonable risks. Therefore, role is to ensure the individual understands the risks and document the outcome.
Example Documentation	• Health and Wellness including Medical • Social Isolation/Loneliness

Contributing Factors	
Identify what factors create the risk.	
Things to Consider	• The needed service/support does not exist in the community or there is no available provider. • The individual could also refuse to address an assessed need. • There may be a lack/instability of natural supports.
Example Documentation	• Increased weakness, confusion, and side effects of medication. • Lack of natural (family/friend) support, lives alone, unable to leave home without hands on support.

Risk Mitigation Plan
Establish a plan for how the risk will be addressed to ensure the individual's health and wellbeing.

Things to Consider	• Identify strategies, services, and supports to minimize the risk. • Strategies do not need to be limited to those services paid through the Waiver but can include natural supports, community resources, Medicaid State Plan, or other resources.
Example Documentation	• Ensure that Ronald's room and hallways are free of clutter. Ensure he uses his cane at all times while ambulating and that he wears well-fitting supportive shoes.

Risk Management and Safeguards		
Identify risks to the individual's health/wellbeing, what creates the risk, and how the risk will be mitigated.		
Risk (*Drop-Down*)	Contributing Factors	Risk Mitigation Plan
Social Isolation/Loneliness	DT lives alone and she does not have a social support system, except for her daughter. She does not reach out to old friends often and does not engage in activities.	Living in an ARF will help DT develop connections and friendships, outside of her daughter. There will be activities available to her as well, to help her socialize.

Back-Up Plan

Back-Up Plan
It is the responsibility of the setting to have a back-up plan in place to ensure continuity of care and services in the event of an emergency, evacuation, or unusual circumstance. Should an evacuation be necessary, the individual requires the following: ☐ Oxygen ☐ Wheelchair ☐ Walker ☐ Ventilator ☐ Medication ☐ Other

Instructions	
Back-Up Plan	
In accordance with 42 CFR §441.301(c)(2)(vi), the *Back-Up Plan* section is another portion of the individual service plan meant to identify risks and mitigation strategies. For the Assisted Living Waiver, the residential setting is required to have a plan on file in the event of an emergency/evacuation, but this section is intended to also identify an individual's specific needs in those situations and in an unusual circumstance.	
Things to Consider	• Does the individual require an assistive device for locomotion/ambulation? • Does the individual require an assistive device for respiratory support? • Is the individual on a treatment plan that requires medication to be taken on a consistent schedule? • Do medications need to be kept cold?
Example Documentation	• Ronald will require medication management due to his Dementia. He will need his cane for stability and safety and proper footwear. He will require supervision due to his Dementia and confusion.

Back-Up Plan
It is the responsibility of the setting to have a back-up plan in place to ensure continuity of care and services in the event of an emergency, evacuation, or unusual circumstance. Should an evacuation be necessary, the individual requires the following: ☑ Oxygen ☑ Wheelchair ☑ Walker ☐ Ventilator ☑ Medication ☐ Other
DT uses a 4WW for all mobility, this needs to be included for any evacuation. For longer distances, she would benefit from a wheelchair. DT is on 2.5 liters of oxygen 24/7 and has medications that must be taken regularly.

Care Coordination Monitoring

Care Coordination Monitoring		
The Care Coordinator has explained the minimum monitoring requirements of the waiver I am enrolled in, and I understand these requirements.	◉ Yes	○ No
I have received training on how to recognize and report instances of abuse, neglect, or exploitation.	◉ Yes	○ No
I prefer my Care Coordinator contact me		
☐ In person ☐ By telephone ☐ By email ☐ By text ☐ Other	If Other, Please Specify	

Instructions
In accordance with 42 CFR §441.301(c)(2)(viii), an individual service plan must identify the individual and/or entity responsible for monitoring the plan. This section documents the individual's communication preferences with his or her care coordinator, as well as with whom important notices are shared besides the individual and with whom the individual prefers to have no contact.
The Care Coordinator has explained the minimum monitoring requirements of the waiver I am enrolled in, and I understand these requirements.
Select "Yes" or "No" based on the individual's response.
I have received training on how to recognize and report instances of abuse, neglect, or exploitation.
Select "Yes" or "No" based on the individual's response.
I prefer my Care Coordinator to contact me
Select all options that apply. If "Other," enter the option in the box provided.

When necessary, I would like the following people to be contacted about my services and supports

Name of Person	Contact Information

Instructions
Name of Person
Enter the name of each person the individual would like notified if an important change occurs.
Contact Information
Enter the contact information for each person identified.

Are there any individuals that you do not want to be in contact with or who should not be around you?			
Name of Person	Relationship to Individual	Is there legal documentation justifying the reason this individual should not contact individual?	Instructions if this person tries to make contact

Instructions
Name of Person
Enter the name of each person the individual does not want to have contact with or be around.
Relationship to Individual
Identify the relationship of each person entered to the individual.
Is there legal documentation justifying the reason this individual should not contact individual?
Enter "Yes" or "No" if there is a legal reason why the identified persons should not be in contact with the individual. Provide a further explanation, if available.
Instructions if this person tries to make contact
Provide a plan of action to take if the identified persons attempt to contact the individual.

Patient's Rights Form

Assisted Living Waiver
Patient's Rights

Name: ______________________________

Client Identification Number (CIN): ______________________________

This document confirms the following: (Check all that apply)

- ☐ I had freedom of choice in choosing my services and provider(s).
- ☐ I had freedom of choice in choosing where I live.
- ☐ I participated in a person-centered planning process.
- ☐ My care coordinator explained my rights and responsibilities.
- ☐ My care coordinator explained my right to a fair hearing.
- ☐ My care coordinator provided me with their contact information and their supervisor's contact information (if applicable).

Instructions
In accordance with 42 CFR §441.301(c)(2)(vi), the individual's understanding and signature consent of his or her individual service plan is required as well as signatures by all individuals and providers responsible for its implementation.
Name
Enter individual's name.
CIN
Enter individual's CIN.
This document confirms the following
Check off each statement as they are covered with the individual. Every statement should be checked off.

Care Coordinator Contact Information:

Name: ___________________________________

Phone: ___________________________________

Email: ___________________________________

Care Coordinator Supervisor Name: ___________________________________

Care Coordinator Supervisor Phone: ___________________________________

Rights Modification Consent (Do not complete if a rights modification does not exist)

My individual service plan includes the modification of my rights, as explained below.

Instructions
Care Coordinator Information – Name
Enter care coordinator's name.
Care Coordinator Information – Phone
Enter care coordinator's phone number.
Care Coordinator Information – Email
Enter care coordinator's email.
Care Coordinator Supervisor Name
Enter care coordinator's supervisor's name.
Care Coordinator Supervisor Phone
Enter care coordinator's supervisor's phone number.
Rights Modification Consent
If the individual has documented rights modifications, summarize them here.

Things to Consider	• It is required that the individual understands and consents to any and all rights modifications in their ISP. • Rights modifications may not initially be known; this form should be updated if/when a modification is implemented. • If consent is not obtained, and a provider is not willing and able to provide services without rights modifications, then the care coordinator must assist the individual in finding a new provider. • The signature line at the end of the document serves as the individual's consent.
Example Documentation	• Harry has a modification of his right to move freely. He has Advanced Alzheimer's and has hurt himself multiple times from wandering. Positive interventions and supports were tried prior to modifying Harry's right. Full details can be found in the Rights Modifications section.

By signing this form, I agree to the services and supports in my individual service plan, including any modification to my rights. I agree to this plan being shared with myself, the people involved in this process, and the people that need it to provide my services.

Individual/Legally Responsible Person (Print Name): ______________________

______________________ ______________________
Individual/Legally Responsible Person Signature Date

Care Coordinator (Print Name): ______________________

______________________ ______________________
Care Coordinator Signature Date

Instructions
Individual/Legally Responsible Person (Print Name)
Enter name of the individual or legally responsible person.
Individual/Legally Responsible Person Signature
Acquire signature of individual or legally responsible person and date.
Care Coordinator Name
Enter name of the care coordinator.
Care Coordinator Signature
Acquire care coordinator signature and date.

Other ISP meeting participants:

☐ Chosen by Individual	☐ Providing Services (if applicable)	
Name:	Title:	Agency:
Signature:	Date:	

☐ Chosen by Individual	☐ Providing Services (if applicable)	
Name:	Title:	Agency:
Signature:	Date:	

Instructions
Chosen by Individual
Check the box if the person listed was chosen by the individual to participate in the ISP.
Providing Services (if applicable)
Check the box if the person listed will be providing services as part of the ISP.
Name
Enter the name of every other ISP meeting participant besides the individual and care coordinator.
Title
Enter the title of the additional participant.
Agency
Enter the name of the agency of the additional participant, if applicable.
Signature
Acquire signatures from each additional participant and date of signatures.

Technical Troubleshooting Tips

Below are a few tips on how to navigate the ISP workbook and make the most use of its functionality.

1. A yellow Security Warning ribbon may pop up at top of the workbook when opened. Be sure to click “**Enable Content**.”
2. If a Security Warning window pops up asking “Do you want to make this file a Trusted Document?”, click “**Yes**.”
3. If radio buttons and/or checkboxes stop working at any point while using the workbook, make sure the file is saved and close the workbook. Reopen the workbook, and the radio buttons and/or checkboxes should work properly.
4. Copying information from another location in the workbook or another document and attempting to paste it into the ISP may not work. If that is the case, please proceed with manually entering in the information.
5. Printing: Under Settings in the Print feature, select “**Fit All Columns on One Page**.” With this option selected, you can print in either Landscape or Portrait mode, depending on preference, and all sections of the ISP will print.