

VIRGINIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES (DBHDS)  
SUPPORTS FOR LIVING BOOKLET/ FUTURE RESIDENTIAL PLANNING

[\* = required by the Code of Virginia 37.2-505 and/or 37.2-837 and must be addressed in Part B: plan]

**SUPPORTS FOR LIVING BOOKLET - Part A**

*Part A is to be completed by the training center staff, at the time of the annual review and when the individual's status changes to the extent that the previous plan no longer accurately reflects the individual's needs.*

Full Name: \_\_\_\_\_  
*Last First M.I.*

DOB: \_\_\_\_\_ Residence/training center: \_\_\_\_\_  
*TC campus/building/unit identifier*

<b>IMPORTANT TO</b>	
<b>IMPORTANT FOR</b>	

VIRGINIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES (DBHDS)  
SUPPORTS FOR LIVING BOOKLET/ FUTURE RESIDENTIAL PLANNING

**Alternative residential options**

Choice of alternative placements: (rank the type of residential supports needed in order of preference:

ICF/MR Residential group home: \_

Waiver group home/congregate living (More than 4 in the home):

Waiver group home/congregate living (4 or less in the home): \_\_\_

Sponsored residential (waiver provider): \_

Family (private) placement (waiver/natural supports only): \_

List any challenges/barriers to community placement and include in Part V: Individual Support Plan (ISP) how the team plans to the address these issues :

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*DISCHARGE and DISCHARE PLANNING*

**VIRGINIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES (DBHDS)  
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<b>IDENTIFICATION</b>	<p>Diagnoses (<i>List Medical and psychiatric diagnoses, including ID level from psychological evaluation and date of evaluation</i>):                  **MR/ID level (Dx code #): _____ Date of psychological evaluation/by whom: _____</p> <p>* Behavioral Health Dx/psychiatric dx (active/history of):    Y    N</p> <hr/> <p>* Substance use (active/history of):    Y    N</p> <hr/> <p>*Medical:</p> <hr/> <p>Name of Authorized Representative/ Legal Guardian and contact information:                  _____                  _____</p> <p>AR Relationship to the Individual: Family Member: <input type="checkbox"/>                      Legal Guardian: <input type="checkbox"/></p> <p>Admission Date: _____                      DBHDS Register #: _____</p>																											
<b>**FINANCIAL</b>	<p><b><i>Check All That Apply:</i></b></p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;"></th> <th style="width:35%;">The individual currently receives:</th> <th style="width:35%;">Anticipated to receive when relocation occurs.</th> </tr> </thead> <tbody> <tr> <td>SSI - Amt. per month:</td> <td></td> <td></td> </tr> <tr> <td>SSDI - Amt. per month:</td> <td></td> <td></td> </tr> <tr> <td>Other Financial Benefit - Amt. per month:</td> <td></td> <td></td> </tr> <tr> <td>Medicaid A &amp; B</td> <td></td> <td></td> </tr> <tr> <td>Medicare Parts A, B &amp; D:</td> <td></td> <td></td> </tr> <tr> <td>-</td> <td></td> <td></td> </tr> <tr> <td>Other Insurance Coverage Type/amt</td> <td></td> <td></td> </tr> <tr> <td>Other Resources (i.e. trust funds) Type/amt</td> <td></td> <td></td> </tr> </tbody> </table> <p><b><u>Burial Fund:</u></b>                  Location: _____ Amount: _____</p>		The individual currently receives:	Anticipated to receive when relocation occurs.	SSI - Amt. per month:			SSDI - Amt. per month:			Other Financial Benefit - Amt. per month:			Medicaid A & B			Medicare Parts A, B & D:			-			Other Insurance Coverage Type/amt			Other Resources (i.e. trust funds) Type/amt		
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**SUPPORTS FOR LIVING BOOKLET**

*To be completed by the Training Center Social Worker/Support Coordinator/QMRP.*

<b>HOUSING</b>	<p><b>Check All That Apply</b></p> <p><input type="checkbox"/> Return to prior living situation (No Needs/supports)</p> <p><input type="checkbox"/> Obtain new living situation</p> <p><input type="checkbox"/> Individual desires to live in/near ( specific area/town/city/person) (<i>specify</i>) - _____</p> <p><i>Special Supports:</i></p> <p><input type="checkbox"/> Nursing Care Available 24 hours – (Certified Nursing Facility or ICF/MR with 24/7 nursing)</p> <p><input type="checkbox"/> Barrier Free    <input type="checkbox"/> Handicapped accessible;    <input type="checkbox"/> Wheelchair accessible</p> <p>Other (<i>specify</i>) - _____</p>
<b>STAFFING LEVEL</b>	<p><input type="checkbox"/> Staff support present: 24 hours per day with <b>awake</b> overnight staff. <i>Specify reason:</i> _____</p> <p><input type="checkbox"/> Staff support present: 24 hours per day with <b>asleep</b> overnight staff. <i>Specify reason:</i> _____</p> <p><input type="checkbox"/> ID waiver _____ hours, _____ days per week. <i>Specify reason:</i> _____</p> <p><input type="checkbox"/> Only periodic checking needed (i.e. Supported living) _____</p> <p><input type="checkbox"/> No staff needed (i.e. living with family/natural supports)</p> <p><input type="checkbox"/> Live independently</p>
<b>TRANSITION</b>	<p><input type="checkbox"/> No Support needed/ Not Applicable</p> <p><input type="checkbox"/> Trial Visits Needed (<i>specify purpose</i>): _____</p> <p><input type="checkbox"/> Transition Needed (<i>specify purpose</i>): _____</p>

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<b>SELF CARE</b>	<p><i>Describe staff supports in the areas of (1) personal hygiene, (2) toileting, (3) bathing and (4) dressing. Place numeral next to category which <b>best</b> reflects need. More than one numeral may be used with each category.</i></p> <p><i>(Example: <b>3, 4 Physical Support</b> means that the individual requires physical support with bathing and dressing.)</i></p> <p> <input type="checkbox"/> Full physical assistance    <input type="checkbox"/> Partial physical assistance    <input type="checkbox"/> Verbal/gestural prompting  <input type="checkbox"/> Monitoring    <input type="checkbox"/> No Support needed </p>
<b>DAILY LIVING</b>	<p><i>Describe supports needed in the areas of (1) meal preparation, (2) care of clothing, (3) maintaining a neat and clean environment and (4) general care of personal belongings. Place numeral next to category which <b>best</b> reflects need. More than one numeral may be used with each category.</i></p> <p><i>(Example: <b>2, 4 Prompts/Reminders</b> means that the individual requires prompts or reminders to properly care for clothing and personal belongings.)</i></p> <p> <input type="checkbox"/> Full physical assistance    <input type="checkbox"/> Partial physical assistance    <input type="checkbox"/> Verbal/gestural prompting  <input type="checkbox"/> Monitoring    <input type="checkbox"/> No Support needed </p>
<b>EATING</b>	<p><b>Check All That Apply</b>  Nutritional Support Plan ( Add supports from Nutritional support plan )</p>

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**\*\*MOBILITY**

***Check All That Apply***

- Non-ambulatory (does not walk)
- Mobile: Supportive or Assistive Devices (*specify*), – \_\_\_\_\_

Mobile: Wheelchair propelled by others at all times;  Mobile: Wheelchair Only for Long Distances, propelled by others;

- Mobile: independent wheelchair: propels self/power
- Ambulatory;  Independently;  with 1 person physical support;  with 2 person physical support  Other: \_\_\_\_\_

Lift needed for Transferring (list type of lift), - \_\_\_\_\_

Cannot Bear Own Weight,  Re-positioning During Day (list frequency): \_\_\_\_\_

Re-positioning During Night (list frequency): \_\_\_\_\_

Physical Therapy (Specify): \_\_\_\_\_

Range of Motion Exercises \_\_\_\_\_

Exhibits Unusual or Unsteady Gait (Describe): \_\_\_\_\_

Falls Risk (specify  low  high):  Cannot Climb Stairs Unassisted

Walks Easily and Climbs Stairs Unassisted,  Crosses Public Streets Safely,

Can use Public Transportation

Other (*specify*): \_\_\_\_\_

**COMMUNICATION**

***Check All That Apply:***

No words spoken  Requires Communication Aids (*specify*): \_\_\_\_\_

uses preferred language (*specify*): \_\_\_\_\_  Speech Therapy (list): \_\_\_\_\_

Screams, Yells at Others or uses Vulgarisms,  Makes Verbal Threats,

Speech is Difficult to Understand,  Speech is Easy to Understand

Other (*specify*): \_\_\_\_\_

**VIRGINIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES (DBHDS)  
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<b>BEHAVIOR SUPPORTS</b>	<p><b><i>Check All That Apply</i></b> Requires On-going Supports for :</p> <p>List the inappropriate behavior observed/ the antecedents and any other specifics (i.e. limited to one environment – day program).</p> <p><input type="checkbox"/> List observation/antecedent/environment: _____</p> <p><input type="checkbox"/> Psychiatric Treatment, <input type="checkbox"/> Requires Medication For Support and /or changes to medication regimen</p> <p><input type="checkbox"/> Other (<i>specify</i>): _____</p>
<b>DAY PROGRAM SUPPORTS</b>	<p><b><i>Check All That Apply</i></b> Requires On-going Training/Support in:</p> <p><input type="checkbox"/> Sensory development, <input type="checkbox"/> Self Care/ADL Skills Building, <input type="checkbox"/> Pre-vocational Skills,</p> <p><input type="checkbox"/> Vocational Skills <input type="checkbox"/> Employment, <input type="checkbox"/> Paid Work, <input type="checkbox"/> With the Assistance of a Job Coach</p> <p><input type="checkbox"/> Volunteer Work <input type="checkbox"/> Older Adults day program/dementia program</p> <p><input type="checkbox"/> Public School Attendance (<i>grade level and school system</i>): _____</p> <p>_____</p> <p>_____</p>

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<b>** HEALTH CARE SUPPORTS</b>	<p><b><i>Check All That Apply (explain)</i></b> Requires On-going Care in the Following Areas:</p> <p><input type="checkbox"/> General Healthy Status,   <input type="checkbox"/> Dental,   <input type="checkbox"/> Seizure Control,   <input type="checkbox"/> Digestion</p> <p><input type="checkbox"/> Psychiatry Dx:,   <input type="checkbox"/> Infections,   <input type="checkbox"/> Orthopedic,   <input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> Cardio-vascular,   <input type="checkbox"/> Respiration,   <input type="checkbox"/> Gynecology,   <input type="checkbox"/> Dermatology,</p> <p><input type="checkbox"/> Metabolic,   <input type="checkbox"/> Ophthalmology</p> <p><input type="checkbox"/> Other (<i>specify below</i>):</p> <hr/> <hr/> <hr/> <p><input type="checkbox"/> Requires Medication Administration ( <u>attach current physicians order</u>)</p> <p><input type="checkbox"/> Requires Regular Lab Work for (<i>specify type, diagnosis and frequency</i>):</p> <hr/> <hr/> <hr/>
<b>LIFE CONCERNS</b>	<p><b><i>Check All That Apply</i></b></p> <p><input type="checkbox"/> Blind,   <input type="checkbox"/> Difficulty hearing (Wears hearing aids   <input type="checkbox"/> Yes   <input type="checkbox"/> No)</p> <p><input type="checkbox"/> Visually Impaired,   <input type="checkbox"/> Deaf,   <input type="checkbox"/> Dual Diagnosis ID/MH,   <input type="checkbox"/> Dual Diagnosis ID/SA</p> <p><input type="checkbox"/> Orthopedic,   <input type="checkbox"/> Paralysis (<i>specify</i>): _____</p> <p><input type="checkbox"/> Spasticity (<i>specify</i>): _____</p> <p><input type="checkbox"/> Mixed spasticity and hypo tonicity</p> <p><input type="checkbox"/> Other (<i>specify</i>): _____</p>

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<b>** LEGAL</b>	<p><i>Check All That Apply</i></p> <p><input type="checkbox"/> Authorized Representative appointed by DBHDS, will need to be changed at time of discharge,</p> <p><input type="checkbox"/> Will Need a Change of Payee Upon Discharge - Current Payee: _____</p> <p><input type="checkbox"/> Custody Assigned by Court order Legal guardian: <input type="checkbox"/> Full over all person and property:  <input type="checkbox"/> Limited (<i>specify</i>): _____ <input type="checkbox"/> Incapacitated : <input type="checkbox"/> Incompetent</p> <p><input type="checkbox"/> Physician has issued DNR Order</p> <p><input type="checkbox"/> Other (<i>specify</i>): _____</p> <p>I have an advance directive. Yes <input type="checkbox"/> No <input type="checkbox"/> I have a living will: Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<b>LIKES</b>	<p><i>Check All That Apply</i></p> <p><input type="checkbox"/> Activities to be Planned by Others, <input type="checkbox"/> Socialization Skills Building, <input type="checkbox"/> Assistance With Hobbies/Crafts</p> <p><input type="checkbox"/> Encouragement to Spend Leisure Time Well or With Others, <input type="checkbox"/> Good Use of Leisure Time</p> <p><input type="checkbox"/> Independently Plans/Spends Leisure Time</p> <p><input type="checkbox"/> Other (<i>specify</i>): _____</p>
<b>OTHER</b>	<p><i>Detail Any Other Support Not Previously Identified</i></p> <p>List date of discharge, if active discharge/transition planning is in process:          _____          _____          _____</p>

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SIGNATURES

Completed by Facility Social Worker/ Support Coordinator/QMRP of Training Center

\_\_\_\_\_  
*Signature and printed name*  
*Date*

*Title*

\_\_\_\_\_  
*Individual's Signature/Mark*

*Date*

\_\_\_\_\_  
*Authorized Representative    Signature and printed name*

*Date*

\_\_\_\_\_  
*Witness:*

*Date*

The undersigned have reviewed the supports as well as my personal preferences for a good life,

## SUPPORTS FOR LIVING BOOKLET – Part B

### VIRGINIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

To be completed **by CSB** at the time of the annual review and when the individual's status changes to the extent that the previous plan no longer accurately reflects the individual's needs. **Key code: \*** = **\*Required by Code of Virginia – completed by CSB**

CSB IDENTIFICATION

Name of CSB: \_\_\_\_\_

Address: \_\_\_\_\_

City

State

Name of Support Coordinator / Case Manager: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

DISCHARGE

Barriers/Challenges to discharge (please list): \_\_\_\_\_

What Community living arrangements are being considered?

With Family:

Sponsored Residential:

Supervised Apartment:

Waiver Group Home:

ICF/MR group home:

Nursing Home:

Home for Adults / Assisted Living:

Other:  \_\_\_\_\_

Is there an active transition plan? Yes:  No:  \_\_\_\_\_

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<b>** SUPPORTS</b>	<p>* A plan is needed for supports for MR (ID) diagnosis (listed above) Yes: <input type="checkbox"/> No: <input type="checkbox"/></p> <p>* A plan needed for supports for MR( ID)/Mental illness Diagnosis (listed above): Yes: <input type="checkbox"/> No: <input type="checkbox"/></p> <p>* A plan needed for supports for Substance Use Disorders listed above: Yes: <input type="checkbox"/> No: <input type="checkbox"/></p> <p>* A plan is needed for supports for Medical diagnoses listed above: Yes: <input type="checkbox"/> No: <input type="checkbox"/></p> <p>If YES to any of above, complete the Individual Support Plan section on the ISP to address how CSB will address these areas.</p>
<b>** SOCIAL</b>	<p><i>Write a statement to describe the individual's social life at the present time. (e.g. I am generally a quiet/loud, energetic/sedentary, young/old person )whose interest in the social skills are described as follows:</i></p> <p>In my new home I want _____ with respect to family and friends?</p> <p><input type="checkbox"/> _____</p> <p><i>CSB Case Manager/Support Coordinator will write the Goals, Objectives and Supports he/she is going to address for Social Skills areas on the ISP.</i></p>
<b>** EDUCATIONAL</b>	<p><i>Write a statement to describe the individual's educational interests in life, (e.g. I would like to do or learn the following:</i></p> <p>(Some choices might include: going to community college, taking music lessons, going to learn a new craft or hobby, learning to cook a specific item, make a pot of coffee etc.)</p> <p><input type="checkbox"/> _____</p> <p><i>CSB Case Manager/Support Coordinator will write the Goals, Objectives and Supports he/she is going to address for Educational areas on the ISP.</i></p>
<b>** MEDICAL (HEALTHCARE SUPPORTS)</b>	<p>I need the following to be provided or available in my new residence: (list what staff supports area needed and what are independent or moderate supports):</p> <p><i>CSB Case Manager/Support Coordinator will write the Goals, Objectives and Supports he/she is going to address for Medical and Healthcare areas on the ISP.</i></p>

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<b>EMPLOYMENT</b>	<p>____ (name) is ____ years of age, and has interests in ____ Paid employment (FT, PT); ____ volunteer experiences in ____ (area); and in attending _____ (program name); and or ____ retiring.</p> <p><i>CSB Case Manager/Support Coordinator will write the Goals, Objectives and Supports he/she is going to address for Medical and Employment areas on the ISP.</i></p>
<b>HOUSING</b>	<p>____ (name) would like to live in the following type(s) of residential areas:</p> <p><input type="checkbox"/> Near pool;    <input type="checkbox"/> Assisted Living Facility(note need to meet Code of Va. 37.2-837)</p> <p><input type="checkbox"/> own apt.        <input type="checkbox"/> Group home (name if known)_____</p> <p><input type="checkbox"/> Sponsored Residential Home with dog/cat;</p> <p><input type="checkbox"/> living with (name of roommate, individual, friend/family)_____</p> <p><input type="checkbox"/> living on a farm with animals/garden</p> <p><input type="checkbox"/> quiet area/home with own TV</p> <p><input type="checkbox"/> living with younger active children</p> <p><input type="checkbox"/> Other: description of housing individual would like:</p> <p><i>CSB Case Manager/Support Coordinator will write the Goals, Objectives and Supports he/she is going to address for areas Housing supports on the ISP</i></p>
<b>LEGAL /ADVOCACY</b>	<p>I need legal/advocacy supports in my new home to include:</p> <p><i>CSB Case Manager/Support Coordinator will write the Goals, Objectives and Supports he/she is going to address for legal and advocacy areas on the ISP</i></p>

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<b>** TRANSPORTATION AND MOBILITY</b>	<p>I need supports with transportation issues by/with _____, for</p> <p><input type="checkbox"/> medical (i.e. laboratory, physician visits)</p> <p><input type="checkbox"/> social (includes family and friend supports)</p> <p><input type="checkbox"/> recreational</p> <p><input type="checkbox"/> religious</p> <p><input type="checkbox"/> other: _____</p> <p>I need support with (items listed in the mobility section above):</p> <p><i>CSB Case Manager/Support Coordinator will write the Goals, Objectives and Supports he/she is going to address for Transportation and Mobility areas on the ISP</i></p>
<b>** OTHER SERVICES/SUPPORTS:</b>	<p>I need supports with:</p> <p>_____ Money management : <input type="checkbox"/> checking/savings account</p> <p style="padding-left: 100px;"><input type="checkbox"/> large amounts of cash (describe large as = _____)</p> <p style="padding-left: 100px;"><input type="checkbox"/> small amounts of cash (describe small as = _____)</p> <p style="padding-left: 100px;"><input type="checkbox"/> Other: _____</p> <p>Self/Administration and medication management: (based on self administration assessment of the Training Center), I will need a program which supports me in the following ways:</p> <p><i>CSB Case Manager/Support Coordinator will write the Goals, Objectives and Supports he/she is going to address for these specified areas on the ISP.</i></p>



**VIRGINIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES (DBHDS)  
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	<hr/> <i>Signature</i>	<hr/> <i>Title</i>	<hr/> <i>Date</i>
	<hr/> <i>Signature</i>	<hr/> <i>Title</i>	<hr/> <i>Date</i>
	<hr/> <i>Signature</i>	<hr/> <i>Title</i>	<hr/> <i>Date</i>
	<hr/> <i>Signature</i>	<hr/> <i>Title</i>	<hr/> <i>Date</i>

A copy of the entire Supports for Living form, and Person Center Planning forms for ICFMR with signatures is to be filed at both the Training Center and the CSB Case Manager/Support Coordinator record for the individual named. The CSB and the Training Center's plans for future are to be included in Part V of the ISP. Where noted above, “

*CSB Case Manager/Support Coordinator will write the Goals, Objectives and Supports he/she is going to address for (area) specified areas on the ISP” intends the meaning to be on Part V, in the “important to” and/or “important for” sections as applicable.*