

Individual Support Plan

I. Essential Information

Contact Information

Legal Name:	Jack Garner	Preferred Name:	Jack
Date of Birth:	09/03/64	Gender:	Male
Marital status:	Single	Admission date:	02/18/91
Medicaid #:	01916150011	Medicare #:	332-09-9920 C1
Home Street Address:	466 Arbor Lane	Insurance:	N/A
Mailing Address or P.O. Box:	Same as above	SSN#:	215-58-9985
City:	Anytown	Zip Code:	20456
Home phone:	540-788-9393	Cell phone:	n/a
Work phone:	n/a	Email address:	Jack@email.com

Emergency Contacts / Representation

Name	Phone:	Fax:	Email:
Relationship:	Address:		
Legal Guardian:	Phone:	Fax:	Email:
Relationship:	Address:		
Authorized Rep:	Phone:	Fax:	Email:
Relationship:	Address:		
Family #1: John Garner	Phone: 778-1235	Fax:	Email:
Relationship: Brother	Address: 3598 Orange Road Anytown, VA 77629		
Family #2:	Phone:	Fax:	Email:
Relationship:	Address:		
Family #3:	Phone:	Fax:	Email:
Relationship:	Address:		
Power of Attorney:	Phone:	Fax:	Email:
Relationship/Type:	Address:		
Emergency Contact:	Phone:	Fax:	Email:
Relationship:	Address:		
Conservator:	Phone:	Fax:	Email:
Relationship:	Address:		
Representative Payee:	Phone:	Fax:	Email:
Relationship:	Address:		
Physician 1: Dr. C Glass	Phone: 778-9989	Fax: 778-9982	Email: glass@email.com

This ISP belongs to: Jack Garner ID# 512 ISP Start: 3/1/09 End: 2/28/10

1

Specialty: Primary Care	Address:4467 Nottingham Way Anytown, VA 77629		
Physician 2:	Phone:	Fax:	Email:
Specialty:	Address:		
Physician 3:	Phone:	Fax:	Email:
Specialty:	Address:		
Physician 4:	Phone:	Fax:	Email:
Specialty:	Address:		
Dentist:	Phone:	Fax:	Email:
Address:			
Other:	Phone:	Fax:	Email:
Relationship:	Address:		
Other:	Phone:	Fax:	Email:
Relationship:	Address:		

Support Coordination and Provider Contacts

Support Role: Residential	Agency: River Creek, LLC		
Name: Stephanie Klein	Address: 446 Arbor Lane Anytown, VA 20456		
Phone: 540-788-9393	Fax: 540-788-9394	Email:SKlein@abcres.com	
Support Role: Day Support	Agency: New Adventures Day Support		
Name: Melissa Schaffer	Address:1223 View Drive Anytown, VA 20456		
Phone:540-200-8980	Fax:540-200-8981	Email:	
Support Role: SC	Agency: Oakridge CSB		
Name: Gloria Jones	Address: 7877 Patton St. Anytown, VA 20456		
Phone: 540-889-1122	Fax: 540-889-1123	Email: gjones@sc.org	
Support Role:	Agency:		
Name:	Address:		
Phone:	Fax:	Email:	
Support Role:	Agency:		
Name:	Address:		
Phone:	Fax:	Email:	
Support Role:	Agency:		
Name:	Address:		
Phone:	Fax:	Email:	
Support Role:	Agency:		
Name:	Address:		
Phone:	Fax:	Email:	
Support Role:	Agency:		
Name:	Address:		
Phone:	Fax:	Email:	

Communication and Sensory Support

Preferred language:	Please <i>check one</i>) <input checked="" type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other (Please Specify):
Describe supports needed for communication (if any):	Jack needs others to wait up to 2 minutes when he forms a response to a question or request. He may become frustrated when rushed through a conversation.
Do I have any difficulty reading a magazine or newspaper?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe. Jack reads short words and phrases. He often enjoys looking at photographs in the newspaper and magazines.
Would a professional evaluation related to sensory or communication abilities be beneficial?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Adaptive Equipment, Assistive Technology and Modifications

Please describe any adaptive equipment and assistive technology supports (if any):	n/a
Would a professional evaluation related to adaptive equipment, assistive technology or other modifications be beneficial?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

Health Information

Do you have an advanced directive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>If yes, please provide a copy to all relevant parties.</i>			
Medication:	Physician:		Reason(s) prescribed:
Dosage:	Route:	Frequency:	Location of potential side effect information:
1: Apidra 20cc subcutaneous	Dr. Glass injection	BID	diabetes type 2 primary record under Side Effects tab
2:			
3:			
4:			
5:			
6:			
7:			
8:			
9:			

This ISP belongs to: Jack Garner ID# 512 ISP Start: 3/1/09 End: 2/28/10

10:			
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<u>HEALTH TOPIC</u>	<u>DESCRIPTON</u>
Date of my last complete physical exam.	Date:7/12/08
Date of my last dental exam.	Date:2/19/09
Do I have any mental health support needs?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Please provide crisis plan (if applicable) and describe support needs:
Do I have any allergies to medication, food, or environmental elements (e.g., mold, dust, etc.)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please describe:
Please describe all recent physical complaints & medical conditions.	Jack ocassionally experiences low blood sugar. He is provided 6 ounces of orange juice when this occurs.
Do I have any issues with physical intimacy, pregnancy or child rearing?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please describe:
Do I have any chronic health conditions?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe: diabetes
Do I have any communicable diseases?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please describe:
Do I have any limitations or restrictions on physical activities?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please describe:
Have I had any serious illnesses, serious injuries, and/or hospitalizations in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:
Have there been any serious illnesses or chronic conditions among my parents, siblings, or grandparents?	There is a history of diabetes in Jack's family.
Have there been any serious illnesses or chronic conditions among significant others in my household (if any)?	None
Have I ever smoked cigarettes/cigars or used smokeless tobacco?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please describe:
a. How often do I drink alcohol? b. Does my current use of alcohol cause problems in any area of my life? Have I ever been told that I drink too much alcohol	a. Number of times and number of drinks per week: n/a b. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please describe: n/a
a. Does my current use of prescription medication cause problems in any area of my life? b. Have I found that I have to take more and more of any prescription medication to feel an effect? c. Have I ever been told that I take my medications incorrectly.	n/a
Have I ever been in treatment for a problem with, or resulting from, use of alcohol, drugs, or prescription medicine?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please describe <i>what type of treatment, was provided and when.</i>

This ISP belongs to: Jack Garner ID# 512 ISP Start: 3/1/09 End: 2/28/10

Is there any other health history or medical information or health preferences that I would like to share?

Jack prefers Viars Medical Center for emergency care. When services began, Jack's mother reported that Jack was diagnosed with diabetes at 16 years of age. She explained that fast acting insulin is the most effective medication that he has taken for his condition. . He is reported to have difficulty following a diabetic diet, however, he is willing to discuss healthy eating options with others and likes sugar free jello and trying new foods. According to Mrs. Garner, Jack is appropriate regarding sexual issues and has had several girlfriends in the past. She is unaware of any sexual concerns in Jack's history and does not suspect any past abuses. Jack is not known to have any communicable diseases. There is no history of substance abuse and Jack states that he does not like to be around others who are smoking.

Summary of Social/Developmental/Behavioral/Family History

Briefly describe my relevant social, developmental, behavioral and family history.

Jack is an only child and resided with his parents until the age of 19 when his father died of natural causes. Mrs. Garner reported that Jack had a typical childhood and was very involved with extended family during his early years. Jack has a history of running away from home when he is upset and when he feels that others are not listening to him. Mrs. Garner reported that a planning time with Jack to discuss concerns is helpful in preventing his running away. He is reported to have always enjoyed walks in his neighborhood and eating out with his friends. His mother reported that she was unable to care for Jack alone following her husband's death, so he moved to an assisted living facility in Anytown, VA. He resided there until the age of 32 when he began leaving the home in the middle of the night placing his safety at risk. At this time, Jack entered ID Waiver services and moved into his current residence on Arbor Lane with ABC Residential Services. Jack's mother passed away last year from congestive heart failure.

Summary of Employment and Educational Background

Education: None Elementary Middle School Some High School High School
 Vocational Some College College degree Some Graduate School
 Masters Degree or Higher

Current Employment status: Unemployed, but want to work Unemployed, not able to or interested in work Employed, Part-Time Employed, Full-time Retired

This ISP belongs to: Jack Garner **ID#** 512 **ISP Start:** 3/1/09 **End:** 2/28/10

5

Describe my educational history.	Jack attended AVS, Anytown Vocational School through 18 years of age when he graduated.
Describe my employment history.	Jack has a history of completing odd jobs for cash and likes working in the yard doing planting and landscaping. He states that he used to work in a restaurant, which he liked when he could cook but disliked when he washed dishes. He expresses that he prefers outdoor jobs.
Describe any volunteer activities in which I now am involved or have been involved in the past (if any).	Note: Please include the types of things I did, the organization(s) involved, and when I volunteered. Jack states that he volunteered at his mother's church until her passing last year.

Exceptional Support Needs

Were any support needs identified on the risk assessment (Supports Intensity Scale Section IV) or elsewhere in the information?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide a description of each support need below: 1) leaving home at night 2) support needed with diabetes 3) 4) 5)
Is there a behavioral or crisis support plan?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Meet criteria for high intensity day services?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please describe:

Ability to Access Services and Supports

What concerns do I have about being able to access services and/or supports?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please provide a description and a plan to resolve the concern(s):
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Legal and Advocacy

Do I have any current legal issues or problems?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please describe:
Do I need any legal advice?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please describe:
Do I need any support with voting? (Understanding my rights, registering or voting)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, please provide brief description of how I will be supported:

Eligibility

Level of Functioning Survey	Date completed: 2/10/09 Categories met: <input checked="" type="checkbox"/> Health Status <input type="checkbox"/> Communication <input type="checkbox"/> Task Learning Skills <input checked="" type="checkbox"/> Personal/Self Care <input type="checkbox"/> Mobility <input checked="" type="checkbox"/> Behavior <input type="checkbox"/> community Living
Diagnosis of MR?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Date psychological completed: 04/12/78
If under 6, at developmental risk?	<input type="checkbox"/> Yes <input type="checkbox"/> No Date evaluation completed:

Back-up and / or Discharge Plan

Am I receiving a Medicaid Home and Community Based Waiver?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please identify which Waiver: ID Waiver ; and please describe or attach my back-up plan (if receiving a service that requires a back-up plan). Jack doesn't need a back-up plan, since he doesn't receive a service that requires one.
If applicable, please describe any transition/discharge plans for any services I currently receive.	Jack receives long-term supports and is not expected to transition or be discharged from the Waiver.

Essential Information completed by:

Review or Revision Date: 6/30/09

Name (print): Gloria Jones

Signature: Gloria Jones **Title:** Support Coordinator **Date:** 6/30/09

This ISP belongs to: Jack Garner **ID#** 512 **ISP Start:** 3/1/09 **End:** 2/28/10

7