GUIDANCE FOR COMPLETION OF INDIVIDUAL SUPPORT PLANS

KEY DEFINITIONS FROM REGULATIONS [12 VAC 30-120-211]

"Case management" [also known as **support coordination**] means the assessing and planning of services; linking the individual to services and supports identified in the Individual Support Plan; assisting the individual directly for the purpose of locating, developing or obtaining needed services and resources; coordinating services and service planning with other agencies and providers involved with the individual; enhancing community integration; making collateral contacts to promote the implementation of the Individual Support Plan and community integration; monitoring to assess ongoing progress and ensuring services are delivered; and education and counseling that guides the individual and develops a supportive relationship that promotes the Individual Support Plan.

"Individual Support Plan" means supports and actions to be taken during the year by each service provider to achieve desired outcomes. The Individual Support Plan is developed by the individual, and partners chosen by the individual, and contains essential information and includes what is important to the individual on a day-to-day basis and in the future and what is important for the individual to keep healthy and safe as reflected in the Plan for Supports. The Individual Support Plan is known as the Consumer Service Plan in the Day Support Waiver.

"Plan for Supports" means each service provider's plan for supporting the individual in achieving his or her desired outcomes and facilitating ongoing health and safety. The Plan for Supports is one component of the Individual Support Plan. The Plan for Supports is referred to as an Individual Service Plan in the Day Support Waiver.

All individuals receiving Targeted Case Management (TCM) or MR/ID Community Waiver Services must have an Individual Support Plan (ISP). The intent of the ISP is to organize and describe the services and supports necessary for meeting an individual's goals and desires for living successfully in the community. Supports for increasing relationships and connections with people in the community should be included in the plan.

The development of the ISP is a shared responsibility of the support coordinator/case manager, the individual and his or her family members, service and support providers, and others interested in the welfare of the person. It involves planning for the person's immediate and more distant future, and considers his or her own personal dreams and desires. It includes determining complementary supports and services to address the individual's desired outcomes and needs for initial and ongoing supports.

Five essential components of a ISP* are:

I. The essential information, completed by the support coordinator/case manager that is needed for accessing services and assuring health and safety.
II. The personal profile that describes a person's vision of a good life, their talents and contributions and information about the person in eight areas of living;
III. The shared plan holds the person's desired outcomes that are based on what is important TO and important FOR the person for the ISP year and that are shared by all partners and service providers.
IV. The agreement questions and signature page where planning is evaluated and all partners and service providers sign in agreement.
V. The plan for supports for every Medicaid service that detail the support activities and action steps (including expected frequency) for meeting the person's desired outcomes, the instructions for supports and the schedule for completion, which is based on information in the person-centered ISP and the Supports Intensity Scale or other approved assessment.

*Please view blank templates, guidance materials, detailed slides and samples online at:
http://www.dbhds.virginia.gov/ODS-PersonCenteredPractices.htm