

Name of Person:

Date of Plan:

Individualized Day Supports – On-Going Community Integration Plan

Important Notes:

- *This form is used to document the plan for Individualized Day Supports after the first 30 calendar days of service have been completed.*
- *This form is due 30 calendar days from the service prior authorization (start) date. Subsequently, an updated On-Going Community Integration Plan is due no less than quarterly or whenever significant/substantive changes are made to the Plan, whichever comes first.*
- *On the due dates, this form should be transmitted via email to the DDA Service Coordinator for review, verification of completeness, and uploading into MCIS.*
- *Quarterly reports are due within seven (7) business days after the conclusion of each quarter of service.*
- *Providers are required to use this form. No alternative versions are acceptable.*
- **Review and use Person-Centered Thinking Tools to develop and update this plan over time.**

Name of the person receiving the service:

Person's Address:

Person's Phone Number and Email:

Emergency Contact:

Name of IDS Provider:

Provider Contact Name:

Phone:

Email:

Effective Date of the On-Going Community Integration Plan:

List Community Integration Goal(s) in the Person's Current ISP:

- 1.
- 2.
- 3.

Name of Person:

Date of Plan:

Authorized schedule of service (list timeframe for service delivery on each day):

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

Check here if above schedule is expected to flex to accommodate the person’s changing work schedule.

Note: Medicaid shall only reimburse Individualized Day Supports services for up to six (6) hours per day, and up to five (5) days in any calendar week.

Direct Service Professionals who will provide the service:

Name of Primary and Back-Up DSP	Name of Direct Supervisor	Cell Phone	Email

Provide the emergency back-up plan for when the primary DSP is unavailable:

Check here if the person has a Behavior Support Plan.

Check here to confirm the DSP’s listed in the above table have been trained on the Behavior Support Plan.

Name of Person:

Date of Plan:

Service Goals:

<p>GOAL CATEGORY A minimum of one (1) is required: Community Integration Self-Determination Relationships Employment Retirement Community Contribution</p>	<p>GOAL STATEMENT Describe the person's individualized goal relating to the Goal Category selected in column one. <i>Note: A person can have more than one goal relating to each Goal Category.</i></p>	<p>ACTIVITIES/OPPORTUNITIES List highly individualized, integrated community activity(s) or opportunity(s) that will support achievement of the goal. List number of hours/week.</p>	<p>SKILL DEVELOPMENT Describe how the activity(s) or opportunity(s) in the previous column will help the person develop, improve or maintain specific skills for community participation.</p>	<p>GOAL ACHIEVEMENT: List measurable outcomes that are expected and will indicate the goal has been achieved.</p>
<p><i>Example: Employment</i></p>	<p><i>Example: John wants to gain experience and develop his skills working with animals so he can pursue a job working with animals.</i></p>	<p><i>Example: 1. Volunteering at the Washington Humane Society (6 hours/week) 2. Volunteering at Washington Animal Rescue League (minimum commitment 8 hours/month after orientation/training;) 3. Tours/Informational Interviews of veterinary clinics/hospitals starting with those closest to John's home. (2 hours/week) 4. Informational interview at colleges offering Veterinary Assistant certificate program. (3 hours/month for 2 months)</i></p>	<p><i>Example: 1. Travel/Commuting Skills John will learn to use city bus to get to specific locations. 2. Interpersonal Skills John will increase his interpersonal skills by working with staff and other volunteers at volunteer sites. 3. Interviewing Skills John will improve his interviewing skills (both asking and answering questions) through tours and informational interview opportunities. 4. Employment Skills John will gain skills for employment in the area of animal care. 5. Time/Schedule Management Skills John will improve his ability to tell time and be on time for his commitments.</i></p>	<p><i>Example: 1. John will learn about available employment opportunities and training programs focused on working with animals which he is eligible to apply for. John will then be able to make an informed choice about whether to pursue a job or training program as a next step on in his career path. 2. John will gain experience and skills working with animals that will lead to him securing paid employment or a place in a training program that involves working with animals. 3. John will be able to use the bus to travel from his home to the 2 volunteer sites with help from recorded instructions on his cell phone and back-up help from his DSP via cell phone/text.</i></p>

Name of Person:

Date of Plan:

GOAL CATEGORY A minimum of one (1) is required: Community Integration Self-Determination Relationships Employment Retirement Community Contribution	GOAL STATEMENT Describe the person's individualized goal relating to the Goal Category selected in column one. <i>Note: A person can have more than one goal relating to each Goal Category.</i>	ACTIVITIES/OPPORTUNITIES List highly individualized, integrated community activity(s) or opportunity(s) that will support achievement of the goal. List number of hours/week.	SKILL DEVELOPMENT Describe how the activity(s) or opportunity(s) in the previous column will help the person develop, improve or maintain specific skills for community participation.	GOAL ACHIEVEMENT: List measurable outcomes that are expected and will indicate the goal has been achieved.

Name of Person:

Date of Plan:

Schedule of Activities for Current Service Quarter:

Start Date of Quarter (same as effective date of this On-Going CIP listed on page one):

End Date of Quarter:

Include the following information on the calendar pages that follow:

- *The months that this quarter of service will cover (note there is one calendar page for each month of the quarter)*
- *Hours the service will be provided on each date (note the numerical date in each box can be changed as necessary)*
- *Service start location and service end location (these locations are where the DSP will meet and drop off the person each day)*
 - *If the service start or service end location is not the person's home, note how transportation from home to service start location and from service end location to home will be handled, including the time of pick-up from home or drop-off at home that will occur on each service day, if applicable*
- *For each date the service will be provided, list the location(s) and type of activity(s) that has been pre-planned. These locations/activities should correlate with the "Activities/Opportunities" column in the Service Goals section above. As the quarter moves on it may be necessary to revise the activities and opportunities to reflect the preferences of the person and new opportunities you may identify.*
- *For each Activity or Opportunity listed, note if another person receiving IDS services will be paired with the person and if yes, only note his/her initials to protect confidentiality.*

If this is the first On-Going Community Integration Plan you are preparing for this person, it is expected that you will be revising the activities and opportunities during the first quarter more often than would normally be the case, as you learn more about the person's preferences and as you identify additional activities/opportunities through Community Mapping.

Name of Person:

Date of Plan:

Month #1:

Sun	Mon	Tue	Wed	Thu	Fri	Sat
26	27	28	29	30	31	1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31	1	2	3	4	5

Name of Person:

Date of Plan:

Month #2:

Sun	Mon	Tue	Wed	Thu	Fri	Sat
26	27	28	29	30	31	1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31	1	2	3	4	5

Name of Person:

Date of Plan:

Month #3:

Sun	Mon	Tue	Wed	Thu	Fri	Sat
26	27	28	29	30	31	1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31	1	2	3	4	5

Name of Person:

Date of Plan:

Skill Development Goals and Strategies:

- For each skill development goal listed in the Service Goals section above (column 4), identify the teaching objectives and strategies that will be used. Ensure these objectives and strategies are consistent with the person’s learning style.
- Also identify how success will be measured by listing measurable goals/outcomes that are expected to result from the teaching.
- Ensure teaching objectives and timeline cover the full quarter (3 months) of service. (For example, if an objective is expected to be completed in one month, list additional teaching objectives that will be addressed in the second and third months of the quarter.)

SKILL DEVELOPMENT GOALS	TEACHING OBJECTIVES AND TIMELINE	TEACHING STRATEGIES	HOW SUCCESS WILL BE MEASURED
<p><i>Example:</i> John will learn to use city bus to get to specific locations.</p>	<p><i>Example:</i> 1. John will learn to get from his home to the closest bus stop. (Month #3)</p>	<p><i>Example:</i> 1. John will be given face-to-face support to walk from his home to the bus stop. As his comfort increases, face-to-face support will fade back to observe from a distance. 2. John will be taught how to call his DSP using his cell phone to get assistance when needed. 3. John will be introduced to unexpected situations that might arise and be assisted to understand what he should do in each situation.</p>	<p><i>Example</i> 1. John will walk from his home to the bus stop without face-to-face support [Target Date: End of Month #3]. 2. John will consistently call his DSP using his cell phone to confirm he has arrived at the bus stop each day. [Target Date: End of Month #3]. 3. John will be able to identify the correct action to take when various unexpected scenarios are explained to him. [Target Date: End of Month #3].</p>

Name of Person:

Date of Plan:

SKILL DEVELOPMENT GOALS	TEACHING OBJECTIVES AND TIMELINE	TEACHING STRATEGIES	HOW SUCCESS WILL BE MEASURED

Name of Person:

Date of Plan:

Name, Title, and Signature of Provider Staff Person Completing this On-Going Community Integration Plan:

Name:

Title:

Signature:

Contact Phone Number and Email:

Signature of Person receiving service indicating that he/she participated in the development of this On-Going Community Integration Plan, it has been reviewed and explained to him/her, and s/he is in agreement with the plan:

PLEASE ATTACH A COPY OF THE PERSON'S POSITIVE PERSONAL PROFILE TO THIS PLAN.

Date this On-Going Community Integration Plan is sent via email to the DDA Service Coordinator: