This Individualized Service Plan (ISP) is to be completed prior to or upon placement (in an emergency placement, the plan must be developed within 7 days after placement). The Interdisciplinary Team (IDT) will coordinate the development of the ISP with the Adult Family Home (AFH) provider at the time the resident is placed in the 1-2 bed Adult Family Home. The member and the member's guardian will also be part of this discussion. **The AFH provider will complete the documentation of the ISP.**

The ISP is to be reviewed with the same participants every 6 months or when changes occur; if changes to ISP are made, all parties receive a copy.

Member Name: _____ Member DOB: _____

Guardian/POA Name: _____ Phone: _____

AFH Provider Name: _____ Phone: _____

CRC Name: _____ Phone: _____

HWC Name: _____ Phone: _____

Do Not Resuscitate (DNR) Status

Does the member have a DNR order? ☐ Yes ☐ No

If "Yes," please attach a copy of the DNR paperwork and ensure this information is given to any medical professional if medical care is sought.

Routine (include specific times or needs)

AM: _____

_____

_____

_____

PM: _____

_____

_____

_____

Adult Family Home (AFH) Provider Will Be Responsible For Room, Board, Laundry, And The Following Services & Supervision:

Please check all that apply

Activities of Daily Living	Resident Independent	Teaching	Reminders	Supervision	Full Care
Bathing	☐	☐	☐	☐	☐
Hair Care	☐	☐	☐	☐	☐
Teeth/Denture Care	☐	☐	☐	☐	☐
Shaving	☐	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐
Glasses	☐	☐	☐	☐	☐
Other: _____					

Comments:

_____

_____

_____

_____

Household Tasks	Resident Independent	Teaching	Reminders	Supervision	Full Care
Meal Preparation	☐	☐	☐	☐	☐
Laundry	☐	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	☐
Cleaning	☐	☐	☐	☐	☐
Other: _____					

Comments:

_____

_____

_____

Resident will assist the family with the following household tasks (check those agreed to by the resident and specify frequency):

☐ Meal Preparation ☐ Table Setting ☐ Dishwashing ☐ Laundry

☐ Shopping ☐ Cleaning ☐ Yard Work

☐ Other: _____

Toileting

	Yes	No
No Assistance Needed	☐	☐

Assistance Needed, describe: _____

Full Cares, describe: _____

Incontinence Supplies Used: _____

Mobility

	Yes	No
Member needs monitoring/assistance with mobility	☐	☐
Member needs monitoring/assistance with transferring	☐	☐
Member uses adaptive aids	☐	☐

If yes to any of the above, describe needs: _____

Behavioral Intervention

Is any teaching or redirection required by the AFH provider? Please specify and attach BSP.

_____

Health Monitoring

	Yes	No
Schedule medical and dental appointments	☐	☐
Monitor physical health	☐	☐
Monitor mental health	☐	☐

If yes to any of the above, explain needs: _____

Medication Management (must match Authorization to Dispense form)

	Yes	No
Member is able to self-administer medications	☐	☐
*Member requires reminders to take medications	☐	☐
*Member requires supervision in taking medications	☐	☐
*Member requires medication administration by the AFH provider	☐	☐

Comments: _____

**Requires MAR (Inclusa Team to set up MAR)*

- *Administration means the AFH provider is responsible for removing the proper dosage from the labeled prescription bottle and giving it to the member*
- *See medication list for current medications and dosages*
- *Provider is responsible for keeping medication logs*

Nutritional Need

Are there any special diet requirements? Please specify. Please include food allergies and specific likes/dislikes: _____

_____

_____

Communication

Please list any specialized communication needs/techniques used with this member:

_____

Supervision

Resident will be supervised overnight by providers or substitute providers who are at least 18 years of age and have an up to date criminal background check on record with Inclusa.

	Yes	No
Member requires 24-hour supervision (cannot be left alone)	☐	☐
Member can spend _____ hours unsupervised	☐	☐
Member can come and go from AFH as they desire	☐	☐

Comments: _____

Money Management

	Yes	No
Member is able to manage all personal finances	☐	☐
Member requires budgeting assistance	☐	☐
Member requires AFH provider to assist with personal funds*	☐	☐
Member has personal spending of	☐	☐

$_____ per _____ (please list "week" or "month"

Comments: _____

**AFH provider must keep financial ledger*

Leisure/Recreation Activities

AFH provider to encourage the following activities: _____

AFH provider to structure and offer at least one activity for one hour per day (unless the resident is already involved in a structured program, e.g., sheltered workshop, adult day care).

Comments: _____

_____

_____

_____

Transportation

	Who is responsible for transportation to:	Who attends/supervises:
Day Services	_____	_____
Work/School	_____	_____
Medical Appointments	_____	_____
Activities/Shopping	_____	_____
Family Visits	_____	_____
Respite	_____	_____

Comments: _____

_____

Is Member Capable of Using A Bedroom Door Lock? _____
(Refer to *AFH Member Keyed Bedroom Door Policy*).

SUBSTITUTE CARE: Adult Family Home (AFH) providers are responsible for arranging substitute care for their residents. The AFH provider needs to make certain that any provider they use has had a criminal background check completed.

NOTIFY COMMUNITY RESOURCE COORDINATOR AS SOON AS POSSIBLE OF ANY CHANGES OR PROBLEMS AFFECTING THE RESIDENT; INCLUDING AREAS SUCH AS MENTAL/PHYSICAL CONDITION, FAMILY, VACATION, AND ANY EMERGENCY SERVICES.

INCLUSA CRC/RN WILL BE RESPONSIBLE FOR THE FOLLOWING:

☐ Information on AFH provided to resident prior to placement
☐ Ensure member has documented physician permission to administer medications, physical and TB test prior to placement; provide AFH with copy.
☐ Provide AFH with Member Information form, MCP, Guardianship/Rep Payee paperwork
☐ Review Adult Family Home placement packet with AFH provider
☐ Set up MAR at the time of initial placement and review at least annually
☐ Coordinate with the AFH, Guardian/Member to develop the ISP in accordance with member Needs. Review every 6 months or upon changes. **The AFH will document the ISP**.
☐ Initiate the 1-2 Bed AFH Agreement for Services and review annually
☐ Support for the Resident/Adult Family Home provider
☐ Have personal contact with resident or sponsor at least quarterly, or as needed
☐ Coordination of community services which are used by the resident. This may include the following: (please check all applicable services)

☐ Family: _____

☐ Mental Health/AODA Staff: _____

☐ Name/Agency Protective Services: _____

☐ Employment Services

☐ Home Health Agency; Name of Agency: _____

☐ Physician: _____

☐ Guardian ☐ Rep Payee ☐ Durable Power of Attorney (check one)
Name: _____

☐ Other: _____

_____

Additional Information

_____

_____

_____

AFH Provider Signature: _____ Date: _____

CRC/HWC Signature: _____ Date: _____

Member Signature: _____ Date: _____

Guardian/POA Signature: _____ Date: _____

ISP Updated and Reviewed

The ISP must be reviewed at least every six months. If there are no changes, please mark the date reviewed and sign. If there are changes, please update any information. At a minimum, the AFH provider, a member of the IDT staff, and the member/guardian must participate in this review.
The AFH provider will complete the documentation of the ISP.

By: _____ Date: _____

By: _____ Date: _____

By: _____ Date: _____

By: _____ Date: _____