|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| TYPE: |  | Initial |  | | | | | **Waiver:** (insert Waiver type) | | | | | | | | |  | | Level of Care: ICF-IID | | | | | | |
|  |  | Annual |  | | | | | ICAP Level (ROW only):  ROW Acuity Level: \_\_\_\_\_\_\_\_\_\_\_  ROW Maximum Budget: | | | | | | | | |  | | SIS LEVEL \_\_\_\_\_\_\_\_  SHARED SUPPORT | | | | | | |
| **Individual’s Name (Last Name, First Name)** | | | | | | | | | | | | | **Legal Guardian/Authorized Representative** | | | | | | | | | | | | |
| **Social Security Number**  **XXX-XX-** | | | | | | | | | | **DOB**  **/ /** | | | **Relationship** | | | | | | | | | | | | |
| **Medicaid #** | | | | | | **Medicare #** | | | | | | | **Legal Status:**  **Minor**  **Interdicted**  **Power of Attorney**  **Competent Major** **Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
| **Address (Physical)** | | | | | | **Mailing** (If Different) | | | | | | | **Address (Physical)** | | | | | | | | | | **Mailing (If Different)** | | |
| **City/State/Zip Code** | | | | | | | **Parish** | | | | | | **City/State/Zip Code** | | | | | | | | | | | **Parish** | |
| **Day Phone** | | | **Night Phone** | | | | | | | | | | **Day Phone** | | | | | | | | | | **Night Phone** | | |
| **Support Coordination Agency (No Abbreviations)** | | | | | | | | | | | | | **Support Coordination Agency Provider Number** | | | | | | | | | | | | |
| **Support Coordination Agency Address** | | | | | | | | | | | | | **Support Coordinator (type/print)** | | | | | | | | | **SC Supervisor (Type/print)** | | | |
| **City/State/Zip Code** | | | | | | | | | | | | | **Telephone Number** | | | | | | | | | | | | |
| **Sex:**  Male  Female | | | | | **Ethnicity:**  African-American  Caucasian  Hispanic  Asian  Other | | | | | | | | | | | | | | | | | | | | |
| **Education:**   Attends School Homebound  N/A | | | | | | | | | | | | **90L:** Physician Date: | | | | |  | | | | SC Rec’d: | | | |  |
| **Primary Disability/Diagnosis:** | | | | | | | | |  | | | | | | **Date of Onset:** | | | | | | | | | / / | |
| **Secondary Disability/Diagnosis:** | | | | | | | | |  | | | | | | **Date of Onset:** | | | | | | | | | / / | |
| **SIL:**  Yes  No  **24-Hour Service:** Yes  No | | | | | | | | | | | **Ambulation:**  Independent  With Personal Assistance  With Assistive Device(s)  Does not ambulate  Wheelchair without assistance  Wheelchair with assistance  Other | | | | | | | | | | | | | | |
| **Emergency Self-Evacuate:**  Yes  No | | | | | | | | | | | | | Attach Individualized Emergency Evacuation/Response Plan | | | | | | | | | | | | |
| **Emergency Response:** | | | **Level 1** Total Assistance with Life Sustaining Equipment | | | | | | | | | | | | | | | **Level 2** Total Assistance | | | | | | | |
|  | | | **Level 3** Can Respond/Needs Transportation | | | | | | | | | | | | | | | **Level 4** Can Respond Independently | | | | | | | |
| Will Residence Change with Waiver Participation?  Yes  No If Yes, When & Proposed Address? | | | | | | | | | | | | | | | | | | | | | | | | | |
| Is This a Transition From a Developmental Center or Nursing Facility?  Yes  No Deposit Required?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are There Multiple Waiver recipients in the Home?  Yes  No If So, How Many? \_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are There Multiple Individuals with Disabilities (Non-Recipient) in the Home?  Yes  No If So, How Many? \_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are Paid Caregivers Related to Individual?  Yes  No If Yes, Relationship & Service Provided | | | | | | | | | | | | | | | | | | | | | | | | | |
| Do Paid Caregivers Live with Recipient?  Yes  No If Yes, Name & Service(s) | | | | | | | | | | | | | | | |  | | | | | | | | | |
| Does Individual Receive Home Health Service?  No  Yes If Yes, Attach a Home Health Plan. | | | | | | | | | | | | | | | | | | | | | | | | | |
| Present Housing Own Home (Alone) Own Home (With Partner) Own Home (With Others) Other’s Home **Anticipated Housing: \_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | ICF/IID | | | | Nursing  Facility | | **Rent Home**:  With Subsidy  Without Subsidy | | | | | | | | | | |
|
| **Rent Apartment:**  With Subsidy  Without Subsidy | | | | | | | | | | |
| **CPOC Begin Date:** | | | |  | | | | | | | | | | **CPOC End Date:** | | | | | |  | | | | | |

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| |  |  | | --- | --- | | Section I: Emergency Information |  | | Attach Individualized Emergency Evacuation/Response Plan | | | | | | | | | | | | | | | | | | | | | | | | |
| Individual’s Name: | | | | |  | | | | | | | | | | | | Age**:** | | |  | | |
| Address: | |  | | | | | | | | | | | | | | | | | | | | |
| Directions to My Home: | | | | | |  | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Person Responsible for Evacuating/Bringing Supplies to Individual’s Home:** | | | | | | | | | | | | | | | | | | | | | |
| Name: |  | | | | | | | | | | | | Relationship: | | | | |  | | | |
| Home Phone: | | | |  | | | | | | | | | Work Phone: | | | | |  | | | |
| Address: | | |  | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | |
| **Family Members/Other to Contact in Case of Emergency (Including Providers):** | | | | | | | | | | | | | | | | | | | | | |
| 1. Name: | |  | | | | | | | | | | | Relationship: | | | | |  | | | |
| Home Phone: | | | |  | | | | | | | | | Work Phone: | | | | |  | | | |
| Address | |  | | | | | | | | | | | | | | | | | | | |
| 1. Name: | |  | | | | | | | | | | | Relationship: | | | | |  | | | |
| Home Phone: | | | |  | | | | | |  | | | Work Phone: | | | | |  | | | |
| Address: | | |  | | | | | | | | | | | | | | | | | | |
| 1. Name: | | |  | | | | | | | | | | Relationship: | | | | |  | | | |
| Home Phone: | | | |  | | | | | | | | | Work Phone: | | | | |  | | | |
| Address: | |  | | | | | | | | | | | | | | | | | | | |
| **Emergency Equipment in Home:** | | | | | | | | | | |  | |  | |  | | |  |  | | |
| Fire Extinguisher Location: | | | | | | |  | | | | | First Aid Supplies Location: | | | | | | | | |  |
| Home Evacuation Plan Location: | | | | | | | | |  | | | Specialized Medical Equipment (e.g., ventilator, suction machine, etc.) Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Smoke Detector(s) Location: | | | | | | | |  | | | | Other: | | | |  | | | | | |
| Special Considerations/Necessities (Detailed Information Required): Uses Assistive Technology, Dependent on Ventilator, Medications, Etc. (See Individual Emergency Evacuation/Response Plan) | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | Primary: |  |
| Doctor’s Name: | | | |  | | | | | | | Specialty: | | |  | | | | | | Phone: |  |
| Doctor’s Name: | | | |  | | | | | | | Specialty: | | |  | | | | | | Phone: |  |
| Doctor’s Name: | | | |  | | | | | | | Specialty: | | |  | | | | | | Phone: |  |
| Doctor’s Name: | | | |  | | | | | | | Specialty: | | |  | | | | | | Phone: |  |
| Doctor’s Name | | | |  | | | | | | | Specialty: | | |  | | | | | | Phone: |  |

|  |  |
| --- | --- |
| Section II. All About Me |  |
| Information in this section is relevant to my life today and is my way of sharing social/family history with you. I hope that this information will be helpful in assisting you to help me achieve my personal outcomes. My personal outcomes worksheet (see attached Personal Outcomes Worksheets) will assist you in helping me tell you about myself. If I need assistance telling my story, please ask those who know me best. | |
| 1. **Historical Information:** Information in this section includes historical issues. Examples include nature and cause of person’s disability, person’s age at onset of disability (if not known, please indicate by writing “unknown” in this section), education, work history; recurring situations that impact support needs; summary of events leading to request for support at this time. | |
| 1. **Current Living Situation: (This section is related to Attachments B and C)** Information in this section includes family’s involvement and understanding of individual’s strengths, skills and abilities, current situations that may present barriers to individual obtaining supports and services they desire, individual’s/family/circle of support knowledge of disability and how individual wants to be supported; economic issues, including current employment; connections to community and natural supports, relationships/friends/family/other, where and with whom individual lives, rural/urban area, accessibility to resources, own home/rents/lives with relative/extended family/alone, does physical home environment meet accessibility/safety needs, health and age of family care-givers (if supported by family), feelings of safety and continuity of supports/care, etc. | |
| 1. **Current Community Supports or Other Agency Involvement:** Information in this section includes significant life events. Examples include family issues, social/law enforcement issues, social services caseworker or probation officer involvement that may require interaction with legal/social agencies, current community supports and resources being used, etc. | |

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| SECTION III: Things You Need to Know to Support Me | |  |
| **A.** | **My gifts and talents:** | |
| **B.** | **I communicate best by (speaking, gesturing, communication board, sign language, behaving in certain ways, etc.):**  **List of non-verbal ways I communicate in this communication log:**   |  |  | | --- | --- | | **When I do this:** | **It means this:** | |  |  | |  |  | |  |  | |  |  | | |
| **C.** | **I understand best when (shown and told how, shown, use hand-over hand techniques, etc.):** | |
| **D.** | **I need help with:** | |
| **E.** | **When I am scared I need someone to:** | |
| **F.** | **When I am angry I need you to:** | |
| **G.** | **Things that work/things I like (favorite things such as…food hobbies, past time):** | |
| **H.** | **Things that don’t work/things I dislike:** | |
| **I.** | **Other things I’d like you to know about me:** | |

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| **Section IV: A. Health Profile** | | | | | | | |
| **Health Support Area** | **Diagnoses/Risks** | **Doctor/Professional Responsible** | **Date of last visit** | **Date of next visit** | **Support needed by paid staff**  **(For all areas that are checked, the provider attachments should include instructions and description of support)** | **No support needed** | **Support needed, but family provides all support** |
| **General Health Supports** |  |  |  |  | Making Appointments  Communicating with Professional During Visits  Monitoring Symptoms  Help when symptoms occur |  |  |
| **Allergies (Medication, food, environmental)** |  |  |  |  | Making Appointments  Communicating with Professional During Visits  Monitoring Symptoms  Help when symptoms occur |  |  |
| **Behavioral and Mental Health Supports** |  |  |  |  | Making Appointments  Communicating with Professional During Visits  Monitoring Symptoms  Help when symptoms occur |  |  |
| **Medical and Mental Health Risks** |  |  |  |  | Making Appointments  Communicating with Professional During Visits  Monitoring Symptoms  Help when symptoms occur |  |  |

**Note:** If there are any checks in “Support Needed by Paid Staff,” then Attachments D and/or G are required.

**B. Incident Reports (For Past 6 months):**

|  |  |  |  |
| --- | --- | --- | --- |
| **Type of Incident** | **Category** | **Number** | **Additional information/Summary** |
| **Critical Incidents** | 1. **Unplanned Hospital** |  |  |
| 1. **ER Visits** |  |  |
| 1. **Psychiatric Admissions** |  |  |
| 1. **Abuse/Neglect** |  |  |
| 1. **Other** |  |  |
| **Non-Critical Incidents** |  |  |  |
| **Hospital Admissions** |  |  |  |
| **Emergency Doctor Visits** |  |  |  |
| **Psychiatric Hospital Admissions** |  |  |  |

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| **Section V: Personal Outcomes** | |  | |
| **Vision:**  NOTE: Planning must include and reflect emergency backup plans where the health and welfare of the recipient may be adversely affected. | | | |
| **My Personal Outcomes** | **Support Strategy Needed** | **How Often for Supports**  **and Services** | **Review/Accomplished Date** |
| * What I want for myself. * What is important to me right now? * What do I want or expect as a result of supports and services? | * What I need to achieve my personal outcomes. * How will services and supports be provided to me? * Who will deliver the services and supports (Paid/unpaid)? * Where will services and supports be provided? * What (if any) assistive devices will be required?   **Be Specific** | * How and when (how often) do I want services and supports provided?   **Be Specific** | * When/how often will the supports and services be reviewed. When was the personal outcome accomplished/achieved? * Is this still an outcome I want in my life now? * Has anything changed in my life that needs to be addressed at this time?   **Be Specific**  **Review Date**  **Accomplished Date** |
|  |  |  |  |
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| **Section V: Personal Outcomes (CONTINUED)** | |  | |
| NOTE: Planning must include and reflect emergency backup plans where the health and welfare of the recipient may be adversely affected. | | | |
| **My Personal Outcomes** | **Support Strategy Needed** | **How Often For Supports**  **and Services** | **Review/Accomplished Date** |
| * What I want for myself. * What is important to me right now? * What do I want or expect as a result of supports and services? | * What I need to achieve my personal outcomes. * How will services and supports be provided to me? * Who will deliver the services and supports (Paid/unpaid)? * Where will services and supports be provided? * What (if any) assistive devices will be required?   **Be Specific** | * How and when (how often) do I want services and supports provided?   **Be Specific** | * When/how often will the supports and services be reviewed. When was the personal outcome accomplished/achieved? * Is this still an outcome I want in my life now? * Has anything changed in my life that needs to be addressed at this time?   **Be Specific**  **Review Date**  Accomplished Date |
|  |  |  | **3.** |
|  |  |  | **4.** |

|  |  |
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| **Section VI: Identified Services, Needs, and Supports** |  |

| **Non-Waiver Support** | **Medicaid Funded Services** | **Supports Waiver** | **ROW Waiver** | **NOW Waiver** | **Children’s Choice Waiver** |
| --- | --- | --- | --- | --- | --- |
| Natural Supports | Dental | Support Coordination | Support Coordination | Prevocational Services | Support Coordination |
| Community Supports | Eye Glasses | Supported Employment - Individual  Supported Employment - Group | Residential (Mandatory)  Community Living Supports  Companion Care  Host Home  Shared Living (New)  Shared Living (Conversion) | Day Habilitation | Family Support    Shared |
| OCDD | Home Health Extended | Prevocational | Respite-Center Based | Day Habilitation  Services Transportation  Transportation-Reg  Transportation-W/C | Crisis Support    Shared |
| LRS | Hospice | Day Habilitation | One-Time Transitional Expense | Supported Employment  Transportation-Reg  Transportation-W/C | Family Training |
| Department of Children and Family Service | Medical Transportation | Habilitation | Assistive Technology/Specialized  Medical Equipment and Supplies | Community Integration Development (CID) | Center-Based Respite |
|  | Mental Health | Respite (In-Home)  Respite (Center) | Environmental Accessibility Adaptations | Supported Independent Living (SIL) | Environmental Accessibility Adaptations |
|  | Podiatry Services | Personal Emergency  Response System | Personal Emergency Response System | Personal Emergency Response System | Specialized Medical Equipment and Supplies |
|  | Substance Abuse | Housing Transition Professional Support | Transportation-Community Access | Environmental Accessibility Adaptations | Housing Transition Professional Support |
|  | Prescriptions/  Medications |  | Nursing Services | Specialized Medical Equipment and Supplies | Therapies  Art  Aquatic  Music  Hippotherapy  ABA  Therapeutic Horse- back Riding  Sensory Integration |
|  | EPSDT |  | Dental Services | One-time Transitional Expenses |
|  | Other |  | Professional Services  Dietary  Speech Therapy  Occupational Therapy  Physical Therapy  Social Work  Psychology | Shared Supports  Day (D)  Night (N)  Shared Supports  Skilled Nursing  CID |
|  |  |  | Supported Employment  Transportation-Reg  Transportation-W/C | Individual Family Support  Day (D)  Night (N) |  |
|  |  |  | Prevocational Services | Substitute Family Care |  |
|  |  |  | Day Habilitation  Transportation-Reg  Transportation-W/C | Center-Based Respite |  |
|  |  |  | Housing Transition Professional Support | Professional Consultation |  |
|  |  |  | Adult Day Health Care (ADHC) | Professional Services |  |
|  |  |  |  | Housing Transition Professional Support |  |
|  |  |  |  | Skilled Nursing |  |
|  |  |  |  | Adult Companion Care |  |

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| NOTE: Informed individual of all state plan services. Support Coordinator Initials: \_\_\_\_\_\_\_\_\_\_\_ |

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| Section VII: Typical Weekly Schedule | | | | | | |  | | | |
| For planning purposes only. If needs change, I will contact my case manager as soon as possible. | | | | | | | | | | |
| **Time** | **Monday** | **Tuesday** | | | **Wednesday** | | **Thursday** | **Friday** | **Saturday** | **Sunday** |
| 12:00 AM |  |  | | |  | |  |  |  |  |
| 1:00 AM |  |  | | |  | |  |  |  |  |
| 2:00 AM |  |  | | |  | |  |  |  |  |
| 3:00 AM |  |  | | |  | |  |  |  |  |
| 4:00 AM |  |  | | |  | |  |  |  |  |
| 5:00 AM |  |  | | |  | |  |  |  |  |
| 6:00 AM |  |  | | |  | |  |  |  |  |
| 7:00 AM |  |  | | |  | |  |  |  |  |
| 8:00 AM |  |  | | |  | |  |  |  |  |
| 9:00 AM |  |  | | |  | |  |  |  |  |
| 10:00 AM |  |  | | |  | |  |  |  |  |
| 11:00 AM |  |  | | |  | |  |  |  |  |
| 12:00 PM |  |  | | |  | |  |  |  |  |
| 1:00 PM |  |  | | |  | |  |  |  |  |
| 2:00 PM |  |  | | |  | |  |  |  |  |
| 3:00 PM |  |  | | |  | |  |  |  |  |
| 4:00 PM |  |  | | |  | |  |  |  |  |
| 5:00 PM |  |  | | |  | |  |  |  |  |
| 6:00 PM |  |  | | |  | |  |  |  |  |
| 7:00 PM |  |  | | |  | |  |  |  |  |
| 8:00 PM |  |  | | |  | |  |  |  |  |
| 9:00 PM |  |  | | |  | |  |  |  |  |
| 10:00 PM |  |  | | |  | |  |  |  |  |
| 11:00 PM |  |  | | |  | |  |  |  |  |
| **CODE** | | | **HOURS** |  | | **COMMENTS:** | | | | |
| F = Family | | |  |  | |
| FR = Friends | | |  |  | |
| S = Self | | |  |  | |
| SC = School | | |  |  | |
| W = Work | | |  |  | |
| PW = Paid Waiver | | |  |  | |
| P = Paid Support | | |  |  | |
| Total | | |  |  | |  | | | | |

\* For all PW Services Identify – Example = PW-IF

# Section VIII – Typical Alternate Schedule

### For planning purposes only. If needs change, I will contact my case manager as soon as possible.

JANUARY 20\_\_ FEBRUARY 20\_\_ MARCH 20\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **1** | | **2** | **3** | **4** | **5** | **6** | **7** |  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **8** | | **9** | **10** | **11** | **12** | **13** | **14** |  | **8** | **9** | **10** | **11** | **12** | **13** | **14** |  | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| **15** | | **16** | **17** | **18** | **19** | **20** | **21** |  | **15** | **16** | **17** | **18** | **19** | **20** | **21** |  | **15** | **16** | **17** | **18** | **19** | **20** | **21** |
| **22** | | **23** | **24** | **25** | **26** | **27** | **28** |  | **22** | **23** | **24** | **25** | **26** | **27** | **28** |  | **22** | **23** | **24** | **25** | **26** | **27** | **28** |
| **29** | | **30** | **31** |  |  |  |  |  | **29** |  |  |  |  |  |  |  | **29** | **30** | **31** |  |  |  |  |
| **COMMENTS:** | | | | | | | | | | | | | | | | | | | | | | | |
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APRIL 20\_\_ MAY 20\_\_ JUNE 20\_\_

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| **1** | | **2** | **3** | **4** | **5** | **6** | **7** |  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
| **8** | | **9** | **10** | **11** | **12** | **13** | **14** |  | **8** | **9** | **10** | **11** | **12** | **13** | **14** |  | **8** | **9** | **10** | **11** | **12** | **13** | **14** |
| **15** | | **16** | **17** | **18** | **19** | **20** | **21** |  | **15** | **16** | **17** | **18** | **19** | **20** | **21** |  | **15** | **16** | **17** | **18** | **19** | **20** | **21** |
| **22** | | **23** | **24** | **25** | **26** | **27** | **28** |  | **22** | **23** | **24** | **25** | **26** | **27** | **28** |  | **22** | **23** | **24** | **25** | **26** | **27** | **28** |
| **29** | | **30** |  |  |  |  |  |  | **29** | **30** | **31** |  |  |  |  |  | **29** | **30** |  |  |  |  |  |
| **COMMENTS:** | | | | | | | | | | | | | | | | | | | | | | | |
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## JULY 20\_\_ AUGUST 20\_\_ SEPTEMBER 20\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **1** | | **2** | **3** | **4** | **5** | **6** | **7** |  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |  | **1** | **2** | **3** | **4** | **5** | **6** | **7** |
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| **29** | | **30** | **31** |  |  |  |  |  | **29** | **30** | **31** |  |  |  |  |  | **29** | **30** |  |  |  |  |  |
| **COMMENTS:** | | | | | | | | | | | | | | | | | | | | | | | |
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## OCTOBER 20\_\_ NOVEMBER 20\_\_ DECEMBER 20\_\_

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| SECTION IX (A) List the Individual’s Requested Services as Described in the CPOC. Last 4 of SSN# | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **TYPICAL WEEKLY SCHEDULE – Daily Service Totals** | | | | | | | | | | | | | | | |  | | |  | | |  | | |  | | |  | | |
| **Provider Name**  **(Full Name)** | | **Service Procedure Code(s)** | | | **Service type** | | **Mon** | | **Tues** | **Wed** | | **Thurs** | | **Fri** | | | | **Sat** | | **Sun** | | | **Total Weekly Service Units** | | | **Number of weeks in POC Year** | | | **Total Weekly Units for the POC Year** | |
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| **TYPICAL ALTERNATE SCHEDULE – Total Additional Units of Service Per Quarter** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | **Mth/Day/Yr\_\_\_\_\_\_\_\_\_**  **Mth/Day/Yr\_\_\_\_\_\_\_\_\_**  **1st Partial Quarter** | | | | **Mth/Yr\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Mth/Yr.\_\_\_\_\_\_\_\_\_\_\_\_**  **1st Full quarter** | | | | | **Mth/Yr.\_\_\_\_\_\_\_\_\_\_\_\_**  **Mth/Yr.\_\_\_\_\_\_\_\_\_\_\_\_**  **2nd quarter** | | | | | | | | **Mth/Yr.\_\_\_\_\_\_\_\_\_\_\_\_**  **Mth/Yr\_\_\_\_\_\_\_\_\_\_\_\_**  **3rd Quarter** | | | | | **Mth/Day/Yr\_\_\_\_\_\_\_\_\_Mth/Day/Yr\_\_\_\_\_\_\_\_\_**  **4th Partial Quarter** | | | |  |
| **Provider Name**  **(Full Name)** | **Service Procedure Code(s)** | | **Service type** | **Total # of Units** | | **Date/**  **Purpose** | | **Total # of Units** | | | **Date/**  **Purpose** | | **Total # of Units** | | | | **Date/**  **Purpose** | | | | **Total # of Units** | | | **Date/ Purpose** | | **Total Units**  **(+ or -)** | **Date/ Purpose** | | | **Total Typical Alternate Schedule Units** |
|  |  | |  |  | |  | |  | | |  | |  | | | |  | | | |  | | |  | |  |  | | |  |
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| **\*I have reviewed the budget sheet and agree to provide the above stated services.** | | | | | | | | | | | | | | | **Total Typical Alternate Schedule Units** | | | | | | | | | | | | | | |  |

\*Provider Name/Provider Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Provider Name/Provider Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Support Coordinator Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I HAVE REVIEWED THE BUDGET SHEET AND AM IN AGREEMENT WITH SERVICES AS OUTLINED ABOVE:**

**RECEIPIENT/GUARDIAN SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

LGE or Support Coordinator Supervisor Approval Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

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| SECTION IX (B): CPOC Requested Waiver Services (Budget Sheet) | | | | | | | | | | | | | | |
| **1. Provider Name (Full Name)** | 1. **Provider Number** | **3. Service Type** | **4. Procedure Code(s)** | **5. Total Weekly Units for POC year** |  | **6. Total Alt Units for POC year** |  | **7. Total Units for POC Year** |  | **8. Rate per Procedure Code Unit** |  | **9. Total Schedule Annual Costs** | |
|  |  |  |  |  | **+** |  | **=** |  | **X** |  | **=** |  | |
|  |  |  |  |  | **+** |  | **=** |  | **X** |  | **=** |  | |
|  |  |  |  |  | **+** |  | **=** |  | **X** |  | **=** |  | |
|  |  |  |  |  | **+** |  | **=** |  | **X** |  | **=** |  | |
| **SUPPORT COORDINATION AGENCY NAME**  **CC, SUPPORTS WAIVER, AND ROW (ONLY)** | **PROVIDER #** | **SERVICE TYPE** | **PROCEDURE CODE** | **MONTHLY UNITS** |  | **COST PER UNIT** |  | **TOTAL MONTHLY COST** |  | **MONTHS IN THE CPOC YEAR** |  | **10. TOTAL ANNUAL SCA COST** | |
|  |  |  |  |  | **X** |  | **=** |  | **X** |  | **=** |  | |
|  | | | **11. Total Typical & Alternate Schedule Annual Cost** | | | | | | | | | |  | |
| **12. Total Support Coordination Annual Cost (cc, sw, row only)** | | | | | | | | | |  | |
| **13. Total Annual Cost for POC** | | | | | | | | | |  | |
|  | | | | | | | | | |  | |
| \*Provider Name/Provider Representative Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \*Provider Name/Provider Representative Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Support Coordinator Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **I HAVE REVIEWED THE BUDGET SHEET AND AM IN AGREEMENT WITH SERVICES AS OUTLINED ABOVE:**  **RECEIPIENT/GUARDIAN SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **ANNUAL BUDGET NOT TO EXCEED MAX ROW BUDGET FOR ASSESSED ROW LEVEL. ANNUAL CHILDREN’S CHOICE BUDGET NOT TO EXCEED $17,495.** | | | | | | | | | | | | | | |
| **For LGE/Support Coordinator Supervisor Use Only:** | | | | | | | | | | | | | | |
| **APPROVED:\_\_\_\_\_\_ DENIED:\_\_\_\_\_\_\_\_ APPROVED CPOC BEGIN DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APPROVED CPOC END DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **ICAP LEVEL: \_\_\_\_\_\_ ROW LEVEL: \_\_\_\_\_\_ \*ROW BUDGET MAX: \_$\_\_\_\_\_\_\_\_\_\_**  **LGE / SUPPORT COORDINATOR SUPERVISOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_INITIALS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | | | | |

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| Section X: CPOC Participants |  | | | | | | | | |
| SIGNATURES OF ALL PLANNING MEETING PARTICIPANTSPlanning Participant/Relationship Planning Participant/Relationship | | | | | | | | | |
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| Support Coordinator Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| |  |  | | --- | --- | |  | Participant/Authorized Representative Initials | | I have been offered a choice between waiver and institutional services, and I have chosen (check one): \_\_\_ waiver \_\_\_ institutional. |  | | I have been informed of the available support coordination agencies and I have chosen: (Name of Agency Chosen) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. |  | | I have been given the OCDD Provider Freedom of Choice Listing of available direct service providers and I have chosen: (List all Chosen Providers)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | | I have been informed of all state plan services. |  | | I have been informed of my rights and responsibilities regarding home and community-based waiver services and have been given the WSS Rights and Responsibilities Form that includes information on how to report abuse, neglect, exploitation, or extortion. |  | | My support coordinator has provided me with the toll-free number to contact the Health Standards Section if I want to report a complaint about my support coordinator or waiver service provider(s). That number is 1-800-660-0488. |  |   I have reviewed the services contained in this plan. I choose to accept this plan and the services described instead of the alternatives explained or offered to me. I understand it is my responsibility to notify my support coordinator of any change in my status, which might affect the effectiveness of this program. I further agree to notify my support coordinator of any changes in my income, which might affect my financial eligibility. I understand that I have the right to accept or refuse all or part of the services identified in this support plan. I understand that if I disagree with any decision rendered regarding the approval of this plan, I have the right to an informal discussion by contacting my LGE Regional Office and/or a fair hearing through the Division of Administrative Law-Health & Hospitals Section within 30 days of the approved/denied decision.However, if I disagree with a recommendation to reduce my NOW Individual & Family Support (IFS) hours through the OCDD Guidelines for Support Planning/Resource Allocation process, I must first request a review by the Local Governing Entity (LGE) Regional Office by contacting my support coordinator who will assist me in submitting a justification to the LGE about why I need more NOW IFS hours. I understand that I must receive the LGE’s final decision before I can appeal and request a fair hearing through the Division of Administrative Law-Health & Hospitals Section. I understand that my LGE Regional Office will provide me with an Appeal Notice for this purpose.I understand that I can contact the Division of Administrative Law-Health & Hospitals Section by mail at P.O. Box 4189, Baton Rouge, Louisiana 70821-4189; or by fax at 225-219-9823; or by phone at 225-342-5800. ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***  **Participant/Guardian Signature Date**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Witness Date** Reviewed by Support Coordinator Supervisor:Signature/Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| **FOR LGE / SUPPORT COORDINATION SUPERVISOR USE ONLY:** | | | | | | | | | |
| **Participant Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | **NOW  Children’s Choice Waiver**  **ROW  Supports Waiver** | | | | |
| **Date Complete CPOC Received by LGE RO/SC Supv.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | **LGE Pre-Cert Home Visit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
| **This CPOC Meets the Identified Needs of the Individual:** | | **Approved** | | | | **Denied** | |  |  |
| **Without the Services Available Through This Waiver, the Recipient Would Qualify for Institutional Care:**  **Yes**  **No** | | | | | | | | | |
| **Approved CPOC Begin Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | **Approved CPOC End Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | |
| **Services Approved. Signature/Title of LGE or Support Coordination Supervisor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | |

**Staff Instruction / Provider Attachments (Check if relevant/needed):**

1. Personal Outcomes Worksheets **Required**
2. Relationship & Community Contacts and Information  Yes  No
3. Sustained Supports for Daily Living/Home Needs Instructions  Yes  No
4. Health and Wellness Support Instructions  Yes  No
5. Medication/Treatments  Yes  No
6. Emotional Wellness & Crisis Prevention Plan  Yes  No
7. Behavioral Support Instructions  Yes  No
8. Emergency Plan **Required**
9. Staff Back-up Plan  Yes  No
10. Day Habilitation, Prevoc, and Group Employment  Yes  No
11. Individual Integrated Employment  Yes  No

**Personal Outcomes Assessment (Attachment A)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Personal Outcomes Area | Current Life Situation | Current Supports (Natural, Paid, Community, Technology) | Level of Satisfaction | Desired Life Situation |
| **Identity – “Who am I?”**  🡪 Goals  🡪 Those closest to me  🡪 Personal life situation |  |  |  |  |
| **Autonomy – “My Space”**  🡪 Preferred daily routines  🡪 Non-negotiables  🡪 Time, space, opportunity for privacy  🡪 Home, work, other environments meeting my needs |  |  |  |  |
| **Affiliation – “My Community”**  🡪 Places I want to be  🡪 Things I want to do/participate in  🡪 Community connections/friends  🡪 Social Roles/respect |  |  |  |  |
| **Attainment – “My Success”**  🡪 Match between what matters to me and my supports  🡪 Achievements and goals |  |  |  |  |
| **Safeguards – “My Safeguards”**  🡪 Feeling of safety in home, work, etc.  🡪 Supports needed |  |  |  |  |
| **Rights – “My Rights”**  🡪 Rights I exercise  🡪 Equality, dignity, and fairness |  |  |  |  |
| **Health & Wellness – “My Health”**  🡪 Health status and needs  🡪 Trauma needs  🡪 Continuity and security |  |  |  |  |

**Purpose of the Personal Outcomes Assessment**: To explore the importance of outcomes in each area for the individual and to look at the current presence or absence of these outcomes as well as to identify areas of achievement and the supports needed in these areas.

The POA should be completed following an interview, discussion, and exploration process with the recipient and those who know them best. Use the other tools to help summarize information in the POA. The current outcomes areas OCDD includes are informed by the Council on Quality and Leadership’s Personal Outcomes Measures.

Use the following guidance to complete the POA:

1. Share the Lifecourse materials with the recipient and family **prior to** any discussion with them.
2. Identify with the recipient the individuals who know them best.
   1. These may include family who are close to the person and/or provide supports. Family who are not involved or do not have a close relationship with the recipient would not be included just because they are family.
   2. May include staff who support the individual, but ideally would not only be paid staff.
   3. Ask about neighbors, friends, and other relationships that may help to identify who should be included.
   4. The individual should guide who this is and agree to who it is. No one should be included if the individual does not want them included.
3. Discuss issues and ask questions using the following:
   1. Review the Lifecourse materials with the recipient and those who know them best and ask any needed follow-up questions (these tools can be used to probe areas even if the recipient/family has not completed them in a formal or written manner).
   2. Look at all the areas in the POA and the life domains in the Lifecourse materials and talk with the recipient and those who know them best to identify the things that matter **most to** them and the things that may be **most important for** them to be healthy and safe in each area. Identify the non-negotiables in each area.
   3. Explore specifics of things that are wanted (i.e., if someone wants a job then explore what interests may be, preferred job schedule, etc.) and that are not working or areas of dissatisfaction (i.e., what is not working, what would something different look like) in each area.
   4. Use the My Routines and Non-negotiables tool to identify a typical day for the person and what can make for a better day versus a challenging day. Identify non-negotiables in the recipient’s day/routine.
   5. Use the My Important Relationships and Connections tools to ask questions about relationships and connections that are most important (and for what/why) and those that are not present but desired; ask about social roles and community involvement (current and desired)
   6. Ask about any important areas of rights/choice and discuss these and any supports needed
   7. Discuss the characteristics of people who support the person best and those they work with best. Use the Finding the Right Fit when I Need Support Staff tool to guide this discussion
   8. Help them to complete Understanding My Communication Style tool if desired
4. If someone other than the individual receiving supports is providing information, remember to explore and document the “how do you know this?” piece.
5. Use the information from the discussion and the tools to complete the POA. Ensure that the individual’s strengths can be seen in the resulting summary of the POA.