INDIVIDUALIZED PLAN OF CARE & SUPPORT

Participant and Caregiver Information

Participants Name: ______________________ DOB ________ Primary Phone ____________

Address: ______________________________________ Secondary Phone ____________

Caregiver Name: ______________________ DOB ________ Primary Phone ____________

Address: ______________________________________ Secondary Phone ____________

Participants Abilities	Participants Strengths	Participants Interest	Participants Preference

DISCHARGE/TRANSITION PLANS

If eligible, the following steps will be followed to transition/discharge participant:
*Social Worker shall schedule a meeting with participans and/or participant representative to explain the transistion/discharge process and rationale, and ascertain their preferences and need for support.

SERVICE AUTHORIZATION

We(I), participant and/or representative of __________________________, hereby certify that on __________________________, we(I) have had the opportunity to participant in the development of the Individualized Plan of Care and Support. My signature certifies that I have been given a copy of this plan, and I understand that I can request to update/change this plan at any time which is convenient for me.

______________________________ Participant's Signature

______________________________ Representative/Caregiver Signature

______________________________ Social Worker Signature

______________________________ Program Director Signature

______________________________ Administrator Signature

______________________________ Other/Title Signature

Description of Participants Needs	Expected Outcomes of Long-term & Short-term Goals	Intervention Provided to reach desired goals	Activities and Services provided by ADC	Person Providing Activities & Service	Time needed to achieve goal

Description of needs is based upon the participant assessement

NOTES

Annual Checklist	
Updated ISP	
Current Photograph	
Nutritional Assessment	
Medical History/Exam	