INDIVIDUALIZED SERVICE PLAN

Member and Caregiver Information

Member Name: ______________________ DOB: ________ Primary Phone: ______________

Address: ______________________ Secondary Phone: ______________

Caregiver Name: ______________________ Primary Phone: ______________

Address: ______________________ Secondary Phone: ______________

Member's Abilities	Member's Strengths	Member's Interest	Member's Preference

SERVICE AUTHORIZATION

We(I), member and/or representative of ___________________________, hereby certify that on __________________________, we(I) have had the opportunity to participate in the development of the Individualized Service Plan. 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.

GRIEVANCES AND COMPLAINTS

We(I), member and/or representative of ___________________________, hereby certify that on __________________________, we(I) have been informed of the process to file a complaint, including an anonymous complaint.

Phone Number for Complaints: (   )   -

Member Signature

Representative/Caregiver Signature

Licensed Nurse Signature

Program Director Signature

Administrator Signature

Other/Title Signature

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Personal Goals: ______________________________

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Service Goals: ______________________________

Description of Member's Needs **including cultural or religious observations, mobility assistance, etc.*	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 member's Plan of Services & Supports (PSS).

NOTES

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

Member Name: Date Completed: