# *Check the appropriate box*: Initial Plan Plan update & progress report Progress report

# First Name: Enter first name Last Name: Enter last name. ADSA ID: Enter ADSA ID.

**Provider Name**: Enter Provider’s name: **Phone:** ###-###-#### **Staff contact person**: Enter staff’s name:

# Annual Plan date: Enter plan start date. To Enter plan end date.

# Max. DDD Authorized Service Hour/Mo. #

1. **Skills, gifts, interest, and preferred activities include** (*this information comes from a discovery process such as a person centered plan, circle of support or other process that helps to identify your preferences)*:

My skills are: Enter skills information.

My gifts are: Enter gifts information.

My interests are: Enter interests’ information.

My preferred activities are: Enter preferred activities information.

1. **Community Access goal:** Enter goal:
2. **Action steps and supports** to reach goal. *(There may be several action steps and supports to reach the goal). Complete each action steps and support separately in the table below. You may identify other persons and/or entities available to assist in reaching the community access goal(s)*.

|  |  |  |
| --- | --- | --- |
| Action Steps and supports: |  | Party(s) responsible: |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |

1. **Select any Supports Intensity Scale (SIS) subscale(s) that most relates to the community access goal**. (*Review the most recent Individualized Support Plan (ISP) for SIS information to help inform your choice).* Choose a SIS item.
2. **Other accommodations, safety, adaptive equipment and/or supports critical to achieve the goal**:

Enter other accommodations……

# The 6 month reporting period: Enter start date. To Enter end date.

1. **For the previous six month progress report list the action steps & supports, the outcome of each activity and status of the action step.** *(not required for the initial plan)*

|  |  |  |  |
| --- | --- | --- | --- |
| Action Steps and supports: | Outcomes |  |  Status |
| 1 |  |  | Choose an item. |
| 2 |  |  | Choose an item. |
| 3 |  |  | Choose an item. |
| 4 |  |  | Choose an item. |
| 5 |  |  | Choose an item. |

1. **Total Service Hours provided during the six month reporting period:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Month: |  |  |  |  |  |  |
| Hours: |  |  |  |  |  |  |

1. **Comments**:

Enter comments

Client’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Click here to enter a date.

Legal Guardian’s signature (as appropriate): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Click here to enter a date.

Provider staff signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Click here to enter a date.

Copies provided to: (check all that apply) Client Legal Guardian DDD CRM County