| **Likes:**  Include:   * What is important to me * What ‘works’ * What brings me joy * Areas where I excel * What makes me happy. |  | **(Person’s Name)**  **Individual Instruction and Support Plan (IISP)**  Date revised | | |  | **Dislikes:**  Include:   * What makes me uncomfortable * What I don’t respond well to * What may elicit a negative response from me * Ways of interacting with me when things ‘don’t work’ |
| --- | --- | --- | --- | --- | --- | --- |
| [Paste Photo here] | | |
|  | | | | | | |
| **Risks**  Include all risks that would present life-threatening danger to me or others. Summarize the risk interventions (including restrictions, supervision protocols, dietary needs, or behavioral triggers). You as the residential provider may add notes to aid someone who supports me. – especially information that keeps me and those around me safe. See the risk section for more information. | | | | | | |
|  | | | | | | |
| **Skills & Abilities:**  List areas where I excel and activities I enjoy doing. Include special talents and skills that may not be readily apparent. | | |  | **Communication Style:**  How I best communicate (verbally, English, ASL, gesturally, etc). Include all information someone needs to better understand me. If I use technology include that and instructions. | | |

| Name  First & Last Name | PCSP effective date | | Date of this IISP | Date IISP Reviewed / Revised |
| --- | --- | --- | --- | --- |
| Click here to enter a date. | | Click here to enter a date. | Click here to enter a date. |
| Individuals who participated in IISP development | | Preparer Name | | |
| Include all participants: My guardian, my friends, my family (make a note if others invited chose not to participate),staff and me. Participation includes people who gave input outside of formal meeting (such as completing a survey or interviewing over the phone). | | Insert printed name of plan writer | | |
| Signature of person indicating their agreement with plan Date | | Signature of Preparer (writer) Date | | |
|  | |  | | |
| Legal Representative:  Self  Guardian Choose an item. Click here to enter text. | | Name of Residential Agency | | |
| Guardian Signature (if applicable): Date | | Residential Agency Name | | |

| I have several documents and plans that provide my staff with instructions on how best to support me. This includes things that are important **for** me, as well as things that are important **to** me. All people who support me need to read, understand, and follow them. | ***The Direct Support Professional’s role is to actively work with me to support me to grow, develop and have a quality life.*** |
| --- | --- |

*This is what the plans are called and where they can be found:*

| Check if applicable | **Plan Name** | **Where to find it** |
| --- | --- | --- |
|  | Person Centered Service Plan (PSCP) |  |
|  | Individual Financial Plan (IFP) |  |
|  | Functional Assessment (FA) |  |
|  | Positive Behavior Support Plan (PBSP) |  |
|  |  |  |
|  |  |  |
|  |  |  |

| **HISTORY** – important events in my life**:** |
| --- |
| Provide brief narrative of important information from my history. Include information that could provide context, insight, or a deeper understanding of who I am.. Alternatively, if I have a description of my history documented in my Functional Assessment that helps the reader understand me, refer to that section. |

**Identified Risks and Interventions**

Review each of the following risk categories and document known risks and the interventions. If no risk is noted, please state that no known risks have been identified.

|  | **RISK ISSUES** – Specific issues or protocols needed to ensure my safety if applicable: |
| --- | --- |
|  | **Abuse / Neglect / Exploitation**  **See risk and intervention detail below  No additional direction or explanation needed** |
| Likelihood: Choose an item.  Consequence:  Choose an item. | Risks:  Interventions: All staff trained in mandatory reporter responsibilities |
|  | **Behavioral**  **See risk and intervention detail below  No additional direction or explanation needed** |
| Likelihood:  Choose an item.  Consequence:  Choose an item. | Risks:  Interventions: |
|  | **Environmental / Specialized Equipment**  **See risk and intervention detail below  No additional direction or explanation needed** |
| Likelihood:  Choose an item.  Consequence:  Choose an item. | Risks:  Equipment:  Interventions: |
|  | **Falls**  **See risk and intervention detail below  No additional direction or explanation needed** |
| Likelihood:  Choose an item.  Consequence:  Choose an item. | Risks:  Interventions: |
|  | **Legal**  **See risk and intervention detail below  No additional direction or explanation needed** |
| Likelihood:  Choose an item.  Consequence:  Choose an item. | Risks:  Interventions: |
|  | **Financial**  **See risk and intervention detail below  No additional direction or explanation needed** |
| Likelihood:  Choose an item.  Consequence:  Choose an item. | Risks:  Interventions: |
|  |  |
|  | **Medical (including allergies, skin integrity)**  **See risk and intervention detail below  No additional direction or explanation needed** |
| Likelihood:  Choose an item.  Consequence:  Choose an item. | Risks:  Interventions: |
|  | **Seizure Disorder (if bath in bathtub, describe protocol to keep me safe?)**  **See risk and intervention detail below  No additional direction or explanation needed** |
| Likelihood:  Choose an item.  Consequence:  Choose an item. | Risks:  Interventions: |
|  | **History of Choking (**must describe the actions staff should take to reduce choking risks based on guidelines from my medical provider ?**)**  **See risk and intervention detail below  No additional direction or explanation needed** |
| Likelihood:  Choose an item.  Consequence:  Choose an item. | Risks:  Interventions: |
|  | **Other**  **See risk and intervention detail below  No additional direction or explanation needed** |
| Likelihood:  Choose an item.  Consequence:  Choose an item. | Risks:  Interventions: |

**Instruction and Support Service Implementation**

1. My PCSP identifies my assessed needs and who is responsible to meet those needs **– *please be sure you have read and understand my PCSP***. This section describes ***how*** staff should provide the instruction support to meet my assessed needs. The **IISP must** describe the specific ways in which staff will provide the instruction and support..

| **INSTRUCTION AND SUPPORT DETAILS** – going beyond the PCSP:  General instructions for how staff should provide motivation, instruction, support, modeling, prompting, and reinforcement: | |
| --- | --- |
| **Home Living** | |
| Choose an item. | Include applicable specific information about how staff should provide instruction and/or supports in this area including any schedules, hygiene routines, dietary considerations, and/or equipment. |
| **Community Living/Peer Relationships/Family Supports** | |
| Choose an item. | Include any applicable specific information about how staff should provide instruction and/or supports in this area including making transportation arrangements, preferred recreation/leisure activities, and relationships with friends, family, and community members. |
| **Educational Supports** | |
| Choose an item. | Include any applicable specific information about how staff should support in regular school attendance, homework, support in extra-curricular activities and support in my self-advocacy and IEP development and updates. |
| **Lifelong Learning** | |
| Choose an item. | Include any applicable specific information about how staff should provide instruction and/or supports for education, technology, self-determination and/or self-management. |
| **Employment Activities** | |
| Choose an item. | Include any applicable specific information about how staff should provide instruction and/or supports in this area including work schedule or routines, communication with employment supports, and/or setting up for success. |
| **Health and Safety** | |
| Choose an item. | Include any applicable specific information about how staff should provide instruction and/or supports in this area including medication, health care, ambulation, diet, physical and emotional health. |
| **Social Activities** | |
| Choose an item. | Include any applicable specific information about how staff should provide instruction and/or supports in this area, including essential lifestyle activities and events, communication, and social skills. |
| **Protection and Advocacy** | |
| Choose an item. | Include any applicable specific information about how staff should provide instruction and/or supports in this area including advocacy, protection and making choices. |
| **Medical Supports** | |
| Choose an item. | For any area identified as requiring some or extensive support, provide specific information on how staff should provide the support or reference plan(s) where additional detail is provided. |
| **Behavior Supports** | |
| Choose an item. | For any area identified as requiring some or extensive support, provide specific information on how staff should provide the support or reference plan(s) where additional detail is provided. |

**Habilitative Goals**

Goals must reflect what I want to accomplish and must be specific. A habilitative goal must be revised or changed when the goal is achieved, if it is requested by me (client) or my legal representative, or if the data indicates the instruction is no longer effective.

Clients receiving children’s out-of-home services **must** have a minimum of three habilitative goals.

| Client Name | Goal Implemented Date | Goal# |
| --- | --- | --- |
|  |  |
| Guiding Value(s) this goal works toward (check all that apply):  Competence  Health & Safety  Integration (Community)  Relationships  Power & Choice  Status | | |

| **Goal** | | | |
| --- | --- | --- | --- |
| What skill will the client acquire, strengthen, or maintain? | | How does this relate to what is important to me ? | |
|  | |  | |
| **Measurement** | | | |
| How goal progress will be measured: | Current (baseline) measurement: | | Desired (goal) measurement: |
|  |  | |  |
| **Staff Instructions/Documentation** | | | |
| How staff will provide instructions: (Modeling/Prompting/Reinforcing) | | | |
|  | | | |
| How staff will document: | | | |
|  | | | |
| **Criteria and timeline for revision** | | | |
| Goal will be reviewed at least every 6 months and revised when goal is achieved, requested by me or my guardian, or if data indicates the instruction is not effective. It will be considered that instruction is not effective if: | | | |
|  | | | |

| **Goal Progress Review** | | | | |
| --- | --- | --- | --- | --- |
| **Date of Review** | **Goal Progress** | **Summary of Goal Progress** | **Changes made (if any)** | **Printed Name & Signature of Reviewer** |
|  | occurring as expected  Not occurring as expected |  |  |  |
|  | occurring as expected  Not occurring as expected |  |  |  |
|  | occurring as expected  Not occurring as expected |  |  |  |

**Habilitative Goals**

| Client Name | Goal Implemented Date | Goal# |
| --- | --- | --- |
|  |  |
| Guiding Value(s) this goal works toward (check all that apply):  Competence  Health & Safety  Integration (Community)  Relationships  Power & Choice  Status | | |

| **Goal** | | | |
| --- | --- | --- | --- |
| What skill will the client acquire, strengthen, or maintain? | | How does this relate to what is important to me ? | |
|  | |  | |
| **Measurement** | | | |
| How goal progress will be measured: | Current (baseline) measurement: | | Desired (goal) measurement: |
|  |  | |  |
| **Staff Instructions/Documentation** | | | |
| How staff will provide instructions: (Modeling/Prompting/Reinforcing) | | | |
|  | | | |
| How staff will document: | | | |
|  | | | |
| **Criteria and timeline for revision** | | | |
| Goal will be reviewed at least every 6 months and revised when goal is achieved, requested by me or my guardian, or if data indicates the instruction is not effective. It will be considered that instruction is not effective if: | | | |
|  | | | |

| **Goal Progress Review** | | | | |
| --- | --- | --- | --- | --- |
| **Date of Review** | **Goal Progress** | **Summary of Goal Progress** | **Changes made (if any)** | **Printed Name & Signature of Reviewer** |
|  | occurring as expected  Not occurring as expected |  |  |  |
|  | occurring as expected  Not occurring as expected |  |  |  |
|  | occurring as expected  Not occurring as expected |  |  |  |

**Habilitative Goals**

| Client Name | Goal Implemented Date | Goal# |
| --- | --- | --- |
|  |  |
| Guiding Value(s) this goal works toward (check all that apply):  Competence  Health & Safety  Integration (Community)  Relationships  Power & Choice  Status | | |

| **Goal** | | | |
| --- | --- | --- | --- |
| What skill will the client acquire, strengthen, or maintain? | | How does this relate to what is important to me? | |
|  | |  | |
| **Measurement** | | | |
| How goal progress will be measured: | Current (baseline) measurement: | | Desired (goal) measurement: |
|  |  | |  |
| **Staff Instructions/Documentation** | | | |
| How staff will provide instructions: (Modeling/Prompting/Reinforcing) | | | |
|  | | | |
| How staff will document: | | | |
|  | | | |
| **Criteria and timeline for revision** | | | |
| Goal will be reviewed at least every 6 months and revised when goal is achieved, requested by me or my guardian, or if data indicates the instruction is not effective. It will be considered that instruction is not effective if: | | | |
|  | | | |

| **Goal Progress Review** | | | | |
| --- | --- | --- | --- | --- |
| **Date of Review** | **Goal Progress** | **Summary of Goal Progress** | **Changes made (if any)** | **Printed Name & Signature of Reviewer** |
|  | occurring as expected  Not occurring as expected |  |  |  |
|  | occurring as expected  Not occurring as expected |  |  |  |
|  | occurring as expected  Not occurring as expected |  |  |  |