



DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  
**Initial Specialized Habilitation Plan**

|             |                   |
|-------------|-------------------|
| CLIENT NAME | CASE MANAGER NAME |
|-------------|-------------------|

|               |                      |                                  |
|---------------|----------------------|----------------------------------|
| PROVIDER NAME | PROVIDER AGENCY NAME | DATE PLAN WAS WRITTEN OR REVISED |
|---------------|----------------------|----------------------------------|

- Indicate the targeted categories of Specialized Habilitation:
- Self-Empowerment – Support to increase self-esteem, self-confidence, and skills to achieve personal development goals.
  - Safety Awareness and Self-Advocacy – Support to increase safety awareness and effectively self-express needs, wants, and goals.
  - Interpersonal Effectiveness and Effective Social Communication – Support to develop social skills to build and maintain relationships or increase inclusion in the community and home.
  - Coping Strategies regarding Everyday Life Challenges – Support to improve problem solving skills and stress management techniques.
  - Managing Daily Tasks and Acquiring Adaptive Skills – Support developing skills to successfully reside in the community and to increase independence.

**SMART goal(s) and objective(s)**

|   |  |
|---|--|
| Describe the goal(s) and objective(s) addressed as they appear in Policy 4.20. No more than three goals per plan. | <b>SMART goals and objective are:</b>  |
| <b>Goal 1</b>   | <ul style="list-style-type: none"> <li>• Specific</li> <li>• Measurable</li> <li>• Achievable</li> <li>• Relevant</li> <li>• Time-bound</li> </ul> |
| <b>Goal 2</b>   |  |
| <b>Goal 3</b>   |  |

**How often is the service provided**

Expected frequency and duration of service (How often, and for how long is the service expected to last for client to reach their goal):

|               |  |
|---------------|--|
| <b>Goal 1</b> |  |
| <b>Goal 2</b> |  |
| <b>Goal 3</b> |  |

**What is the plan? What methods and techniques will be used to support the client? How will progress be measured and how will measures determine the conclusion of service?**

|               |  |
|---------------|--|
| <b>Goal 1</b> |  |
| <b>Goal 2</b> |  |
| <b>Goal 3</b> |  |

List referral recommendations if the client presents with potential underlying medical, mental health, or educational support needs (referral may be to Care Coordinator, treating professional, or DDA):

Date of referral:

**Signatures**

|                    |      |                                |      |
|--------------------|------|--------------------------------|------|
| CLIENT SIGNATURE   | DATE | LEGAL REPRESENTATIVE SIGNATURE | DATE |
| PROVIDER SIGNATURE | DATE |                                |      |

## Instructions for Initial Specialized Habilitation Plan

**Client Name:** Add in the name of the client.

**Case Manager:** Add in the name of your current case resource manager.

**Provider Name:** Add in the name of your Community Engagement provider.

**Provider Agency Name:** If you are a provider within a contracted agency, please indicate your agency here.

**Date plan as written or revised:** Include when this plan was completed.

**Indicate the targeted categories of Specialized Habilitation:** Check the box according to the category of Specialized Habilitation that the client would like to work with. Do not check more boxes than goals. Example: If the client has three (3) goals (which is the maximum at any time), there must only be three (3) or less boxes checked. There may be multiple goals that fit under one category, so it is possible to have three (3) goals, but only two (2) boxes checked in this area.

**Describe the goal(s) and objective(s) addressed as they appear in Policy 4.20. No more than three goals per plan:** Identify the goals that the client has, in S.M.A.R.T goal criteria, using the small chart to the right of the form as a guide. What does the client want? What is their goal? This needs to be person-centered, and in the client's words.

**What is the expected frequency and duration of the service?** Describe how long the service of Specialized Habilitation is expected to last until the client is able to reach their goal. How often will the client need to work with the provider in order for them to reach their goal? Example: Once per week for two (2) hours, for the next three (3) months.

**What is the plan? What methods and techniques that will be used to support the client and how will the client know that they have reached their goal?** Describe them here.

**List referral recommendations if the client presents with potential underlying medical, mental health, or educational support needs (referral may be to Care Coordinator, treating professional, or DDA):** List in this section any referrals necessary for the client that are outside of what Specialize Habilitation can provide. Consideration examples: Are there any concerns of client's mental health presentation or education needs for school aged client? Does the client need referral to resources they are not yet connected with?

**Client Signature:** The client must sign here.

**Legal Representative's Signature:** When applicable, the client's legal representative needs to sign here, agreeing to this initial plan.

**Provider Signature:** The Specialized Habilitation provider will sign here.