

Individualized Service Plan

Name of the Person: _____ ISP Effective Date: _____

Medicaid State Plan Services:

For each service briefly state the **name** of the provider or agency (e.g., Dr. Smith, ARC Day Treatment Center, Southern DDSO Clinic); the **type** of service (e.g., physician, day treatment, MSC, transportation, durable medical equipment, etc.); the **frequency** of the service (e.g., daily, 5 days a week, yearly); the **duration** (e.g., on-going) and **effective date** (e.g., 3/97, 5/14/99, or approximate time frame: within the past year, etc.) and the **person's valued outcome** (from Section 1 of the ISP) **or reason** for receiving the support or service.

Examples of Medicaid State Plan Services: Medicaid Service Coordination, Day Treatment, Physician, Pharmacy, Laboratory, Hospital, Dental, Audiological, Personal Care, Certified Home Health Care, Durable Medical Equipment, Transportation, other.

Note: Long term therapies provided in Article 16, 28, or 31 Clinic should not be included below. (See section "Medicaid State Plan Services: Article 16, 28, or 31 Clinic Long-term Therapies Only"). However, medical or dental state plan service provided in an Article 16, 28, or 31 Clinic should be described below.

Name of Provider: _____
Type of Medicaid Service: _____
Frequency: _____ Duration: _____ Effective Date: _____
Person's Valued Outcome or Reason for Receiving the Service: _____

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Type of Medicaid Service: _____
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Medicaid State Plan Services – Article 16, 28, and 31 Clinics Long-Term Therapies Only (Physical Therapy, Occupational Therapy, Speech, Rehabilitation Counseling, Nutrition, Psychology, Social Work and Psychiatry):

For each service briefly state the **name** of the provider or agency (e.g., Metropolitan Article 28 Clinic, Western Article 16 Clinic); check the box to indicate the Clinic **Certification Category** (e.g., Article 16); the **type** of clinic service (e.g., physical therapy, speech pathology); the **frequency** of the service (e.g., 3 days a week); the **duration** (e.g., on-going) and **effective date** (e.g., 3/97, 5/14/99; or approximate time frame: e.g., within the past year); the **person's valued outcome** (from Section 1 of the ISP) or **reason** for receiving the support or service; and **location the service will be provided** (e.g., main clinic site, day program, or residential program).

Name of Provider: _____

Article 16 Article 28 Article 31

Type of Clinic Service: _____

Frequency: _____ Duration: _____ Effective Date: _____

Person's Valued Outcome or Reason for Receiving the Service: _____

At what location will the service be provided (e.g., main clinic site or at the day or residential program)?

Name of Provider: _____

Article 16 Article 28 Article 31

Type of Clinic Service: _____

Frequency: _____ Duration: _____ Effective Date: _____

Person's Valued Outcome or Reason for Receiving the Service: _____

At what location will the service be provided (e.g., main clinic site or at the day or residential program)?

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HCB Waiver Service Summary: Complete a section below for each waiver service. Add more pages as needed.

For each service briefly state the **name** of the provider or agency (e.g., Sunshine Co. UCP, Southern DDSO); the **type** of service (e.g., residential habilitation, supported employment, environmental modification); the **frequency** of the service (billing unit of service); the **duration** (e.g., on-going) and **effective date** (e.g., 1/1/99) and the **person's valued outcome** (from Section 1 of the ISP) or **reason** for receiving the support or service.

Name of Provider: _____
Type of Waiver Service: _____
Frequency: _____ **Duration:** _____ **Effective Date:** _____
Person's Valued Outcome or Reason for Receiving the Service:

Name of Provider: _____
Type of Waiver Service: _____
Frequency: _____ **Duration:** _____ **Effective Date:** _____
Person's Valued Outcome or Reason for Receiving the Service:

Name of Provider: _____
Type of Waiver Service: _____
Frequency: _____ **Duration:** _____ **Effective Date:** _____
Person's Valued Outcome or Reason for Receiving the Service:

Types of HCB Waiver Services:

- | | | |
|--------------------------|------------------------------------|------------------|
| residential habilitation | prevocational services | day habilitation |
| supported employment | environmental modifications | respite |
| adaptive devices | plan of care support services | |
| fiscal/employer agent | consolidated supports and services | |
| transitional services | family education and training | |

