Vision for a Good Life: Summary from the Person Centered Planning Process which Includes information about: What an overall 'Good Life' looks like: Hopes, Dreams & Wants; Needs or conditions that must be in place to achieve a good life; Personal Strengths and Assets; Preferences Likes (Special Interests) & Dislikes; What the Individual Would Like to Try; Support Preferences (e.g., Does the individual prefer a female or male for his/her support needs or for a specific task / activity such as bathing?); Reflects cultural considerations of the individual**;** Information about the general topic of important relationships; Information about relationships the individual may want to enhance or explore; or other important information that is not in the body of the ISP.

<table>
<tr><td>DEMOGRAPHIC and CONTRIBUTORS INFORMATION</td><td>Full Legal Name (may use middle initial) ; Nicknames and/or alias ; Date of Birth ; DMH ID ; Individual Plan Meeting Date ; Regional Office ; TCM Agency ; Healthcare Resources Utilize (Including Medicare, Medicaid, dental insurance, and private health insurance) ; Spend down $</td></tr>
<tr><td>LEGAL DEMOGRAPHICS</td><td>Legal Status
Guardianship (Yes or NO) if Yes Guardian Name , address , phone number and relationship to the individual
Specific restriction placed by court ; Voter Status ; Custody (children)</td></tr>
<tr><td>CONTRIBUTORS</td><td>How the individual participated in the development of their ISP ; If the individual is not present at the planning meeting, the team must justify the individual’s absence and how the individual was otherwise involved in the planning process .
<table>
<tr><td>Person Who Contributed to the ISP</td><td>Relationship to Individual</td><td>How they did so</td></tr>
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Tools/Assessments Summary

Assessment have been done or reviewed in the following areas, and the identified supports and/or Personal Outcomes are addressed in the ISP as noted below

Missouri Quality Outcome Domain	**Support Area**	**Tools/Assessment Used (Yes or NO)**	**Comments**
Daily Life & Employment	Employment / Career Planning	Employment ISP Question	
Community Living	Choice Housing/Setting	Housing ISP Questions	
	Transitioning into Different Living Settings		
Social and Spirituality	Community Connection	Community Life ISP Questions Personal Relationship ISP Questions	
Healthy Living	Health Risk	Healthy Living ISP Questions Self-Medication Assessment Health Inventory	
Safety & Security	Supports needed for safety	Safety and Security ISP Questions	
	Behavioral Risk and Prevention	Behavioral Risk ISP Questions Assessment of Common Risk Factors	
	Individual Rights/Due Process	Individual Rights ISP Questions	
Citizenship & Advocacy	Personal Income	Personal Income ISP Questions	
	Self-Directed Supports	Support Brokers Assessment Personal Assistance Assessment with Training Exemptions Community Specialist Assessment	
		MOCABI	
		SIS	
		Health Vineland	

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Daily Life & Employment
Employment / Career Planning

Please answer (Yes, No or NA) to the following questions:
Are you provided the opportunity to complete tasks/chores on your own: At home? , At school or other day settings? Have you had the opportunity to observe and explore potential careers? , Have you visited any businesses with these careers? Do you know your relative strengths, skills, abilities, interests and talents as it relates to career planning? ;Are you able to communicate your wants, needs and desires with others? ;

Have you utilized DB101 or completed other benefits planning consultation? ; Do you understand your education and employment rights? ; Are you knowledgeable of the support and services available to you through: School Transition Teams? , Vocational Rehabilitation? , Centers for Independent Living? , Division of Developmental Disabilities? ;

Do you know the types of jobs available in your community? ; Do you know the accommodations or support you need in order to assist you with maximizing your independence? ; Do you have a preferred learning style? ; Are you supported in having instruction which is aligned with this learning style? ; Do you have enough information to be empowered with potential career decisions? ; Do you have a specific job goal? ;Do you know the specific skills you would need to perform your job goal? ; Is additional training and assistance needed to develop your skills for employment? ; If you have a job, do you like your job? ; Is the career planning/employment activity you currently participate in your choice, reflect your preference and optimize your independence? ; Do you know how to complete an application form? ; Do you have a current written or video resume? ; Are you able to contact potential employers on your own?

FOR EVERYONE:
Documentation of benefits counseling and planning to assist individuals and stakeholders with making informed choices on asset development and financial literacy.
Documentation of benefits counseling and planning to assist individuals and stakeholders with making informed choices on asset development and financial literacy.

FOR EMPLOYED INDIVIDUALS: Name of employer ; average number of hours worked a week ; hourly wage ; job title .
For waiver funded services: Describe how natural supports are being developed ; and the specific-targeted job skills being developed ; Include the methodology for evaluating the need for continuation of these services .
For Individuals in Group Supported Employment: The justification for Group Supported Employment if the individual demonstrates the capacity to work in an individual setting similar to those not receiving HCB services.

FOR INDIVIDUALS WITHOUT CAREER PLANNING OUTCOMES: Describe the rationale for excluding employment as an outcome . Outline the activities, experiences and conversations which will occur promoting future career planning outcomes .

Support/Services Needed *What do you need to know to support me*	Frequency & Duration	How documented Is this Outcome area? Is this Personal Outcome Implementation Plan required?	Type of Provider (Technology, relationship based (natural support), Community based, eligibility based); Waiver Service Title; Person/Agency Responsible

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Community Living Choice Housing

Please answer (Yes, No or NA) to the following questions:
Are you happy living in this home and want to continue to live here? ; Did you choose your current housemates? ; Do you enjoy living with your housemates and do you get along with them? ; Do you share your bedroom with someone? ; If so did you choose to share your room with him or her? ; Is there anyone you would prefer to live with in the future? ; If so who? ; Do you have space for privacy? ; Do you feel that you have control within your home?
Can move around freely in your home? ; Do you know how much you pay for your rent, and utilities? ; Do you know about resources which can help pay for part of a person's rent or help with utilities? ; Do you need basic furnishings such as furniture and household items? ; Did you choose how to decorate your home? ; Are there any home modifications needed that would enhance your quality of life or your ability to be independent? (Yes, No or NA) ; Do you need help making choices about your housing? ; Does anyone help you take care of your home? Who? What? Paid? Unpaid? ; Is it easy for you to get to work from your home? ; Are there are fun places you like to go close to your home? ; Is your home located among other private homes and businesses so it is easier for you to do things in your community? ; Do you have friends who live in your neighborhood/close by? ; Are you part of making your community better? ; Do you decide who can and cannot come into your home?) ; Do you decide what activities you do in your home, and your daily schedule? ; Do you need help cleaning your home? ; If yes, what type of cleaning help do you need? ; Making home repairs ; Do you need assistance in these homemaking activities? ; Are you able to be on your own without risk of serious harm or injury to yourself? ; Did you choose to live in this home and location?) ;

<u>If you don't live in your own home or a home with family:</u>
Do you have a lease or written residency agreement? ; Does the lease or written agreement include language that provides protections to address eviction processes? ; Do you know your rights and responsibilities regarding housing and when you could be required to relocate? ; Do you know how to relocate and request new housing? ; What other living situations did you consider prior to choosing your current home?

Support/Services Needed *What do you need to know to support me*	Frequency & Duration	How documented Is this Outcome area? Is this Personal Outcome Implementation Plan required?	Type of Provider (Technology, relationship based (natural support), Community based, eligibility based); Waiver Service Title; Person/Agency Responsible

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Community Living Transitioning into Different Living Settings

Is the individual moving from a nursing home or Habilitation Center and eligible for 'Money Follows the Person'? (Yes, No or NA) ; If so please complete the following:

"As *(Individuals Name)* is moving into a (*number)* person ISL/group home, he/she is eligible for the Money Follows the Person Demonstration. *(Individuals Name)/* Guardian has been notified of this option and has signed the agreement for their participation for one year. During this time, surveys will occur prior to discharge from *(Institution's Name)* , at one year and again at two years. If *(Individuals Name)* is hospitalized or placed in an inpatient setting, regardless of the amount of time, the MFP project director (Julie Juergens: 573-751-8021) must be contacted. This will be the responsibility of *(Support Coordinator Name)* Support Coordinator. The Regional Office provides a 24 hour call-in number for emergency back-up assistance if needed. *(Individuals Name)* and his/her guardian have been provided this number in the event that emergency back-up is needed."

Assessment of Need for Community Transition Services:

Are goods or services needed in any of the following areas (Yes, No or NA):

Expenses to transport furnishings and personal possessions to the new living arrangement ; Essential furnishing: bed , a table , chairs , window blinds , eating utensils , and food preparation items ; Security deposits ; Utility set-up fees or deposits: a telephone , water , electricity , heating , trash removal ; Health and safety assurances: pest eradication , allergen control or one-time cleaning prior to occupancy .

Details about options explored prior to requesting Community transition service: (*such as natural supports, including donations of cash or donations of second-hand goods from charitable organizations and assistance from family and friends. Effforts made to purchase the lowest cost items available, including second-hand goods when reasonable and appropriate. And other resources for getting start-up items may include family donations, Goodwill, Salvation Army, second hand stores, local service organizations and businesses, etc*.):

Are any additional supports needed in changing living situation? ; Has the post move review meeting been scheduled to develop Personal Outcomes? ; What 'back up' plans are in place in case of an emergency? ;

Support/Services Needed *What do you need to know to support me*	Frequency & Duration	How documented Is this Outcome area? Is this Personal Outcome Implementation Plan required?	Type of Provider (Technology, relationship based (natural support), Community based, eligibility based); Waiver Service Title; Person/Agency Responsible

Draft

Social and Spirituality Personal Relationships

Please answer (Yes, No or NA) to the following questions:
Do you have friends (not paid supports) who you can spend time with? ; Do you need help to contact your friends/family on a regular basis? ; Do you interact well with others by being a good listener and expressing yourself? ; Do you have friends who will share decision-making about what you both talk about and do together? ; What kind of relationships do you have or want in your life? ; Do you know where/how you can find someone to date? ; Do you want to get married or have children? ; Do you have ways to express your sexuality and choices regarding love and intimacy? ; Can you differentiate appropriate relationship behaviors as with family, co-workers, intimate partners (how we talk and touch others)? ; Are you able to make appropriate decisions concerning marriage and intimate relationships? ; Do you understand consent and permission with regard to sexual contact? ;

Support/Services Needed *What do you need to know to support me*	Frequency & Duration	How documented Is this Outcome area? Is this Personal Outcome Implementation Plan required?	Type of Provider (Technology, relationship based (natural support), Community based, eligibility based); Waiver Service Title; Person/Agency Responsible

Draft

Social and Spirituality Community Connection

Please answer (Yes, No or NA) to the following questions:
Do you need help to plan or participate in social or community activities? : Religious activities? , Ethnic Activities? ; Are there activities you would like to try? ; Are the activities your currently participate in your choice and reflect your likes and preferences? ; Do you understand your rights? ; Are there community resources that you need? ; Can you start your day without help? ; Can you schedule and keep your appointments? ; Do you need help with shopping? ;

Do you need help in traveling around the community because of health, safety or behavioral needs? ; Do you want or need help to vote? ; Do you need or want help with making choices about your activities? ; Does anyone help you do things in the community? ; Who? What? Paid? Unpaid? ; Do you choose your daily activities? ; Do you feel that you have enough information to feel empowered to make decision?

Support/Services Needed *What do you need to know to support me*	Frequency & Duration	How documented Is this Outcome area? Is this Personal Outcome Implementation Plan required?	Type of Provider (Technology, relationship based (natural support), Community based, eligibility based); Waiver Service Title; Person/Agency Responsible

Draft

Healthy Living

Please answer (Yes, No or NA) to the following questions:
Do you have a primary care Physician? ; Do you see any specialist and if so for what reason? ; Do you see a counselor or psychiatrist? ; Do your doctors help you understand issues with your health? ; Do you need speech, physical for therapy services? ; Do you need help getting any of these services? ; How do you let people know that you are not feeling well? Do you have a medical problem which requires regular monitoring? ; Do you need assistance with eating or drinking? Is your nutrition and exercise adequate for good health? ; What do you do to stay healthy? ; Do you need help to take your medications? ; Do you need help to order or refill prescriptions? ; Do you need help to notify people when your medication changes? ; Do you need any medical or adaptive equipment? ; Do you have any allergies? ; Do need or want help with making choices about your health? ; Does anyone help you take care of your health? (Who? What? Paid? Unpaid? ; Can you make and communicate decision regarding medical treatment, including understanding the consequences of not accepting treatment? ; Do you understand health consequences associated with high risk behaviors (substance abuse, overeating, high-risk sexual activities, etc.)?

Support/Services Needed *What do you need to know to support me*	Frequency & Duration	How documented Is this Outcome area? Is this Personal Outcome Implementation Plan required?	Type of Provider (Technology, relationship based (natural support), Community based, eligibility based); Waiver Service Title; Person/Agency Responsible

Safety & Security
Supports Needed for Safety

Are supports needed in any of the following areas (Yes, No or NA):
Do you avoid common environmental dangers (traffic, sharp objects, hot stove, and poisonous products)? ; Are you able to recognize when someone is taking advantage of you or abusing you (physical, sexual, emotional) and protect yourself? ; Do you know who to contact if you are in danger, being exploited or being treated unfairly? ; Individual needs supports due to refusal for services to maintain their health and safety? ;

Developing and implementing an emergency plan to safely manage emergency situations: evacuating the home ; taking shelter in the event of a major emergency ; Practice safety drills ; Manage/utilize safety devices in the home: changing batteries in smoke detectors, CO indictors, flashlights ; radio for energies ; visual fire alarms; Contacting emergency services ;

Support to safely regulate water temperature? ; Support to effectively manage strangers who visit home? ; Support to carry and use personal identification? : Support to respond in potentially unsafe situations in the community? ; Support to ask assistance such as directions to destinations? ; Support to provide medical information to first responders? ;

Support/Services Needed *What do you need to know to support me*	Frequency & Duration	How documented Is this Outcome area? Is this Personal Outcome Implementation Plan required?	Type of Provider (Technology, relationship based (natural support), Community based, eligibility based); Waiver Service Title; Person/Agency Responsible

Safety & Security Behavioral Risk and Prevention	**Are supports needed in any of the following areas (Yes, No or NA):** Current or past engaging in behavior that is: injurious to self ; incident of physical or verbal aggression towards others ; behavioral of sexual nature ; behavioral expression resulting in property damage ; elopement where absences raised reasonable concern for safety ; activities that illegal . Have you been hospitalized or sought hospitalization for behaviors that put yourself or others in danger? Are you prescribed behavioral control or psychotropic medications? ; Have you lost services (day services, employment, residential) because of behavioral problems?

Does the individual have a:
"Crisis Safety Plan" ; is the "Crisis Safety Plan" Attached to the ISP? ; was an "Assessment of Behavioral Risk Factors" completed .
Functional Behavioral Assessment ; Is the Functional Behavioral Assessment attached to the ISP? ; Date of most recent Functional Behavioral Assessment ;
Behavior Support Plan ; Is the Behavior Support Plan attached to this ISP? ; Date of Behavior Support Plan ;

Support/Services Needed *What do you need to know to support me*	Frequency & Duration	How documented Is this Outcome area? Is this Personal Outcome Implementation Plan required?	Type of Provider (Technology, relationship based (natural support), Community based, eligibility based); Waiver Service Title; Person/Agency Responsible

Draft

<table>
<tr><td rowspan="6">
Citizenship & Advocacy
Individual Rights/Due Process</td><td colspan="2">The individual received information about rights in which of the following formats:</td></tr>
<tr><td></td><td>A Guide for Individuals with Developmental Disabilities to Understanding Rights and Responsibilities</td></tr>
<tr><td></td><td>Individual Rights of Persons Receiving Services</td></tr>
<tr><td></td><td>Brochure for community services</td></tr>
<tr><td></td><td>ASL Video</td></tr>
<tr><td></td><td>Los derechos de los consumidores</td></tr>
</table>

Are supports needed in any of the following areas (Yes, No or NA):
Do you understand your rights and responsibilities? ; Can you communicate for yourself? ; Do you understand the process to making an official complaint? ; Are you able to understand and communicate consent and/or permissions regarding legal documents? ; Are you registered to vote? Are your Rights restricted? if yes proceed to the next page.

Support/Services Needed *What do you need to know to support me*	Frequency & Duration	How documented Is this Outcome area? Is this Personal Outcome Implementation Plan required?	Type of Provider (Technology, relationship based (natural support), Community based, eligibility based); Waiver Service Title; Person/Agency Responsible

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Citizenship & Advocacy
Individual Rights/Due Process
Right Restrictions

Justification - purpose & rationale
Describe the restriction:
Document less intrusive methods of meeting the need that have been tried but did not work.
Identify a specific and individualized assessed need

- Explain the reason the limitation or restriction is being put in place.
- Explain if the restrictions or limitations are necessary to keep the person safe or others safe?

Describe any historical pattern or significant situation which has occurred that would justify a limitation or restriction?

Conditions - under which the restriction is applied: Explain where the restriction or limitation will be imposed (i.e. only at home, in the community, day program, in kitchen, etc.) ; Include a clear description of the condition that is directly proportionate to the specific assessed need. ; Explain when the restriction will be imposed (i.e. at all times, in morning, after/before a specific event or situation, if family present, only when…..)?

Teaching or Support Strategies: Outcomes/Strategies that are being taught to help an individual develop skills in order to overcome the need for this restrictive support?

Document the positive interventions and supports used prior to any modifications to the person centered service plan.

- Provide evidence that this type of intervention/teaching has worked in the past and information on why this is the method by which the person learns best.
- There may be situations where an individual has multiple restrictions. If a team decides to prioritize/focus teaching outcomes on only a few restrictions at a time, versus all the restrictions at once, the team will need to justify
- If there are restrictive supports that are required to keep the person or others safe and teaching strategies have not been identified, then the supports need to be identified in the ISP and the efforts that are being explored to support the person in the least restrictive way.

For teaching and support strategies, document who is responsible for the training of the strategies.

Monitoring methods: Include an assurance that interventions and supports will cause no harm to the individual.
Include a regular collection and review of data to measure the ongoing effectiveness of the modification.
Information on data collection methods should include…

- Who is documenting ; Where data is kept (i.e., daily progress notes, outcome data sheets, MAR, etc.) ; What is the frequency of documentation (i.e. daily, weekly, monthly, etc.) How often is the data reviewed by team

If the plan is being referred for annual review, there must be documentation noting the progress or lack of progress from the past year of implementation (i.e. summary of monthly reviews, quarterly reviews, behavioral data results, evaluations about the effectiveness of medications/interventions)

Criteria for restoration: Describe what will it take for the restriction to be lifted / how will the individual and team know when the restrictive support is no longer needed or could be reduced in intensity/frequency?
The criterion needs to be in specific observable & measurable terms (i.e. if individual has three consecutive months of no attempts to elope, chimes will be removed from the exterior door)

Review schedule: Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
State how often team will submit plan to Due Process Committee for review (minimum is annually)

Notice of right to due process: Include informed consent of the individual.

Signing documents that the individual and the guardian are aware of the restrictions, were part of the planning process to develop interventions, know they have a right to due process, and have information on what to do if they do not agree with the restrictions or interventions.

Individual's Name: : Signature:_______________________________________
Guardian's Name: : Signature:_______________________________________

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Citizenship & Advocacy
Personal Income

Income Sources: Government Benefits ; Wages ; Trust Fund ; Other
Other Sources: Food Stamps ; Home Energy Assistance Program (HEAP) ; Housing Assistance (HUD, Metro, etc) ; Medicaid ; Medicare ; Insurance ; Checking Account ; Savings Account ; Other

Are supports needed in any of the following areas (Yes, No or NA):
Do you need help maintaining or obtaining benefits? ; Do you need help setting up automated payments? ; Does the individual have a Medicaid spend down? ; Do you need help with banking? ; Do you need help managing your money?
Do you want to be more involved in: Paying your bills ; Budgeting your money? ; Banking? ; □ Saving money? ;
Do you need additional supports when caring and/or spending money for purchases? ; Do you have any needs for shelter or food that are not met by your resources? ; Do you have other financial needs that have not been met? ; Do you have outstanding debt? ; Is there anything that you want to save money for? ;
Would you like supplemental insurance? ; Do you have burial arrangements? ; Do you need or want help making choices about your money and benefits? ;
Does anyone help you with your money or benefits: Who ? , What? , Paid? , Unpaid? .

Support/Services Needed *What do you need to know to support me*	Frequency & Duration	How documented Is this Outcome area? Is this Personal Outcome Implementation Plan required?	Type of Provider (Technology, relationship based (natural support), Community based, eligibility based); Waiver Service Title; Person/Agency Responsible

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Self-Directed Supports	Designated Representative (Yes or NO) (if yes) Name: ; What is the Back-up plan which includes provisions for support in the case of scheduled employees not being able to provide the support . Paid Family member (Yes or NO) (if yes): The individual is not opposed to the family member providing the support. (Yes or NO) ,The supports to be provided are solely for the individual and not household tasks expected to be shared with people who live in a family unit. (Yes or NO) The support team agrees that the family member providing the individual assistance will best meet the individual's needs (Yes or NO) Is the individuals receiving State Plan Personal Care Services through DHSDS (Yes or NO) ; Are DHSDS services self-directed? (Yes or NO)

Training Exemptions	**Justification/Individualized Support in Place**
CPR/ First Aid (Cannot be exempt for Enhanced Medical PA)	
Medication Administration (Cannot be exempt for Enhanced Medical PA if providing medication administration)	
Behavior Intervention Crisis Management (Cannot be exempted for if physical intervention is needed)	
Positive Behavior Supports training (Cannot be exempted for Enhanced Behavioral PA)	

Assessment of Need for Support to Self-Direct Services:

Is information or assistance needed in the following area (Yes or No) : Recruiting workers ; Hiring workers ; Managing workers ; Terminating workers ; Managing and approving timesheets ; Organization/ maintaining documents ; Problem solving ; Conflict resolution ; Conflict resolution ; Filing grievances and complaints ; Establishing work schedules ; Understanding documentation requirements ; Assisting with monthly reviews ; Managing budget & Employee Rate Setting ; Seeking supports or resources ; Define goals, needs and preferences ; Development of Emergency Back-up Plan ; Employee training ; Understanding the Role of Employer/DR, SC, FMS and RO

Support/Services Needed *What do you need to know to support me*	Frequency & Duration	How documented Is this Outcome area? Is this Personal Outcome Implementation Plan required?	Type of Provider (Technology, relationship based (natural support), Community based, eligibility based); Waiver Service Title; Person/Agency Responsible

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Citizenship & Advocacy
Choice of Service, Provider and Self-Directed Supports

Are supports needed in any of the following areas (Yes, No or NA):
Are you knowledgeable of other providers who provide the services you receive? ; Do you know how and to who make a request for a new provider of services? ;

How was the individual educated and informed of the options list in the "*Medicaid Waiver, Provider, and Services Choice Statement*." ;
How was the individual educated and informed of the full range of HCBS available to support achievement of personally identified goals. ;
What is the method for the individual to request updates to the ISP? ;
What are the alternate home and community-based setting that were considered by the individual? ;

Support/Services Needed *What do you need to know to support me*	Frequency & Duration	How documented Is this Outcome area? Is this Personal Outcome Implementation Plan required?	Type of Provider (Technology, relationship based (natural support), Community based, eligibility based); Waiver Service Title; Person/Agency Responsible

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Citizenship & Advocacy Conflict Resolution	**What to do if I am unhappy with services or supports** **If at any time you feel that our Support Coordination Agency** (or any of its employees or contract agencies) has not helped you in obtaining your needed s**upports or goals, please bring it** to **our** attention, as follows:

Bring your concern(s) as quickly as possible to the attention of: , Support Coordinator; ,**TCM Agency;** *Address* ; *phone* ; ***e-mail:***

You may also address your concern(s) to: ,Support Coordinator Supervisor; ,**TCM Agency;** address as above; *phone* ; ***e-mail:***

You may also address your concern(s) to: , *Name* , Director; ,**TCM Agency;** address as above; *phone* ; ***e-mail:***

Individuals and family members may contact the office of Constituent Services (**http://dmh.mo.gov/constituentservices/index.html**) regarding concerns about Division of DD facilities or community providers in various ways:

- Call toll-free at 1-800-364-9687;
- Complete and mail in a grievance form;
- Send us an email;
- Or, write to the Department of Mental Health, Attn: Constituent Services, 1706 E. Elm St., Jefferson City, MO 65101.

In addition to talking to the people listed above, you also have the opportunity to request a Fair Hearing regarding Medicaid waiver services if you are not given the choice to receive waiver services, you are denied the waiver services or providers of your choice, or your waiver services are denied, suspended, reduced or terminated.

Waiver Adverse Action

If you feel that there has been an adverse action regarding your waiver services (denial, reduction, or termination of a specific service or services) with which you disagree, there is a dispute resolution process you can follow if you wish to appeal a decision that you feel adversely affects your services while preserving your right to a fair hearing.

You have the right to appeal through the Department of Mental Health and Department of Social Services, MO Health Net Division at 1-800-392-2161. While not required to do so, you are encouraged to begin with the Department of Mental Health's appeal process. You may, however, appeal to the MO HealthNet Division, before, during, or after exhausting the Department of Mental Health's process. However, once an individual begins the appeal process with the Department of Social Services, all appeal rights with the Department of Mental Health end. Please contact your Support Coordinator about your appeal rights.

Citizenship & Advocacy Conflict of Interest	**Information regarding any potential conflict of interest:**

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Citizenship & Advocacy Dissenting Opinions	**Dissenting Opinions of Team Members** *This section includes information of dissenting opinions of team members*
Name of Tream Member/ Telationship to Indiviual	**Dissenting Opinions**

Personal Outcomes

Personal Outcome:
Information Important to know about the Personal Outcome. **Current situation and things that have been tired or would like to try:** **Why it is the Outcome important to the individual (and family)** *in* *their words* *if possible*:
What personal strengths and assets does the individual have in relation to the Personal Outcome:
What technology can be used to achieve the Personal Outcome:
What personal relationships does the individual have which can help achieve the Personal Outcome:
What community resources can be used to achieve the Personal Outcome:
Frequency, duration of working on Personal Outcome and Time lines regarding completion of Personal Outcome:
If Waiver Supports are needed who is responsible for writing the Implementation Plan:

Personal Outcome:
Information Important to know about the Personal Outcome. **Current situation and things that have been tired or would like to try:** **Why it is the Outcome important to the individual (and family)** *in* *their words* *if possible*:
What personal strengths and assets does the individual have in relation to the Personal Outcome:
What technology can be used to achieve the Personal Outcome:
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What community resources can be used to achieve the Personal Outcome:
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If Waiver Supports are needed who is responsible for writing the Implementation Plan:

Personal Outcome:
Information Important to know about the Personal Outcome. **Current situation and things that have been tired or would like to try:** **Why it is the Outcome important to the individual (and family)** *in* *their words* *if possible*:
What personal strengths and assets does the individual have in relation to the Personal Outcome:
What technology can be used to achieve the Personal Outcome:
What personal relationships does the individual have which can help achieve the Personal Outcome:
What community resources can be used to achieve the Personal Outcome:
Frequency, duration of working on Personal Outcome and Time lines regarding completion of Personal Outcome:

Draft

If Waiver Supports are needed who is responsible for writing the Implementation Plan:

Individual Service Plan Approval

My signature below gives consent for service delivery as outlined in the personal plan dated ____________ which I have reviewed and approved (RSMO 633.110). I understand that services are rendered during the whole span of this plan, unless the plan says otherwise. I will do my part to get to my desired outcomes. I have made an informed choice.

	Signature	**Date**
Individual:		
Parent/Legal Guardian:		
Parent/Legal Guardian:		

Agreement to Provide Services

The undersigned agree to the services at the frequencies indicated in this plan for which they are named as responsible party. No service or support that the Regional Office is requested to fund should begin until approval is given by the appropriate parties (Utilization Review Committee-local or state level depending on amount of funding requested).Unless otherwise noted, all services continue for the entire span of the plan.

	Signature	**Date**
Provider		
Provider		
Provider		
Provider		
Unpaid support provider(s) or personal advocate(s) (Signature Optional)		
Service Coordinator		
Approval by Regional Office		

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