LOUISIANA DEPARTMENT OF HEALTH
OCDD WAIVER SUPPORTS AND SERVICES
COMPREHENSIVE PLAN OF CARE
CONFIDENTIAL

TYPE: ☐ Initial ☐ Annual

Waiver: (insert Waiver type)
☐ ICAP Level (ROW only):
☐ ROW Acuity Level: _____
☐ ROW Maximum Budget:

Level of Care: ■ ICF-IID
☐ SIS LEVEL _____
☐ SHARED SUPPORT

Individual's Name (Last Name, First Name)		**Legal Guardian/Authorized Representative**	
Social Security Number XXX-XX-	**DOB / /**	**Relationship**	
Medicaid #	**Medicare #**	**Legal Status:** ☐ **Minor** ☐ **Interdicted** ☐ **Power of Attorney** ☐ **Competent Major** ☐**OTHER** _____	
Address (Physical)	**Mailing** (If Different)	**Address (Physical)**	**Mailing (If Different)**
City/State/Zip Code	**Parish**	**City/State/Zip Code**	**Parish**
Day Phone	**Night Phone**	**Day Phone**	**Night Phone**
Support Coordination Agency (No Abbreviations)		**Support Coordination Agency Provider Number**	
Support Coordination Agency Address		**Support Coordinator (type/print)**	**SC Supervisor (Type/print)**
City/State/Zip Code		**Telephone Number**	

Sex: ☐ Male ☐ Female **Ethnicity:** ☐ African-American ☐ Caucasian ☐ Hispanic ☐ Asian ☐ Other

Education: ☐ Attends School ☐Homebound ☐ N/A **90L:** Physician Date: _____ SC Rec'd: _____

Primary Disability/Diagnosis: _____ **Date of Onset:** / /

Secondary Disability/Diagnosis: **Date of Onset:** / /

SIL: ☐ Yes ☐ No

24-Hour Service: ☐Yes ☐ No

Emergency Self-Evacuate: ☐ Yes ☐ No

Ambulation: ☐ Independent ☐ With Personal Assistance ☐ With Assistive Device(s) ☐ Does not ambulate ☐ Wheelchair without assistance ☐ Wheelchair with assistance ☐ Other

Attach Individualized Emergency Evacuation/Response Plan

Emergency Response: ☐ **Level 1** Total Assistance with Life Sustaining Equipment ☐ **Level 2** Total Assistance ☐ **Level 3** Can Respond/Needs Transportation ☐ **Level 4** Can Respond Independently

Will Residence Change with Waiver Participation? ☐ Yes ☐ No If Yes, When & Proposed Address?

Is This a Transition From a Developmental Center or Nursing Facility? ☐ Yes ☐ No Deposit Required? ☐ Yes ☐ No

Are There Multiple Waiver recipients in the Home? ☐ Yes ☐ No If So, How Many? _____

Are There Multiple Individuals with Disabilities (Non-Recipient) in the Home? ☐ Yes ☐ No If So, How Many? _____

Are Paid Care Givers Related to Individual? ☐ Yes ☐ No If Yes, Relationship & Service Provided

Do Paid Care Givers Live with Recipient? ☐ Yes ☐ No If Yes, Name & Service(s)

Does Individual Receive Home Health Service? ☐ No ☐ Yes If Yes, Attach a Home Health Plan.

Present Housing
☐ Own Home (Alone)
☐ Own Home (With Partner)
☐ Own Home (With Others)
☐ Other's Home
☐ ICF/IID ☐ Nursing Facility

Rent Home: ☐ With Subsidy ☐ Without Subsidy

Rent Apartment: ☐ With Subsidy ☐ Without Subsidy

Anticipated Housing: _____

CPOC Begin Date:		**CPOC End Date:**	

Section I: Emergency Information **Confidential**

Attach Individualized Emergency Evacuation/Response Plan

Individual's Name: _____ **Age:** _____

Address: _____

Directions to My Home: _____

Person responsible for Evacuating/Bringing Supplies to Individual's Home:

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address: _____

Family Members/Other to Contact in Case of Emergency (Including Providers):

1. Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address _____

2. Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address: _____

3. Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address _____

Emergency Equipment in Home:

☐ Fire Extinguisher: Location _____

☐ First Aid Supplies: Location _____

☐ Home Evacuation Plan: Location: _____

☐ Specialized Medical Equipment: (e.g., ventilator, suction machine, etc.)

☐ Smoke Detector(s): location: _____

Location: _____

☐ Other _____

Special Considerations/Necessities (Detailed Information Required): Utilizes Assistive Technology, Dependent on Ventilator, Medications, Etc. (See Individual Emergency Evacuation/Response Plan)

Doctor's Name: _____ Primary: _____ Phone: _____

Doctor's Name: _____ Specialty: _____ Phone: _____

Doctor's Name: _____ Specialty: _____ Phone: _____

Doctor's Name: _____ Specialty: _____ Phone: _____

Doctor's Name _____ Specialty _____ Phone: _____

Section II. All About Me Confidential

Information included in this section is relevant to my life today and is my way of sharing social/family history with you. I hope that this information will be helpful in assisting you to help me achieve my personal outcomes. My personal outcomes worksheet (see attached Personal Outcomes Worksheets) will assist you in helping me tell you about myself. If I need assistance telling my story, please ask those who know me best.

A. Historical Information: Information in this section includes historical issues, for example, nature and cause of person's disability, person's age at onset of disability (if not known, please indicate by writing "unknown" in this section), education, work history; recurring situations that impact support needs; summary of events leading to request for support at this time.

B. Current Living Situation: (This section is related to Attachments B and C) Information in this section includes family's involvement and understanding of individual's strengths, skills and abilities, current issues/situations that may present barriers to individual obtaining supports and services they desire, individual's/family/circle of support knowledge of disability and how individual wants to be supported; economic issues, including current employment; connections to community and natural supports, relationships/friends/family/other, where and with whom individual lives, rural/urban area, accessibility to resources, own home/rents/lives with relative/extended family/alone, does physical home environment meet accessibility/safety needs, health and age of family care-givers (if supported by family), feelings of safety and continuity of supports/care, etc.

C. Current Community Supports or Other Agency Involvement: Information in this section includes significant life events, including family issues, social/law enforcement issues, social services caseworker or Probation Officer involvement which may require interaction with legal/social agencies, current community supports and resources being utilized, etc.

A. My gifts and talents:

B. I communicate best by (speaking, gesturing, communication board, sign language, behaving in certain ways, etc.):

List of non-verbal ways I communicate in this communication log:

When I do this:	It means this:

C. I understand best when (shown and told how, shown, use hand-over hand techniques, etc.):

D. I need help with:

E. When I am scared I need someone to:

F. When I am angry I need you to:

G. Things that work/things I like (favorite things such as…food hobbies, past time):

H. Things that don't work/things I dislike:

I. Other things I'd like you to know about me:

Section IV: A. Health Profile

Health Support Area	Diagnoses/Risks	Doctor/Professional Responsible	Date of last visit	Date of next visit	Support needed by paid staff (For all areas that are checked the provider attachments should include instructions and description of support)	No support needed	Support needed, but Family provides all support
General Health Supports					☐ Making Appointments ☐Communicating with Professional During Visits ☐ Monitoring Symptoms ☐ Help when symptoms occur	☐	☐
Allergies (Medication, food, environmental)					☐ Making Appointments ☐Communicating with Professional During Visits ☐ Monitoring Symptoms ☐ Help when symptoms occur	☐	☐
Behavioral and Mental Health Supports					☐ Making Appointments ☐Communicating with Professional During Visits ☐ Monitoring Symptoms ☐ Help when symptoms occur	☐	☐
Medical and Mental Health Risks					☐ Making Appointments ☐Communicating with Professional During Visits ☐ Monitoring Symptoms ☐ Help when symptoms occur	☐	☐

Note: If there are any checks in "Support Needed by Paid Staff", then Attachments D and/or G are required.

B. Incident Reports (For Past 6 months):

Type of Incident	Category	Number	Additional information/Summary
Critical Incidents	1. Unplanned Hospital		
	2. ER Visits		
	3. Psychiatric Admissions		
	4. Abuse/Neglect		
	5. Other		
Non-Critical Incidents			
Hospital Admissions			
Emergency Doctor Visits			
Psychiatric Hospital Admissions			

Vision:

NOTE: Planning must include and reflect emergency backup plans where the health and welfare of the recipient may be adversely affected.

MY PERSONAL OUTCOMES	SUPPORT STRATEGY NEEDED	HOW OFTEN FOR SUPPORTS AND SERVICES	REVIEW/ACCOMPLISHED DATE
What I want for myself. What is important to me right now? What do I want /expect as a result of supports and services?	What I need to achieve my personal outcomes. How will services and supports be provided to me? Who will deliver the services and supports (Paid/unpaid)? Where will services and supports be provided? What (if any) assistive devices will be required? **Be Specific**	How and when (how often) do I want services and supports provided? **Be Specific**	When/how often will the supports and services be reviewed. When was the personal outcome accomplished/achieved? Is this still an outcome I want in my life now? Has anything changed in my life that needs to be addressed at this time? **Be Specif.** **Review Date Accomplished**
1.	**1.**	**1.**	**1.**
2.	**2.**	**2.**	**2.**

NOTE: Planning must include and reflect emergency backup plans where the health and welfare of the recipient may be adversely affected.

MY PERSONAL OUTCOMES	SUPPORT STRATEGY NEEDED	HOW OFTEN FOR SUPPORTS AND SERVICES	REVIEW/ACCOMPLISHED DATE
What I want for myself. What is important to me right now? What do I want /expect as a result of supports and services?	What I need to achieve my personal outcomes. How will services and supports be provided to me? Who will deliver the services and supports (Paid/unpaid)? Where will services and supports be provided? What (if any) assistive devices will be required? **Be Specific**	How and when (how often) do I want services and supports provided? **Be Specific**	When/how often will the supports and services be reviewed. When was the personal outcome accomplished/achieved? Is this still an outcome I want in my life now? Has anything changed in my life that needs to be addressed at this time? **Be Specific** **Review Date Accomplished**
3.	**3.**	**3.**	**3.**
4.	**4.**	**4.**	**4.**

SECTION VI: IDENTIFIED SERVICES, NEEDS, AND SUPPORTS

Non-Waiver Support	Medicaid Funded Services	Supports Waiver	ROW Waiver	NOW Waiver	Children's Choice Waiver
☐Natural Supports	☐ Dental	☐Support Coordination	☐Support Coordination	☐ Prevocational Services	☐ Support Coordination
☐ Community Supports	☐Eye Glasses	☐Supported Employment - Individual ☐Supported Employment - Group	☐Residential (Mandatory) ☐Community Living Supports ☐Companion Care ☐Host Home ☐Shared Living (New) ☐Shared Living (Conversion)	☐ Day Habilitation	☐ Family Support ☐ Shared
☐ OCDD	☐Home Health Extended	☐Prevocational	☐Respite-Center Based	☒ Day Habilitation Services Transportation ☐ Transportation-Reg ☐ Transportation-W/C	☐ Crisis Support ☐ Shared
☐ LRS	☐Hospice	☐Day Habilitation	☐One-Time Transitional Expense	☐ Supported Employment ☐ Transportation-Reg ☐ Transportation-W/C	☐ Family Training
☐ Department of Children and Family Service	☐Medical Transportation	☐Habilitation	☐Assistive Technology/Specialized Medical Equipment and Supplies	☐Community Integration Development (CID)	☐ Center Based Respite
	☐Mental Health	☐Respite (In-Home) ☐Respite (Center)	☐Environmental Accessibility Adaptations	☐Supported Independent Living (SIL)	☐Environmental Accessibility Adaptations
	☐Podiatry Services	☐Personal Emergency Response System	☐Personal Emergency Response System	☐Personal Emergency Response System	☐Specialized Medical Equipment and Supplies

Non-Waiver Support	Medicaid Funded Services	Supports Waiver	ROW Waiver	NOW Waiver	Children's Choice Waiver
	☐Substance Abuse	☐Housing Transition Professional Support	☐Transportation-Community Access	☐Environmental Accessibility Adaptations	☐Housing Transition Professional Support
	☐Prescriptions/ Medications		☐Nursing Services	☐Specialized Medical Equipment and Supplies	☐Therapies ☐Art ☐Aquatic ☐Music ☐Hippotherapy ☐ABA ☐Therapeutic Horse-back Riding ☐Sensory Integration
	☐EPSDT		☐Dental Services	☐One-time Transitional Expenses	
	☐Other		☐Professional Services ☐Dietary ☐Speech Therapy ☐Occupational Therapy ☐Physical Therapy ☐Social Work ☐Psychology	☐Shared Supports ☐Day (D) ☐Night (N) ☐Shared Supports ☐Skilled Nursing ☐CID	
			☐Supported Employment ☐ Transportation-Reg ☐ Transportation-W/C	☐Individual Family Support ☐Day (D) ☐Night (N)	
			☐Prevocational Services	☐Substitute Family Care	
			☐Day Habilitation ☐ Transportation-Reg ☐ Transportation-W/C	☐Center Based Respite	
			☐Housing Transition Professional Support	☐Professional Consultation	
			☐Adult Day Health Care (ADHC)	☐Professional Services	
				☐Housing Transition Professional Support	
				☐Skilled Nursing	
				☐Adult Companion Care	

NOTE: Informed individual of all state plan services. Support Coordinator Initials: _____

Section VII: Typical Weekly Schedule Confidential

FOR PLANNING PURPOSES ONLY. IF NEEDS CHANGE, I WILL CONTACT MY CASE MANAGER AS SOON AS POSSIBLE.

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
12:00 AM							
1:00 AM							
2:00 AM							
3:00 AM							
4:00 AM							
5:00 AM							
6:00 AM							
7:00 AM							
8:00 AM							
9:00 AM							
10:00 AM							
11:00 AM							
12:00 PM							
1:00 PM							
2:00 PM							
3:00 PM							
4:00 PM							
5:00 PM							
6:00 PM							
7:00 PM							
8:00 PM							
9:00 PM							
10:00 PM							
11:00 PM							

CODE	HOURS
F = FAMILY	
FR = FRIENDS	
S = SELF	
SC = SCHOOL	
W = WORK	
PW = PAID WAIVER	
P = PAID SUPPORT	
Total	

COMMENTS:

* FOR ALL PW SERVICES IDENTIFY – EXAMPLE = PW-IFS

JANUARY 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

COMMENTS:

FEBRUARY 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29						

MARCH 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

APRIL 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

COMMENTS:

MAY 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

JUNE 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

COMMENTS:

JULY 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

COMMENTS:

AUGUST 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

SEPTEMBER 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

COMMENTS:

OCTOBER 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

COMMENTS:

NOVEMBER 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

DECEMBER 20__

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

COMMENTS:

SECTION IX (A) List the Individual's Requested Services as Described in the CPOC.

Last 4 of SSN# _____

TYPICAL WEEKLY SCHEDULE – Daily Service Totals

Provider Name (Full Name)	Service Procedure Code(s)	Service type	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Total Weekly Service Units	Number of weeks in POC Year	Total Weekly Units for the POC Year

TYPICAL ALTERNATE SCHEDULE – Total Additional Units of Service Per Quarter

			Mth/Day/Yr_____ Mth/Day/Yr_____ 1st Partial Quarter		Mth/Yr_____ Mth/Yr._____ 1st Full quarter		Mth/Yr._____ Mth/Yr._____ 2nd quarter		Mth/Yr._____ Mth/Yr_____ 3rd Quarter		Mth/Day/Yr_____ _Mth/Day/Yr_____ __ 4th Partial Quarter		
Provider Name (Full Name)	**Service Procedure Code(s)**	**Service type**	**Total # of Units**	**Date/ Purpose**	**Total # of Units**	**Date/ Purpose**	**Total # of Units**	**Date/ Purpose**	**Total # of Units**	**Date/ Purpose**	**Total Units (+ or -)**	**Date/ Purpose**	**Total Typical Alternate Schedule Units**

***I HAVE REVIEWED THE BUDGET SHEET AND AGREE TO PROVIDE THE ABOVE STATED SERVICES.**

Total Typical Alternate Schedule Units

*Provider Name/Provider Representative Signature: _____ Date: _____

*Provider Name/Provider Representative Signature: _____ Date: _____

Support Coordinator Signature: _____ Initials: _____ Date: _____

I HAVE REVIEWED THE BUDGET SHEET AND AM IN AGREEMENT WITH SERVICES AS OUTLINED ABOVE:

RECEIPIENT/GUARDIAN SIGNATURE _____Date_____

LGE or Support Coordinator Supervisor Approval Signature: _____ Date: _____

SECTION IX (B): CPOC Requested Waiver Services (Budget Sheet)

1. Provider Name (Full Name)	2. Provider Number	3. Service Type	4. Procedure Code(s)	5. Total Weekly Units for POC year		6. Total Alt Units for POC year		7. Total Units for POC Year		8. Rate per Procedure Code Unit		9. Total Schedule Annual Costs
					+		=		X		=	
					+		=		X		=	
					+		=		X		=	
					+		=		X		=	
SUPPORT COORDINATION AGENCY NAME CC, SUPPORTS WAIVER, AND ROW (ONLY)	PROVIDER #	SERVICE TYPE	PROCEDURE CODE	MONTHLY UNITS		COST PER UNIT		TOTAL MONTHLY COST		MONTHS IN THE CPOC YEAR		10. TOTAL ANNUAL SCA COST
					X		=		X		=	
			11. TOTAL TYPICAL & ALTERNATE SCHEDULE ANNUAL COST									
			12. TOTAL SUPPORT COORDINATION ANNUAL COST (CC, SW, ROW ONLY)									
			13. TOTAL ANNUAL COST FOR POC									

*Provider Name/Provider Representative Signature: _____ Date:_____

*Provider Name/Provider Representative Signature:_____ Date:_____

Support Coordinator Signature:_____Initials:_____ Date:_____

I HAVE REVIEWED THE BUDGET SHEET AND AM IN AGREEMENT WITH SERVICES AS OUTLINED ABOVE:

RECEIPIENT/GUARDIAN SIGNATURE _____Date_____

ANNUAL BUDGET NOT TO EXCEED MAX ROW BUDGET FOR ASSESSED ROW LEVEL. ANNUALCHILDREN'S CHOICE BUDGET NOT TO EXCEED $17,495.

FOR LGE / SUPPORT COORDINATOR SUPERVISOR USE ONLY:

APPROVED:_____ DENIED:_____ APPROVED CPOC BEGIN DATE: _____ APPROVED CPOC END DATE:_____
ICAP LEVEL: _____ ROW LEVEL: _____ *ROW BUDGET MAX: _$_____

LGE / SUPPORT COORDINATOR SUPERVISOR: _____INITIALS: _____ DATE: _____

Section X: CPOC Participants	Confidential

SIGNATURES OF ALL PLANNING MEETING PARTICIPANTS

Planning Participant/Relationship	Planning Participant/Relationship

SUPPORT COORDINATOR SIGNATURE: _____ **Date: _____**

	Participant/Authorized Representative Initials
I have been offered a choice between waiver and institutional services, and I have chosen (check one): ___ waiver ___ institutional.	
I have been informed of the available support coordination agencies and I have chosen: (Name of Agency Chosen) _____.	
I have been given the OCDD Provider Freedom of Choice Listing of available direct service providers and I have chosen: (List all Chosen Providers)_____	
I have been informed of all state plan services.	
I have been informed of my rights and responsibilities regarding home and community-based waiver services and have been given the WSS Rights and Responsibilities Form which includes information on how to report abuse, neglect, exploitation, or extortion.	
My support coordinator has provided me with the toll-free number to contact the Health Standards Section if I want to report a complaint about my support coordinator or waiver service provider(s). That number is 1-800-660-0488.	

I have reviewed the services contained in this plan. I choose to accept this plan and the services described instead of the alternatives explained or offered to me. I understand it is my responsibility to notify my support coordinator of any change in my status, which might affect the effectiveness of this program. I further agree to notify my support coordinator of any changes in my income, which might affect my financial eligibility. I understand that I have the right to accept or refuse all or part of the services identified in this support plan.

I understand that if I disagree with any decision rendered regarding the approval of this plan, I have the right to an informal discussion by contacting my LGE Regional Office and/or a fair hearing through the Division of Administrative Law-Health & Hospitals Section within 30 days of the approved/denied decision.
However, if I disagree with a recommendation to reduce my NOW Individual & Family Support (IFS) hours through the OCDD Guidelines for Support Planning/Resource Allocation process, I must first request a review by the Local Governing Entity (LGE) Regional Office by contacting my support coordinator who will assist me in submitting a justification to the LGE about why I need more NOW IFS hours. I understand that I must receive the LGE's final decision before I can appeal and request a fair hearing through the Division of Administrative Law-Health & Hospitals Section. I understand that my LGE Regional Office will provide me with an Appeal Notice for this purpose.
I understand that I can contact the Division of Administrative Law-Health & Hospitals Section by mail at P.O. Box 4189, Baton Rouge, Louisiana 70821-4189; or by fax at (225)219-9823; or by phone at (225) 342-5800.

_____ _____
Participant/Guardian Signature **Date**

_____ _____
Witness **Date**

Reviewed by Support Coordinator Supervisor:
Signature/Title: _____ _____ Date:_____

FOR LGE / SUPPORT COORDINATION SUPERVISOR USE ONLY:

PARTICIPANT NAME:_____ ☐ **NOW** ☐ **ROW** ☐ **CHILDREN'S CHOICE WAIVER** ☐ **SUPPORTS WAIVER**

DATE COMPLETE CPOC RECEIVED BY LGE RO/SC SUPV.: _____ **LGE PRE-CERT HOME VISIT DATE:** _____

THIS CPOC MEETS THE IDENTIFIED NEEDS OF THE INDIVIDUAL: ☐ **APPROVED** ☐ **DENIED**

WITHOUT THE SERVICES AVAILABLE THROUGH THIS WAIVER, THE RECIPIENT WOULD QUALIFY FOR INSTITUTIONAL CARE: ☐ YES ☐ NO

APPROVED CPOC BEGIN DATE:_____ **APPROVED CPOC END DATE:**_____

SERVICES APPROVED. SIGNATURE/TITLE OF LGE OR SUPPORT COORDINATION

SUPERVISOR:_____ **DATE:** _____

Staff Instruction / Provider Attachments (Check if relevant/needed):

A. Personal Outcomes Worksheets	**Required**
B. Relationship & Community Contacts and Information	**☐ Yes ☐ No**
C. Sustained Supports for Daily Living/Home Needs Instructions	**☐ Yes ☐ No**
D. Health and Wellness Support Instructions	**☐ Yes ☐ No**
E. Medication/Treatments	**☐ Yes ☐ No**
F. Emotional Wellness & Crisis Prevention Plan	**☐ Yes ☐ No**
G. Behavioral Support Instructions	**☐ Yes ☐ No**
H. Emergency Plan	**Required**
I. Staff Back-up Plan	**☐ Yes ☐ No**
J. Day Hab, Prevoc, and Group Employment	**☐ Yes ☐ No**
K. Individual Integrated Employment	**☐ Yes ☐ No**

PERSONAL OUTCOMES WORKSHEETS
(Required as part of CPOC)
Attachment A

	CURRENT LIFE SITUATION	**CURRENT SUPPORT SITUATION – NATURAL AND PAID** (WHAT'S GOING ON THAT SUPPORTS MY DESIRED OUTCOME?)	**CURRENT LEVEL OF SATISFACTION** (1 TO 5 SCALE)
Identity – "Who Am I?"			
1. What Goals have I set for myself? 2. Where and with whom do I want to live? 3. What do I want to do for my work? 4. Who is closest to me? 5. How satisfied am I with the services and supports I receive? 6. How satisfied am I with my personal life situation?			
Autonomy – "My Space"			
7. What are my preferred daily routines? 8. Do I have the time, space, and opportunity for the privacy I need? 9. Am I in control of who knows personal information about me? 10. Do my home, work, and other environments support what I want and need to be?			
Affiliation – "My Community"			
11. Do I have access to the place I want to be? 12. Do I participate in what happens in my community? 13. Am I pleased with the type and extent of my interaction with other people in my community? 14. Am I known for the different social roles I play? 15. Do I have enough friends? 16. Am I respected by others?			
Attainment – "My Success"			
17. Are the supports and services I receive the ones I want? 18. Have I realized any of my personal goals?			
Safe Guards – "My Safe Guards"			
19. Am I connected to the people who support me the most? 20. Am I safe?			
Rights – "My Rights"			
21. Do I exercise the rights that are important to me? 22. Do I feel that I am treated fairly?			
Health and Wellness – "My Health"			
23. Is my health as good as I can make it? 24. Am I free from Abuse and Neglect? 25. Do I have a sense of continuity and security?			

CURRENT LEVEL OF SATISFACTION:

1 – NOT AT ALL SATISFIED: AREA DISCUSSED BUT NO PLANS TO ADDRESS – NOT AT ALL SATISFIED/NO PROGRESS

2 – NOT VERY SATISFIED: AREA DISCUSSED BUT NO ADEQUATELY ADDRESSED/PLANNED FOR – LITTLE OR NO SATISFACTION/PROGRESS

3 – SOMEWHAT SATISFIED: AREA DISCUSSED AND ADDRESSED/PLANNED FOR – SOME SATISFACTION/PROGRESS

4 –SATISFIED: AREA DISCUSSED/PLANNED FOR – MOSTLY SATISFIED WITH NOTICEABLE PROGRESS

5 –VERY SATISFIED : AREA DISCUSSED AND ADEQUATELY PLANNED FOR (I.E., TO MAINTAIN CURRENT STATUS, CONTINUE WITH CURRENT OR ADJUSTED PLAN, ETC.) – VERY SATISFIED AT THIS TIME

Top/Most Important Personal Outcomes/Goals

Look at the Personal Outcomes Worksheet, Personal Outcomes Importance and Satisfaction Worksheet, as well as other information that will help you in choosing the top/most important things you would like to see change, improve or maintain in your life right now. What matters to you the most? The number of Personal Outcome/Goals will be based on what is most important to you. (Copy this form as needed.)

Use the space below to help you with identifying what matters the most to you in your life right now, and then decide what help/support you need to get what you want.

Outcome/Goal # _____

I want (my desired outcome/goal):

What is currently in place to support/help me get what I want?

What are some barriers that may keep me from getting what I want? (Things/actions that move me further away from what I want):

What do I need to help me get what I want (reach my desired outcome/goal)?

Top/Most Important Personal Outcomes/Goals

Look at the Personal Outcomes Worksheet, Personal Outcomes Importance and Satisfaction Worksheet, as well as other information that will help you in choosing the top/most important things you would like to see change, improve or maintain in your life right now. What matters to you the most? The number of Personal Outcome/Goals will be based on what is most important to you. (Copy this form as needed.)

Use the space below to help you with identifying what matters the most to you in your life right now, and then decide what help/support you need to get what you want.

Outcome/Goal # _____

I want (my desired outcome/goal):

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