1 Each person served by OPTIONS will have an Individual Service Plan (ISP) that addresses the specific issues leading to the persons referral to OPTIONS. The ISP will be based on each persons preferences and needs. In addition to the input of the person served, input from other members of the Interdisciplinary Team will be taken into account. All goals and objectives will be identified at the ISP meeting, with the person served present as an active member of the team. Each plan will include, but not be limited to, the following information:

1.1 Identification of the person's qualifying status, including functional limitations, specific disabilities, behavioral excesses or deficits, medical concerns, adaptive living skills proficiencies, and any other relevant concerns.

1.2 The person's strengths, needs, preferences and desired outcomes from services rendered by OPTIONS.

1.3 Individual service goals and objectives, written in measurable terms with a set criterion for each, including anticipated time frames and specific instruction for the accomplishment of goals.

2 The ISP will be written and communicated in a manner that is understandable to both the person served and to the individuals responsible for implementing the plan.

3 The initial ISP meeting will be held and implemented within thirty days following the person's admission to any of OPTIONS' programs.

3.1 The initial ISP will be based on an assessment containing information from the Pre-admission Screening Evaluation, direct observation, and baseline data. In some departments a Person Centered Plan, professional assessments and Functional Strengths and Needs Assessment may also be utilized based upon the needs of the individual.

4 Regular reviews of each person's progress toward specific ISP goals and objectives will be conducted as an integral component of OPTIONS services. When revisions to the ISP are indicated, they will be made with the consent of the person and with input from the ID Team.

5 All ISPs will be formally reviewed by the ID Team on a regular basis (no less than annually). An updated Person Centered Plan and Functional Strengths and Needs Assessment will be completed annually and when desired by person served for persons receiving ICF-DD/H residential services.

6 Transition Plans will be developed by the ID Team when a person has reached his/her ISP goals and objectives and wishes to transition to a less restrictive living environment or as agreed upon by the IDT.

7 Monthly reports will be completed in the ICF/IDH homes, and will reflect the person's progress toward their ISP goals and objectives. Other programs will prepare quarterly progress reports.

8 The Program Manager/QIDP will be responsible for the overall direction and implementation of the ISP, and will ensure Community Support Specialists implement ISP strategies and procedures consistently and reliably, accurately charting progress.

9 OPTIONS is committed to acting in the best interest of each person served in its programs. When appropriate, OPTIONS will refer persons to other programs and/or advocacy services.

10 A Discharge report will be completed within one week when a person exits from any OPTIONS program.

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