CONFIDENTIAL

NAME:_____ DATE:_____/_____/_____ PAGE:_____OF_____

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

INDIVIDUAL PROGRAM PLAN

_____	_____	____/____/____
PARTICIPANT	AGENCY/FACILITY	DATE

I. Evaluations and Assessments Performed: List the Dates Assessments Completed

Medical / Nursing	Initial Medical Evaluation ____/____/____ Dental Evaluation ___/___/___ Neurological Exam ___/___/___ Nutrition ___/___/___ Motor ___/___/___ Speech ___/___/___ Nursing ___/___/___ Hearing ___/___/___ Vision ___/___/___ Language ___/___/___ Other _____ ___/___/___
Psychological	ABS ___/___/___ WAIS ___/___/___ CIIS ___/___/___ WISC-R ___/___/___ ABAS-II ___/___/___ Other _____ ___/___/___
Habilitative / Social	Social History ___/___/___ Training/Education ___/___/___ Recreation/Leisure ___/___/___ Habilitation - WVATTS ___/___/___ Brigance ___/___/___ L.A.P. ___/___/___ Other _____ ___/___/___

NAME:_____ DATE:_____/_____/_____ PAGE:_____OF_____

II. Evaluation and Assessment Summary: (List Strengths/Needs in all Areas)

a. Medical/Health:	
Strengths	Needs

b. Psychological:	
Strengths	Needs

c. Social:	
Strengths	Needs

d. Habilitation:	
Strengths	Needs

e. Other:	
Strengths	Needs

f. Projected Date of Community Placement: _____/_____/_____

NAME:_____ DATE:_____/_____/_____ PAGE:_____OF_____

III. Individual Service Plan (Staff Actions Based on Assessment Results)

Area	Service Needs	Availability Accessibility	Provider

Frequency Days/Hours	Duration	Plan of Action	Responsible Person

III. Individual Service Plan (Continued)

Area	Service Needs	Availability Accessibility	Provider

Frequency Days/Hours	Duration	Plan of Action	Responsible Person

REEVALUATION DATE _____/_____/_____

_____ _____/_____/_____ _____ _____/_____/_____

PARTICIPANT DATE SERVICECOORDINATOR DATE

_____ _____/_____/_____ _____

PARENT/LEGAL REPRESENTATIVE DATE SERVICE COORDINATOR

NAME:_____ DATE:_____/_____/_____ PAGE:_____OF_____

IV. Individual Habilitation Plan

#	Goal/Need	#	Behavioral Objective	Barriers

Activities and Methods	Date Initiated	Date Completed	Responsible Person

#	Goal/Need	#	Behavioral Objective	Barriers

Activities and Methods	Date Initiated	Date Completed	Responsible Person

NAME:_____ DATE:_____/_____/_____ PAGE:_____OF_____

IV. Individual Habilitation Plan (Continued)

#	Goal/Need	#	Behavioral Objective	Barriers

Activities and Methods	Date Initiated	Date Completed	Responsible Person

RE-EVALUATION DATE _____90 DAYS _____180 DAYS _____ANNUAL

_____	_____	_____	_____
PARTICIPANT	DATE	SERVICE COORDINATOR	DATE
_____	_____	_____	_____
PARENT/LEGAL REPRESENTATIVE	DATE	SERVICE COORDINATOR SUPERVISOR	DATE

NAME:_____ DATE:_____/_____/_____ PAGE:_____OF_____

V. **Signatures:**

Participant's Printed Name/Role	**Signature**	**Agency**	**Agree**	**Disagree***	**Time Spent**
Individual					
Parent/Legal Rep.					
Service Coordinator					
Physician/RN					
Psychologist					
Social Worker					
Advocate					
Day Program Supervisor					
QIDP					

*** IDT Member has disagreed with the IPP; rationale for disagreement is attached.**

VI. **RATIONALE FOR DISAGREEMENT WITH IPP:**