Pennsylvania
Department of Human Services

# INDIVIDUAL SUPPORT PLAN SIGNATURE FORM

MCI #: Name:

**PURPOSE:** This Office of Developmental Programs (ODP) Individual Support Plan (ISP) Signature Form (revised 4/2024) is required to be completed during the following:

- Initial ISP meetings
- Annual Review Update ISP meetings
- Team meetings regarding service changes that result in a critical revision to the ISP

Note: For individuals enrolled in the Adult Autism Waiver, please use the AAW Individual Support Plan Signature Form.

## INSTRUCTIONS FOR COMPLETING THE ISP SIGNATURE FORM

**At the conclusion of the meeting, the individual and ISP team members should complete the ISP Signature Form.**

- It is essential for the individual to attend their meeting whenever possible. Each person who attends the meeting, including the individual, should sign and date the signature column across from their name and complete the title, agency, and relationship to individual sections on the ISP Signature Form. Electronic signatures are permissible for the completion of the form.
- If the individual, surrogate, or any other invited ISP team member chooses not to attend, the Supports Coordinator (SC) should list that person on the form, and note that they were absent.
- If the individual attends the meeting but chooses not to sign or is unable to sign the form, the SC must indicate this on the form, on the line designated for the individual's signature.
- If the individual did not attend the meeting, the SC must review the results of the meeting with the individual as soon as possible and have the individual sign the form, noting the date that the review was held.
- If the individual is under the age of 18 and/or has a legal guardian, the individual does not have to sign the form, but should be given the option. The individual's parent or legal guardian is required to sign.
- If the individual, the individual's parent, legal guardian, or any ISP team member disagrees with the content of the ISP, they must sign at the designated content objection section at the bottom of the signature page, and then the SC will elevate the disagreement to the Administrative Entity (AE) for resolution.

The table below contains information in the "Response indicates:" column that supplements the statements in the "Acknowledgements & Attestations" column. The SC should use this information to thoroughly explain each statement to the individual/surrogate prior to indicating their provided response in the appropriate response column. This table must be completed by the SC. The SC will attach a copy of the completed ISP Signature Form to the ISP and send it to everyone who was invited to the ISP meeting, including those who did not attend. For providers, the SC need only send a copy of the ISP Signature Form, since providers can access the ISP electronically.

| Acknowledgements & Attestations | Response indicates: | Yes | No | N/A |
|---|---|---|---|---|
| 1. I participated in my ISP meeting. | The individual did participate in the ISP meeting. If the individual did not attend their meeting, the individual needs to sign this form to indicate when the SC reviewed the results of their meeting with them. | ☐ | ☐ | |
| 2. An interpreter was present if needed. | If the individual needs an interpreter, one was present. N/A indicates the individual does not need an interpreter. | ☐ | ☐ | ☐ |
| 3. My ISP team and I reviewed my current Supports Intensity Scale - Adult Version (SIS-A®) Summary Report during this meeting. | The individual's SIS-A® Report was used during the ISP meeting. N/A indicates the individual has not had a SIS-A® completed. | ☐ | ☐ | ☐ |
| 4. I have selected and agree with the identified services and qualified providers identified in my ISP. | The individual agrees with identified services and chosen qualified providers reflected in their current ISP. | ☐ | ☐ | |
| 5. I have selected and agree with the settings in my ISP and understand that I can choose to receive services in non-disability specific settings. | The individual agrees with identified settings reflected in their current ISP and understands the non-disability specific settings available to them. | ☐ | ☐ | |

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MCI #: Name:

| Acknowledgements & Attestations | Response indicates: | Yes | No | N/A |
|---|---|---|---|---|
| 6. I agree: | | | | |
| a) To comply with all centers for Medicare and Medicaid services and ODP requirements, e.g. SC individual monitoring frequency and location requirements, reevaluation, SIS-A®, etc. | The individual agrees to comply with all requirements. | ☐ | ☐ | |
| b) To receive Targeted Support Management (TSM). | The individual agrees to participate in TSM. N/A indicates the individual is enrolled in a waiver or is not MA eligible. | ☐ | ☐ | ☐ |
| c) With the goals in my ISP. | The individual agrees with all goals identified in their ISP. | ☐ | ☐ | |
| 7. I have been informed of: | | | | |
| a) My fair hearing and appeal rights and the department's fair hearing and appeals process for my approved Home and Community-Based Waiver Services (HCBS) or TSM. | The individual was informed of their fair hearing and appeal rights and the department's fair hearing and appeals process. N/A indicates the individual is receiving base-funded services. | ☐ | ☐ | ☐ |
| b) My fair hearing and appeal rights and my county program's appeal process for my base-funded services. | The individual was informed of their fair hearing and appeal rights and their right to appeal with their county program. N/A indicates the individual is receiving HCBS. | ☐ | ☐ | ☐ |
| c) My right to choose a qualified provider and supports coordination organization at any time. | The individual has been informed of their choice of qualified providers, including SCOs. | ☐ | ☐ | |
| d) My right to choose from the types of services that are available to me. | The individual has been informed of their right to choose from the types of services available to them. | ☐ | ☐ | |
| e) My right to request a change in my services at any time. | The individual has been informed of their right to request a change in their services at any time, due to changes in assessed need. The ISP must be updated, approved, and authorized if changes occur. | ☐ | ☐ | |
| f) Competitive integrated employment and options for supported employment, advanced supported employment, and benefits counseling services. | The individual was informed of options for supported employment, advanced supported employment, and benefits counseling services by their SC. (There are resources available to SCs to support conversations about employment at https://home.myodp.org/employment/supports-coordinatorsofconsolidated-pfdscommunity-living-waivers/.) N/A indicates the individual is less than 14 years of age. | ☐ | ☐ | ☐ |
| g) Options to self-direct my services. | The individual has been informed about options to self-direct, regardless of their current living arrangement. | ☐ | ☐ | |
| h) My SC will provide a copy of my ISP to the persons and/or agencies listed on this form. | The individual was informed that copies of their ISP will be provided to all ISP team members, by their SC. Providers having electronic access shall obtain the ISP electronically and only receive a copy of the ISP Signature Form from the SC. | ☐ | ☐ | |

# INDIVIDUAL SUPPORT PLAN SIGNATURE FORM

MCI #:

Individual's name: _____ Type of meeting: ☐ Initial ISP Meeting ☐ Annual Review ISP ☐ Team Meeting

Date of meeting: _____ Annual review update date: _____

Signature or mark of individual or surrogate/legal representative: _____ Relationship: _____

Signing this form below certifies that you attended the ISP meeting and you agree with the discussion, including the the responses to the acknowledgments and attestations.

| PRINTED NAME | TITLE, AGENCY, AND RELATIONSHIP TO INDIVIDUAL | SIGNATURE AND DATE |
|---|---|---|
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If individual did not attend their meeting, the individual needs to sign below to indicate when the SC reviewed the results of their meeting with them:

Signature of individual: _____ Date: _____

Anyone disagreeing with the discussion held during this meeting, please sign below. Resolving content objections is the responsibility of the AE and resolution should not delay service authorizations.

| Printed Name | Title, Agency, Or Relationship To Individuals, If Applicable | Signature and Date |
|---|---|---|
| Printed Name | Title, Agency, Or Relationship To Individuals, If Applicable | Signature and Date |