pennsylvania
DEPARTMENT OF HUMAN SERVICES

ADULT AUTISM WAIVER
INDIVIDUAL SUPPORT PLAN SIGNATURE FORM

PURPOSE: The Supports Coordinator (SC) is responsible to complete the Adult Autism Waiver ISP Signature Form during the following:

- Initial ISP meetings
- Annual Review Update ISP meetings

INSTRUCTIONS FOR COMPLETING THE ISP SIGNATURE FORM

At the conclusion of the meeting, complete the ISP Signature Form.

- All boxes at the top of the page should be completed by the SC.
- If the participant agrees to the changes discussed at the meeting, the participant will check Yes and sign and print his/her name. If the participant has a representative, he/she should also sign and print his/her name along with listing his/her relationship to the participant.
- The SC shall assist the individual or representative to place their initials in the initials box to confirm that statements 1-14 are true. The SC is responsible to ensure that each of the 14 listed statements are true and have occurred during the ISP meeting. If the participant and/or representative feels that any of the statements are not true, the participant and/or representative shall not initial it and shall complete the "Note" on Page 2.
- Please include any updates to the participant's demographic information at the bottom of the page and incorporate that information to the Demographics section of the participant's ISP.
- The SC should use the information below to thoroughly explain each statement to the participant and/or representative prior to asking them to place their initials in the initials box.

QUESTIONS FOUND ON THE ISP SIGNATURE PAGE	DESCRIPTION
1. I attended and led my ISP meeting, where possible.	It is essential for the participant to attend and lead, where possible, his/her own meeting; do not just defer to parents, guardians, representatives, etc., unless the participant requests it. If the participant is unable to lead their own ISP meeting, please document the reason in a service note. If the participant did not attend their meeting, the participant needs to sign this form to indicate when the SC reviewed the results of their meeting with them.
2. My ISP team includes people that I have chosen.	The participant's ISP team should only include people that the participant chose.
3. An interpreter was present, if needed.	If the participant needs an interpreter, one was present. N/A indicates the participant does not need an interpreter.
4. My ISP team and I reviewed the assessment results during the ISP meeting.	The assessment results should be reviewed by the SC during the ISP meeting and incorporated into the ISP.
5. I have been informed of the right to select a qualified and willing provider (including Supports Coordination Organization) at any time.	The SC is responsible to inform the participant of free choice of all willing and qualified providers, including Supports Coordination Organizations. The SC is responsible to ensure the participant has access to the list of qualified providers. If the participant does not have access to the list the SC must provide a copy of the statewide list of all qualified providers to the participant.
6. I have been informed that I have the right to receive the services on my ISP and the right to choose when, where, and how to get those services.	The participant has the right to choose the time, location, and how they get their services.
7. I have been informed about Participant Directed Services (PDS).	The SC should inform the participant about the opportunity to direct their services through PDS by explaining the basics of PDS services and the ability to change their mind at any time during the process. The SC should ask the participant if he/she is interested in learning more about the PDS services and choices. If interested, the SC should get a release signed and make the referral for PDS services.

8. I have selected and agree with the identified services and providers (both paid and unpaid) identified in my ISP.	The SC has ensured that the participant agrees with the identified services (both paid and unpaid) and providers reflected in his/her ISP.
9. The services in the waiver have been reviewed and explained to me, including employment services that may lead to competitive integrated employment.	The SC is responsible to ensure the participant is aware of and understands the types of services that are available in the Adult Autism Waiver (AAW) and has been offered employment services that may lead to competitive integrated employment. Here is a resource available to SCs to support conversations about employment on: PA Pathways to Employment Tool 1-29-21 – MyODP
10. I agree with the goals in my ISP.	The individual agrees with all goals identified in their ISP.
11. My rights were reviewed and explained to me and my designated representative(s), and I received a copy of my rights. This includes 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).	The SC is responsible to review the rights with the participant as part of the ISP meeting. Hand them a copy of the rights and inform them that this document can also be found in the AAW participant handbook. The individual was informed of their fair hearing and appeal rights and the Department's fair hearing and appeals process.
12. My responsibilities were reviewed and explained to me and my designated representative(s). My responsibilities include complying with all Centers for Medicare and Medicaid Services and the Office of Developmental Programs requirements, e.g., SC individual monitoring frequency and location requirements, and reevaluation.	The SC is responsible to review the participant's responsibilities as part of the ISP meeting and inform them that this document can also be found in the AAW participant handbook. The SC should explain or make sure the participant knows the importance of maintaining eligibility in order for services in the ISP to be provided.
13. My HIPAA rights were reviewed at this meeting. I was made aware that I can change my current HIPAA release form at any time.	The SC is responsible to review this information with the participant/representative and ensure the participant understands the importance of keeping his/her release up to date: HIPAA mandates certain standards and practices with regard to the privacy of consumer health information. The law requires BSASP to obtain written permission before BSASP uses or releases medical and certain other information. Participants have the right to see and copy his/her health information, to correct or add information, to receive a list of where his/her protected health information has been sent, to ask BSASP to restrict the use and disclosure of his/her protected health information, and to request BSASP to communicate with him/her in a certain way or at a certain location. The participant may change his/her current HIPAA release form at any time.
14. I have been informed that I may request updates to my ISP at any time.	The SC is to inform the participant/representative of the right to update the ISP at any time.

If the participant (or his/her representative) does not initial any of the boxes following statements 1-13, the "Note" box on page 2 of the form must be completed.

Each person who attended the meeting should print their name, title, agency, and relationship to the participant; phone number and/or email address; sign and date their signature and date column; and check that he/she attended in person on the signature page. If a team member joined by phone, the SC should print that team member's name, title, agency, and relationship to the participant, and check off that the team member joined by phone.

The SC will attach a copy of the completed ISP Signature Form to the ISP and send to all team members who do not have access

to the ISP in the system within 14 days of its approval and authorization, in a manner chosen by the team member. The SC will send only a copy of the ISP Signature Form to providers who have access to the ISP in the system.

Note: The SC is responsible to fully document the ISP meeting details, as well as the completion of this form, in a service note.

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Name of Participant: _____ Date of meeting: _____

SC Organization: _____ SC Name: _____

Type of meeting: ☐ Initial Plan ☐ Annual Plan

I agree to the changes to be made to the ISP as discussed in the is meeting: ☐ Yes ☐ No

Participant's Signature: _____ Print Name: _____

To be completed if a person other than the Participant signs the form:

Representative's Signature: _____ Print Name: _____

Relationship to Participant: _____

FOR THE PARTICIPANT OR REPRESENTATIVE

Please initial to confirm that these statements are true:

	INITIALS
1. I attended and led my ISP meeting, where possible.	
2. My ISP team includes people that I have chosen.	
3. An interpreter was present if needed.	
4. My ISP team and I reviewed the assessment results during the ISP meeting.	
5. I have been informed of the right to select a qualified and willing provider (including Supports Coordination Organization) at any time and have been given a list of qualified providers.	
6. I have been informed that I have the right to receive the services on my ISP and the right to choose when, where, and how to get those services.	
7. I have been informed about the opportunity to direct my services through Participant Directed Services in the Bureau of Community Services.	
8. I have selected and agree with the identified services and providers (both paid and unpaid) identified in my ISP.	
9. The services in the waiver have been reviewed and explained to me, including employment services.	
10. I agree with the goals in my ISP.	
11. My rights were reviewed and explained to me and my designated representative(s), and I received a copy of my rights.	

FOR THE PARTICIPANT OR REPRESENTATIVE

Please initial to confirm that these statements are true:

	INITIALS
12. My responsibilities were reviewed and explained to me and my designated representative(s).	
13. My HIPAA rights were reviewed at this meeting. I was made aware that I can change my current HIPAA release form at any time.	
14. I have been informed that I may request updates to my ISP at any time.	

Note: If any of the Initials boxes for statements 1-14 above are blank, complete the following:

I do not agree with numbers _____ listed above and will have/had the opportunity to discuss them further.

_____ Participant's Initials

Please include any updates to the participant's demographic information:

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Other ISP Team Member Attendees:

All other meeting participants must be indicated here. Use second form to accomodate additional attendees, if needed.

PRINTED NAME	TITLE, AGENCY AND RELATIONSHIP TO INDIVIDUAL	PHONE NUMBER AND/OR EMAIL ADDRESS	SIGNATURE AND DATE	PARTICIPATION
				☐ In Person ☐ By Phone
				☐ In Person ☐ By Phone
				☐ In Person ☐ By Phone
				☐ In Person ☐ By Phone
				☐ In Person ☐ By Phone
				☐ In Person ☐ By Phone
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