

Individual Support Agreement Guidelines

	PAGE
I. Introduction	1
Who is Involved in Writing Your Individual Support Agreement	3
II. Sharing Information	
Your Personal Goals and Dreams	4
Your Story	6
Assessments	7
III. Individual Support Agreement	
General Information	7
Supports Received	11
Individual Support Agreement Approvals	18
IV. Reviewing Your ISA	19
V. Changing to Your ISA	20
VI. Extending Your ISA	21
VII. Terminating Your ISA	22
ISA Basic Form	
ISA Picture Form	
ISA Required Approvals Form	
ISA Review Form	
ISA Change Form	



INDIVIDUAL SUPPORT AGREEMENT GUIDELINES



I. INTRODUCTION

An Individual Support Agreement (ISA) is a document that tells about your services and supports. It is an agreement between you, your guardian (if you have one) and your provider(s). If you are managing some or all of your supports, you are still required to have an ISA. This agreement addresses YOUR needs that you, your Designated Agency and others have prioritized through a process that helps to identify your needs for support.

The agreement describes what you expect to be different in your life as a result of receiving Medicaid supports funded by the Division of Developmental Services (DDS). It also describes HOW you wish to be supported and what your responsibilities and your provider's responsibilities are to make the plan work.

If you self- or family-manage your services you must also have a separate agreement that outlines what you can expect from your Designated Agency and what your responsibilities are.

NOTE: Before any supports are provided, you must first be found eligible to receive services. Next, you and your Designated Agency (DA) figure out what your needs are, what can be paid for and then what your funding limit is. (Talk to your DA for more information about this.)

INFORMATION IN THIS COLUMN WAS DEVELOPED TO ASSIST PEOPLE WHO ARE SUPPORTING AN ADULT WITH DEVELOPMENTAL DISABILITIES OR A FAMILY WHOSE CHILD HAS DEVELOPMENTAL DISABILITIES TO THINK THROUGH AND UNDERSTAND THE ISA GUIDELINES. THIS INFORMATION IS INTENDED TO SUPPLEMENT AND CLARIFY THE INFORMATION IN THE LEFT HAND COLUMN AND SHOULD ALWAYS BE USED IN CONJUNCTION WITH THE INFORMATION ON THE LEFT.

NOTES FOR PEOPLE HELPING WITH THE ISA:

If a person chooses to self- or family-manage their supports and hire an independent QDDP, the Designated Agency is still responsible for providing some level of oversight. The level of oversight provided, and the fee for providing this, must be discussed with the person. The DA or SSA is responsible for developing a "self-management agreement" between the person self- or family-managing and the DA/SSA. Even if the person chooses to have little or no Designated Agency contact, the Division of Developmental Services has some minimum requirements.

Not all of an individual's needs may be funded through DDS. Informal supports as well as other sources of support (paid and unpaid) need to be taken into consideration.

Your Individual Support Agreement:

- ◆ is developed by you and your circle of support;
- ◆ identifies how you expect to be supported to meet your needs;
- ◆ is based on your wishes for your own future; and,
- ◆ is flexible and personalized so you can be creative with how you are supported and how you and your support people can tell how things are going.

The reasons you need an Individual Support Agreement are to:

- ◆ make sure your support people understand what you expect from the supports you receive;
- ◆ make certain your supports meet your needs;
- ◆ help you plan for supports, help support people know what they must do to support you and when; and,
- ◆ make sure the State and Federal money spent on supports you receive is spent correctly. All supports Medicaid pays for through the Division of Developmental Services must be included in your ISA.

Please note there may be other State or Federal regulations you need to be aware of other than these guidelines.

NOTES FOR PEOPLE HELPING WITH THE ISA:

The individual is receiving a funded area of support for a reason. The need that has been identified must be addressed within the ISA. Most needs are addressed as outcomes. While the ISA is person-centered, that does not mean that the circle of support or team should not include skill development outcomes to address the needs. These will, in turn, enable the individual to increase his/her independence in the home and community.

If a support is provided through DDS funding (i.e., Medicaid waiver, targeted case management; ICF/MR, clinic and rehabilitation, including nursing day rehabilitation), it must be included in the ISA. Individuals/families who only receive Flexible Family Funding do not require an ISA.

Who is involved in writing your Individual Support Agreement?

You can invite anyone you choose to help write your plan. You may invite family members or friends or support workers. If you have a guardian, your guardian will usually be part of the planning process and part of your circle of support.

- ◆ A guardian is someone appointed by a court for a person. A court appoints a guardian if it finds that the person cannot make certain major life decisions for himself/herself.
- ◆ If a guardian is appointed for you, the court tells the guardian what major life decisions to help you with. In those areas listed by the court, the guardian has a responsibility to the court and to you to be involved with all decisions. In all other areas, the guardian should be involved only if you ask him or her for help.
- ◆ If you are not sure about what responsibilities a court has given the guardian, ask your guardian or someone else to go over the court order with you.
- ◆ The role of a guardian is to assist and empower you to make decisions for yourself. A guardian also encourages you to be as independent and responsible for yourself as possible. The guardian should listen to your opinions, and help you tell others what you think. The guardian should make sure other people listen to you and think about what is best for you. The guardian should make sure that any decisions are respectful of what you like and what you don't like and what you want in the future. The guardian will be working with you and others to be sure that plans and decisions are safe and fair for you and others. If sometimes you are not able to make a decision, the guardian will go ahead and make the decision. If the guardian makes the decision, the guardian should always try to think about what you would want to do if you were making the decision.

NOTES FOR PEOPLE HELPING WITH THE ISA:

It is important to verify if a person has a guardian; guardianship should not be assumed. People who have not been appointed by the court to be a person's guardian should not be treated as though they have been with respect to making decisions on behalf of the person. Family members do have a role in supporting the individual to make decisions, as the individual chooses.

- ◆ Sometimes a person doesn't get along with a guardian. If you would like a different guardian, you can usually get a change. Usually it helps to tell your guardian you want a change; many guardians will help you get a new guardian if they know this is what you want. If you have a State Guardianship Services Specialist for a guardian, you can ask the guardian's supervisor for a change. If you have a private guardian (such as a family member) you must ask the court for a change. The Vermont Disabilities Law Project can help you do this.
- ◆ If you don't think you need a guardian any more, you can ask the court to end the guardianship. You can ask the Vermont Disabilities Law Project to help you. Sometimes the court will be willing to end the guardianship, and sometimes the court will decide you still need a guardian. Sometimes you would like your guardian to keep helping you even if the person is no longer your guardian. Most guardians are willing to do this.

II. SHARING INFORMATION

In order for others to do their very best to support you, you may need to share personal information about yourself. Remember that you only have to share what others need to know so they can help.



A. Your Personal Goals and Dreams:

It is important that you keep in mind what you want to do with your life. You should be encouraged and supported by the people around you to make those dreams come true.

If you need help thinking about your dreams and what you need to reach them, there are plans available to help you. You may have heard of some of them like MAPS or PATH. You may wish to use one of these planning processes with the help of your friends and family. You may already have some very good ideas about what you want without using one of these. Either way, you should be able to answer the following questions BEFORE you develop an ISA. You should review your goals as you reach them or as your dreams or needs change.

- ◆ What do you want? What are your goals and dreams for your future?
- ◆ What do you need?
- ◆ What supports are necessary for meeting your goals/dreams?
- ◆ What supports are available to you now or do you have access to now?
- ◆ How can a support person help you meet your needs?
- ◆ What characteristics or skills must a support person have?
- ◆ How will you know when supports are working?
- ◆ Who do people talk to in order to get answers to these questions?

YOU ARE NOT REQUIRED TO SHARE THE ANSWERS TO ALL OF THESE QUESTIONS WITH OTHERS. YOU ONLY NEED TO SHARE INFORMATION THAT OTHERS NEED TO HELP YOU WITH SERVICES AND SUPPORTS. IF YOU HAVE A GUARDIAN, THE AGENCY ALSO NEEDS TO GET YOUR GUARDIAN'S PERMISSION TO LOOK AT PRIVATE INFORMATION ABOUT YOU.

NOTES FOR PEOPLE HELPING WITH THE ISA:

A person-centered planning process is critical and required for the development of a quality ISA. The process is flexible. It can be accomplished through a formal process such as MAPS, PATH, or Futures Planning. Or, the needed information can be gathered informally by asking the person and those who know the person best. What is vital is that the information is obtained from the individual and those who know the person best.

Either way, in addition to the questions on the left, it is important to think about:

- What does the person really enjoy doing?
- How can that area of interest be further developed or expanded?
- What skills are important for the person to learn?
- How does this person spend their day/week?
- Ideally what would the person want their day/week to look like?
- Is there anything non-negotiable that the person must have in their day or week?
- Is there anything they used to do that they would like to start again?
- How does the person see their future? What will things look like in three years, five years and how do we get from here to there?
- Are there opportunities to connect with non-paid relationships?
- What does the person do already and how can these skills and talents be expanded? What are the next logical steps?
- What don't you know about this person?

B. Your Story:

It may be necessary for support people to have even more information about you than what your needs and dreams are. Each of us is who we are, in part, because of our histories. You or your provider needs to put some things down in writing so that important information is considered as you receive supports.

These are important things for people to know: things about when you were a baby; your family; your schooling; the places you have lived; important people in your life; and other important life events. Other supports you already have that are not funded through the Division of Developmental Services (DDS) should be listed so supports can be well planned and coordinated.

What you need to know: ***This information needs to be documented within sixty (60) calendar days of the first day you receive paid supports. The information needs to be updated whenever important events happen in your life and should be reviewed with you at least once a year. If you are managing some or all of your supports, keeping this information updated may be your responsibility. Your story and any updates to it need to be signed and dated by the person who wrote it.***

NOTES FOR PEOPLE HELPING WITH THE ISA:

The Person's Story is their history! It is based on information that the person, his/her guardian and significant others are willing to share. Certain things should be considered. They are:

- Significant childhood developmental milestones, including a pre-natal and birth history.
- The family's history, including information about siblings and the family's medical history.
- Significant events in the person's life, both good and bad, including medical events.
- Educational experiences and schools that the person attended.
- The most important people and significant relationships in the person's life, including who the person stays in touch with.
- Natural supports the person has already established.
- Summary of supports/services that the person has received in the past (e.g., home, community, employment supports).
- Anything the person feels that others should know about (e.g., "I love baseball").

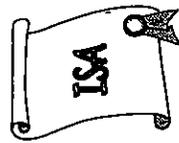
Consider including first-hand accounts of memories and experiences. In some cases the person may want to either dictate or write their own story, which is encouraged. If the person wishes to withhold information about some personal area, his/her privacy should be respected. However, questions about the above areas should still be asked.

The Person's Story must be updated at least annually, or sooner if significant events occur during the year (e.g., move to a new home; illness, hospitalization, loss of family, etc.). The annual update does not require re-writing the entire story; it is adding to it. **Both the Person's Story and the Person's Story Update must be signed and dated.**

C. Assessments:

You may arrange for special assessments if you or your circle of supports thinks it would be helpful for support planning (e.g. communication, employment, PT/OT assessments, etc.). If you are new to services or during transition times (first grade, school to adult life) the DA is required to arrange for some specific assessments to determine if you are eligible or continue to be eligible for services.

What you need to know: *Other than noted above, it is your responsibility and that of your circle of support to determine the focus and frequency of assessments and evaluations.*

III. INDIVIDUAL SUPPORT AGREEMENT (ISA)

YOU need to be thinking about what you want in your ISA before it gets written. You may get help from anyone you want and may even write up your own ISA.

There is certain information that needs to be included in the ISA. DDS has two suggested ISA forms you can use (see ISA Basic Form and ISA Picture Form); however any form may be used so long as the following things are present and it is simple and clear to understand:

A. General Information:

1. Your name.
2. The name of your Designated Agency (the place where the money is approved).

NOTES FOR PEOPLE HELPING WITH THE ISA:

Special assessments are determined by the individual's needs; however, assessments to determine eligibility are required at the time of original application and during specific transition times (first grade, school to adult life) and are the responsibility of the DA. It is also the responsibility of the DA to perform or arrange for certain assessments if, at any time there is reason to believe the person may no longer be eligible for services.

People are not required to use any specific form whether it is the State forms or provider forms. However, the required elements need to be clearly present and legible.

3. **The names of all agencies providing you supports and services.** This may be your designated agency, specialized service agency or another agency. If you are self- or family-managing your services, state this here.

4. **Both the beginning and end dates of the ISA term.**

What you need to know: (1) The length of time that any agreement can be in effect may not be greater than one year. (2) Paid supports do not begin until an ISA is in place. (3) The ISA should always be followed as written.

There is only one exception. In the case of a crisis situation, you may receive immediate support. However, an ISA or a change to your existing ISA must be developed within thirty (30) calendar days either from the first day of billed supports (if you are new to services) or from the onset of your crisis (if you were already receiving DDS funded services). This will assure you get the critical supports you need when you need them even if they have not been planned for.

5. **A brief description of your life goals and dreams** so support people can do their best to help you reach those goals. The supports described in your ISA may include some of these goals if they relate to the needs your DA has identified for funding.

What you need to know: Though you may have many dreams and needs, it is probable not all of them will be (or should be) funded through DDS. Your ISA must address all the identified needs that meet the System of Care Plan funding priorities. However, you, and whomever else you include, decide HOW your supports will look.

NOTES FOR PEOPLE HELPING WITH THE ISA:

If the current ISA needs to be extended, please refer to page 21.

This description is derived from the person-centered planning process noted previously. Some people, when asked, may not be able to identify personal goals or dreams for their future because of limited experience, a learned unwillingness to take risks, or other reasons. In such cases you may wish to consider helping the person explore their world, develop interests, broaden their experiences or acquire confidence in their decision making skills in order to make knowledgeable decisions.

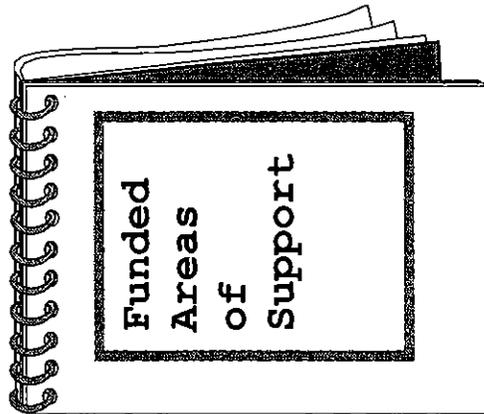
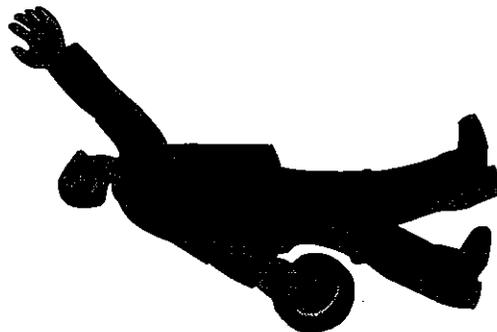
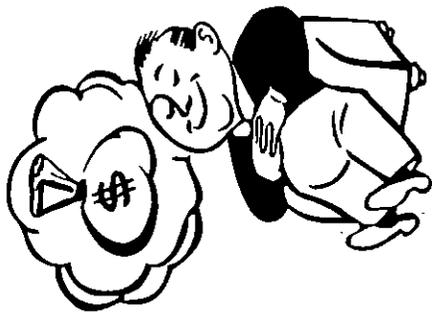
It is critical to understand what each dream means to the person. Ask questions that help everyone understand the dream and how it can be translated into reality. For example, someone's life goal or dream may be to become a movie star, live in town on their

NOTES FOR PEOPLE HELPING WITH THE ISA:

own, run a business, or obtain a driver's license. Being a movie star may mean that they want to be in a local play, be accepted and applauded, be popular, have nice clothes, or have money to do things, etc. Another example is that the dream of continuing to live with the Smith's might be translated into what the person values about living with the Smith's as well as what they are afraid of risking. It is important to honor the dream and take steps to help realize the dream.

Use the person's words to describe his/her dreams and goals whenever possible. When this is not possible, an individual who knows the person well may describe what they believe the person's dreams and goals might be based on their understanding of the person. This is the person's wishes for him or herself, not a projection of what or who other people would like the person to become. Use the first person when it is the person's actual words (e.g., "I want..."). If explanations of the person's words are needed, italics may be used to help identify this information. If it is someone else's words, indicate so ("Because Harry has a big grin when he gets his paycheck, Harry's best friend, Sam, believes that he likes...").

As you help the person explore their goals and dreams, keep in mind their needs assessment and funded areas of support. Because something is identified as a goal and dream does not necessarily mean that support for obtaining this will be funded with DDS funding. For example, people may state a desire to have a large screen television or to vacation in Aruba. This could be included in Personal Goals and Dreams; however it will not be funded. That does not mean that the person cannot be assisted through supports to attain the dream. For example, if someone is funded for employment supports he or she can receive assistance with budgeting their paycheck to save for the above items. Dreams or needs identified by the person that are not funded areas of support



6. The name of the **person to contact** so support people can learn about your personal life goals and dreams. In most cases this would be you. However, you may wish to name someone else who knows you very well.

7. The **funded areas of support** (e.g. home supports, employment supports, community supports etc.). These are the different types of support and the amount of money the DA estimates your supports will cost.

What you need to know: The DA has made these determinations through an assessment of need, reviewing the System of Care Plan funding priorities, and their professional experience in setting and managing budgets. If you disagree with their assessment, you may appeal the determination of your needs, but not the dollar amounts. If you need more information about the appeals process, please ask your DA.

8. Your **Authorized Funding Limit**. This is the total dollar amount from the funded areas of support, plus a share of administration, that you have to spend on your personal services. It is not the waiver budget, which may include other items that benefit everyone receiving services like the Vermont Crisis Intervention Network, or local crisis services.

can be included, but it should be clearly identified that it is not a funded area.

It may be helpful for the input of the circle of support or team to be included in this section. For example, "The team believes Alice would benefit from learning more effective ways to express her feelings."

The intent here is to have a contact person, if someone is unclear about or needs more information about the person's dreams and goals. Typically, this would be the person or someone else they trust to express their thoughts.

Indicate the funded areas of support and whether they are funded by waiver, fee-for-services (e.g., clinic, rehab., TCM, Medicaid transportation) or ICF/MR. The funded areas of support must be consistent with the person's authorized funding limit. There should be one or more of the following funded areas of support [list dollar amount and general amount of each service (e.g., 20 hours/week) for each or attach a separate sheet]:

- Service Planning and Coordination
- Community Supports (goods* and services)
- Employment Services (goods* and services)
- Respite (individual only)
- Clinical Interventions
- Crisis Services (individual only)
- Housing and Home Support (goods* and services)
- Transportation
- Administration

*Goods – Specify what these funds are purchasing (e.g., communication equipment; home modifications; accessible transportation, etc.). Goods are only funded in the areas of Community Supports; Employment Services; Housing and Home Supports and Administration. There is a limit of \$3,000/year or 25% of the person's waiver budget, whichever is less. Exceptions may be made for home modifications for physical accessibility and accessible vans.

NOTES FOR PEOPLE HELPING WITH THE ISA:

B. Supports Received:

1. **Describe what you expect to be different or expect to continue as a result of receiving supports.** What do you expect to accomplish or to be accomplished from the supports in your ISA? Do you expect to learn something specific, have any changes in your life as a result of supports, be safe, be employed, etc.?

What you need to know: *These expectations must be related to the identified needs that qualify you to receive services and to your funded areas of support. If you are not sure what these are, ask your DA for the information.*

NOTES FOR PEOPLE HELPING WITH THE ISA:

Note: Identified expectations or outcomes must be related to funded areas of support.

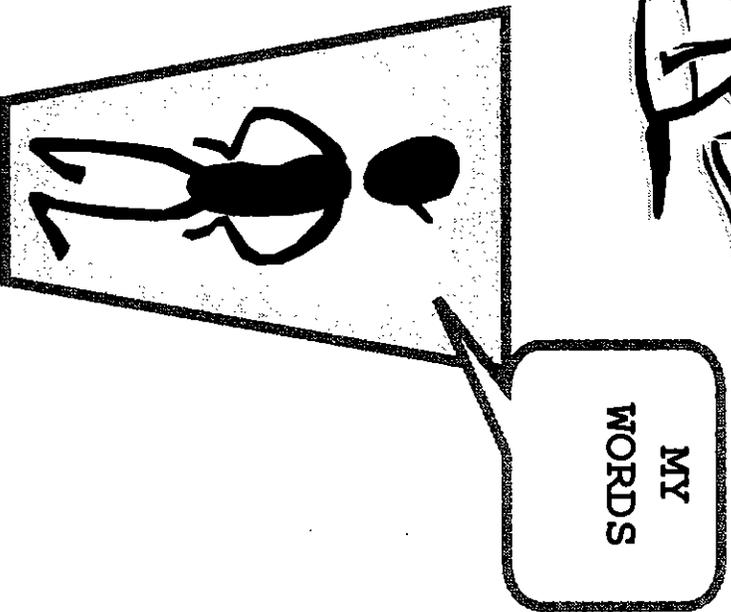
Expectations are **outcomes** or results that people would like. What are the outcomes that people want, can or should accomplish this year? State the expected outcomes of the supports received. An outcome is a clear statement of how the person's life will change or what will happen in the person's life as a result of supports. This is not about the service (e.g. Sally will receive 10 hours of respite), but about what the person will achieve in his/her life. What will happen this year as a result of getting this support? It should be about growth that the person will strive for this year, skills learned, changes in the person's life such as obtaining a job, developing a relationship, or finding a new home.

Ask questions to tease out the specifics of the stated request that make the wish or goal important for that person. Outcomes are meaningful, personalized and specific. Outcomes should be related to what is explained in the Summary of Goals and Dreams and Funded Areas of Support. This is where person-centered planning is most valuable.

Whenever possible, the outcome should be stated in the person's words. If additional explanation is needed to indicate why the outcome is relevant for the person, this can be added in italics or parentheses.

Outcomes for maintenance may be appropriate (e.g., continue to live with the Jones') but should be used cautiously and sparingly in those instances when it is clear that this is an important goal for the person and it must reflect why the person values this. What need will be addressed? The same is true for "participation" outcomes.

Ask Questions



NOTES FOR PEOPLE HELPING WITH THE ISA:

Keep in mind the intent of services is to promote the individual's growth and independence, as well as make friends, be connected in their community, have a good quality of life. While honoring that "David" wants to continue living with his current home provider, look at skills that can be increased. Are there ways he can become more independent or more responsible at home? If "Sandy" wants to have more friends, what social or communication skills will help her accomplish this dream?

For example, outcomes related to employment may be about learning how to make a resume, have a successful interview, get to your job on your own, how to get along better with co-workers, or learn how to do the job satisfactorily. Outcomes under home support may range from learning to cook a meal (for yourself and/or the rest of the people in the home) to learning how to be more independent in doing personal hygiene, cleaning up personal space, dressing appropriately, etc. There could be outcomes about joining the "Jones" family in activities (e.g., fishing, camping, scouting, etc.) or developing new friends or interests. Community support outcomes may range from the general goals of learning how to use the post office (with details outlined in the strategy section such as writing a card to a family member, getting to the post office, buying a stamp and mailing the card). Other outcomes may center on making contacts or trying out a variety of activities to develop a hobby. Shopping for meals or clothing for a given event is also appropriate. People can have "fun" while learning. Outcomes related to respite should address the intended purpose of respite, such as giving the family a break.

2. **Define what you expect from support workers.** Describe what they do, when they do it, where they do it, and (if necessary) how they support you. Name the people who will support you.



What you need to know: These are supports and people paid through a provider or hired by you. The supports must be specific enough so that there will be no misunderstanding about your needs or expectations. For example, if you want help getting a job and you will need transportation once one is found, do not forget to include transportation as part of your support expectations.

NOTE: Both your expectations of paid supports and how people support you must be consistent with best practices and must reflect the *Guidelines for Quality Services*. This means that the way your supports are provided and what people help you with must be done in certain ways (e.g., respecting choices, training workers, background checks, etc.). Ask your provider for a copy of these guidelines if you do not already have them and ask them to explain the guidelines to you if necessary.

NOTES FOR PEOPLE HELPING WITH THE ISA:

This section describes (for each outcome) the agreed upon **support strategies** that will assist the person to achieve the outcome. There should be enough information in this section to make clear who is responsible and what they are doing, when and where this is happening, and clear, agreed upon (between the person and people helping him/her) support strategies for how support workers help the person. For example, if the outcome is that the person wants to shop for meals, strategies may look like this:

- Sally and the community support worker will meet 1 time/week on Tuesdays from 9 – 11 a.m. (or for 2 hours).
- Sally and the support worker will discuss possible meals, nutritional pros and cons, ingredients needed for the meal (those on hand and those needed to be purchased).
- The support worker will help Sally make a list and provide transportation to the store. The support worker will help Sally locate the needed items and make the purchase. Sally will be assisted in determining the necessary money to make the purchase and will pay for the items.
- Sally will be assisted by the support worker to put the food away and review how to prepare the meal.

Be as specific as needed; there should be enough information so that it is clear what support strategies are being used, who is doing this, and generally the number of hours per day and days per week that it is being provided.

Note: It is acceptable to write, "See attached plan" rather than duplicating this information in a strategy if there is an existing plan for communication, behavior support, work, etc. A separate sheet may be attached if the strategies are too detailed to list in the strategy section.

3. **Describe how you and others will know when each of your expectations are being met.** For example, will you feel differently; will the supports you receive need to change; will you have something you didn't have before such as a job; will you be doing something different or doing something in a different way; will you require less help?

What you need to know: *Feeling satisfied with supports is important and an okay way to say that things are going well. However, in most instances you should describe another way in which you and others can determine if supports are going okay. The reason is that someone can be very satisfied with his or her support person and even with what they do together, without getting any closer to meeting the expectations of the person's ISA.*

4. **What information needs to be gathered, and how often, to know if this is happening? How is this documented? Who is responsible for doing this?**

What you need to know: *Two of the reasons why an ISA is necessary are: 1) to make certain your supports are meeting your needs and; 2) to make sure state and federal money is appropriately spent on your supports. Both reasons require documentation of some kind.*

For example, if your expectation is to be more independent and you decide that you are becoming more independent by managing your money on your own when you once needed help; do support workers write what's happening every month when you pay your bills or each time you go to the bank?

NOTES FOR PEOPLE HELPING WITH THE ISA:

How will support workers and the person know that the outcome has been achieved or that you are on the way to achieving the outcome? What specific indicators let the person know that this has occurred or he/she is moving in the desired direction? The person and the support team jointly define this. An indicator for the example on the previous page may be that the person is starting to pick out the shopping items for him/herself and can identify 2 or 3 appropriate meals for lunch or dinner.

There should be indicators for each outcome that are concrete and specific enough to allow progress to be evaluated and to determine when the outcome has been achieved.

Indicators must be more specific than "will be happy, satisfied". For example, if the outcome is that the person wants to make more friends, indicators might be that someone sleeps over at the person's house periodically, that they have another person that they go to the movies with, that people call them up to invite them out, etc.

How information is collected is flexible as long as it is agreed upon. Examples may include videotaping or photographing the achievement of the outcome (moving into new home), a narrative note, data (number of hours worked), a calendar of what the person did, etc. How often this information is collected and who is responsible for documenting the information also needs to be noted in this section.

Please note: "fee for service billing" has its own documentation requirements (Targeted Case Management, Clinic, Rehabilitation, and Medicaid Transportation Services).

5. **Decide how often a Qualified Developmental Disabilities Professional (QDDP) should review the information collected on each of your expectations to determine if supports are working.**

*What you should know: These reviews need to happen often enough to know if supports are meeting your expectations. The frequency of review will naturally depend upon the amount of time necessary to see results from supports; **this is more often than once a year.** Often a monthly review schedule is convenient to keep track of whether services are meeting your expectations.*

The QDDP cannot be you, your parent, step-parent, guardian, spouse, domestic partner, or a person you live with who gets paid (like your home provider). Please ask your designated agency or specialized service agency for assistance in identifying the most appropriate person to do this.

6. **Name the person responsible for coordinating and monitoring your ISA.** State how often your entire ISA should be reviewed.

*What you should know: This person must be someone who is a QDDP (see above). **At a minimum, the ISA is reviewed once a year prior to the start of a new ISA.** (See Section IV, page 19 for more details.)*

NOTES FOR PEOPLE HELPING WITH THE ISA:

This section asks about what information is reviewed on a regular basis to evaluate whether progress is happening toward each expectation/outcome. The time frame is stated for each expectation and should be on a time frame that is relevant for that expectation. **These reviews, and recommendations resulting from the review, need to be documented.** Reviews need to happen often enough (more than once a year) to know if supports are meeting the person's expectations.

The purpose of these reviews is to help ensure that expectations are being met. If this is not the case, the team and the person should discuss why, and what (if anything) needs to change. Are the strategies listed adequate to support the person in realizing this expectation? Is the teaching style used working? Is the expectation more than the person can accomplish within the stated timeframe? This is also an opportunity to review expectations that have been met, and to re-negotiate new or "next" expectations.

If changes are made, they should be documented through an "ISA Change Form".

This is not the same as the review of each outcome in the preceding section. Please state the name of the person and time frame (e.g. three months, four months, seven months) when the ENTIRE ISA is reviewed. This is different than a case management note. The ISA review is documented on an ISA Review Form. The ISA must be reviewed at least once during the year, prior to the start of a new ISA. Reviewing the ISA more frequently may be a good practice, depending on the complexity of the person's needs. The date that the entire document is reviewed is flexible and should reflect the ISA. For example, for a person whose ISA revolves around obtaining work and the person expects to be employed at the end of six months, it would be a good idea to review the ISA at the end of three or four months to see whether

NOTES FOR PEOPLE HELPING WITH THE ISA:

there is progress towards these expectations. It would not be a good idea to wait until the ninth, tenth or eleventh month to review the document. When ISA's are reviewed shortly before the next ISA meeting, you risk losing a whole year on a plan that may not have worked well.

Additional supports are jointly agreed upon and are not addressed as an expectation/outcome. These are things that you and the person have agreed will happen. They are specific to the individual and the supports listed. Examples include attending an IEP meeting with a person who goes to school; helping to coordinate Vocational Rehabilitation or Personal Care Services, helping to research and arrange for adaptive communication equipment, speaking with the person's landlord (on the person's behalf) or assisting someone with their SSI benefits.

This section really has three interrelated components.

A. Is the person receiving twenty-four hour home support provided and funded through the agency?

If the answer is "yes" the agency service coordinator is responsible for ensuring that health care issues are monitored, addressed, and documented in accordance with the *Health and Wellness Guidelines*. Even if others assist in parts of the process (e.g. the home provider makes medical appointments and takes the person to appointments) the service coordinator is still the person who is responsible.

B. Who is responsible for making medical decisions?

This is different than the previous question. Even if a person receives home supports they may have a guardian or may themselves be the person that is responsible for decision making about medical matters.

C. Does the person need help with medical care and monitoring? If a person does not receive twenty-four hour funded services, they may still need assistance

7. **List additional supports, services and resources your provider is expected to either coordinate or provide.** These may be things that together you have agreed will simply be expected to happen. Examples of this MAY be assisting you with grocery shopping, supporting you in your morning routines, transportation, assisting you with banking activities, etc.

8. **Name the person responsible for assuring your health needs are met.** This person may or may not be a paid individual. In fact it may be you or perhaps a family member or your guardian. If you receive home supports twenty-four hours/day from an agency, this will be your service coordinator.

Specific information that must be included within your ISA includes health supports, how often you need to have someone with you to be safe and other safety supports.

NOTES FOR PEOPLE HELPING WITH THE ISA:

in accessing health care. Describe what supports, if any, the person needs (e.g., assistance in scheduling appointments, following recommendations made by a health care provider, etc.). You may wish to list roles that various support people have.

This section asks you to specifically spell out the person's supervision needs. Generalizations such as "24/7" are not sufficient. How long may the person be left alone? In what environments – home, yard, community, car? Does someone need to be close by – outside the door, within eyesight, etc.? This section should provide helpful guidance to support workers about the person's supervision needs.

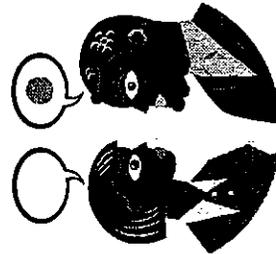
What restrictions are necessary in order to assure the person's health and safety? Some restrictions are court imposed – for example, restraining orders or specific supervision needs. Support workers and others may impose other restrictions in order to keep the person safe. For example, a person may not be allowed in the kitchen of a home unsupervised or may not be allowed to be around knives. A person may need to have door alarms, may be restricted from smoking in the house, or may need supervised phone access. As noted, the person and/or their guardian must agree and approve of the restrictions before they are in place (unless ordered by a court). If a behavior support plan is available for the person that provides information about the restrictions, information does not need to be repeated again in this section, but the behavior support plan needs to be referenced in this section and attached to the ISA. For additional information please refer to the *Behavior Support Guidelines*.

Communication is a required area that must be addressed for all individuals in their ISA. The ISA process must ask how the person communicates and how the person can be supported to increase his/her

9. **Be specific about how much of your day you need to have someone with you (paid or unpaid) to be safe.** For example, do you need someone in the same room or in the same house or reachable by phone or beeper at all times, just some of the time, etc.?

10. **Describe any specific restrictions that you have.** In order to assure your basic health and safety, your provider(s) may consult with you about whether you have or need specific restrictions or circumstances that other people may not have. Please talk to your family, guardian (if you have one), friends and providers about the necessity of all restrictions, if there are other ways of achieving the same outcome, and what the plans are to end the restrictions.

What you need to know: *If you do have any restrictions, you and your guardian (if you have one) must agree and approve of them before they are in place (unless a court has ordered them to be part of your services).*



11. **Describe how you communicate with others. Do you have a need to increase your ability to communicate?**

What should others know about how you communicate in order to understand you and help you understand others? Is there a best

way to provide information to you so that you understand the information? Tell others what they need to know about how you communicate to best understand you. For example, some people need time to think before answering a question. Some people need more time to say everything that they want to say. Some people communicate by talking, others may use a device or facilitated communication; others may sign; some may use eye contact.

Communication is tied to making decisions, to interacting with others, to letting others know how you feel, what you want and what you don't want – to being in charge of your life. Do you need to increase your ability to communicate?

Specific information about how you communicate and ways that others can help you communicate must be included in your ISA.

12. **Describe any accommodations you need.** Describe any accommodation that you need like adaptive equipment, support with walking or climbing stairs, handrails, etc.

13. **Check off any attachments that are part of your ISA.** List any formal assessments or informal letters, notes, drawings, tapes, etc. that YOU feel are relevant to your ISA. When you and your providers sign your ISA, these attachments are considered part of your ISA.

C. The Individual Support Agreement

Approvals:

You, your guardian (if you have one), your QDDP, and the agency providing your services must approve the ISA before it is official.



NOTES FOR PEOPLE HELPING WITH THE ISA:

communication skills. If needed, a plan to increase communication must be developed. Keep in mind that needs vary depending on the individual (e.g. one person may need to learn to use an augmentative device; another may need to increase her assertiveness). Communication support needs should be specified here unless they are addressed in an attached communication plan or addressed under support strategies as part of an ISA expectation. Refer to the *Communication Bill of Rights* and to the *Communication Task Force Guidelines* for best practices.

- Documents that are required to be attached to the ISA, as applicable, are the person's:
- Education Plan (IEP if attending school)
 - Communication Plan (see above)
 - Behavior Support Plan or Support Plans for Medications
 - Work Plan - a plan for supporting the person in employment
 - Special Care Procedures Plan as defined in *Health and Wellness Guidelines*
 - Other (specify)

All required approvals must be documented in order for the ISA to be implemented. All indications of approval should be obtained within thirty (30) days of the completion of the ISA. If the person is unable to sign, consider other meaningful ways that the person indicates their approval or non-approval (nodding to show agreement during meeting, refusing

What you need to know: You may indicate agreement in any way that is meaningful to you. If you indicate approval in a way other than by signature, a notation of that approval is documented. (If a minor, the individual's approval is not required; however, it is suggested for older children.)

Your guardian's signature is required if you are an adult and a court has appointed a guardian for you in any area covered by the ISA. If you are a minor, the signature of your parent or guardian is required. If you are unable to obtain your guardian's signature, efforts to obtain approval must be documented. If your guardian is not responding to letters or phone calls about you, your provider can help you get a different guardian.

The signatures of a Qualified Developmental Disabilities Professional (QDDP), as well as all developmental services agencies that provide services, are required.



IV. REVIEWING YOUR ISA

You have defined how often your QDDP needs to review each of your expectations to make sure they are being adequately met. Of course, that person should be asking how you feel your supports are working. How this is documented is up to you, but it must be documented.

You have also defined how often your QDDP must review your whole Individual Support Agreement (ISA). The ISA Review Form may be used (see attached). Any form is acceptable as long as the required information is included.

NOTES FOR PEOPLE HELPING WITH THE ISA:

to participate in implementation of ISA activities) and document this. Please do not indicate the person is unable to sign and do not include an "assisted" signature.

A guardian's signature is required if the person is an adult and a court has appointed a guardian for the person for any of the areas covered in the ISA. If the person is a minor, the signature of their parent or guardian is required. If you are unable to obtain the guardian's signature, efforts to do so must be documented.

The signature of a Qualified Developmental Disabilities Professional (QDDP) is required. This is the signature of the person who is monitoring the plan. If the QDDP is employed by the agency providing services, this approval covers the agency approval as well.

If the person receives non-waiver, clinic, rehabilitation (including PASARR), ICF/MR or transportation services, a physician's signature is also needed.

Review of the ISA must be documented. This review is completed by the QDDP. This is also one of the times that the QDDP must check in with the individual and his/her guardian, if there is one, to get their perspective on whether supports are being provided as expected and meeting the needs as identified.

The QDDP must document each ISA review with the following information.

- Your name.
- The implementation term of your ISA.
- The date of the ISA review and the name of the person completing the review (the QDDP).
- Summaries of how helpful supports have been in achieving each of your support expectations. The summaries must mention those things you have indicated will be present (or absent) when your expectations are being met.
- An indication of your level of satisfaction with supports. Your satisfaction is documented in whatever way is meaningful to you! This means support people are responsible for making sure your thoughts and feelings about services are communicated and documented. If you are not satisfied with supports, you must let people know what they could do to make things better.
- Your guardian's (if you have one) expressed level of satisfaction.
- Comments by your family members (if applicable).
- Comments by your provider(s).
- A notation if a change has been planned to your ISA. **You and your guardian (if you have one), your QDDP and the agency providing services must approve all changes.**
- A notation if your personal goals or dreams have changed, if you want to share this with your support people.

V. CHANGING YOUR ISA

When a significant change to your supports is planned, the ISA must first be changed.

*What you need to know: Any change must happen in a way that is consistent with these guidelines. Indications of agreement must be obtained from all relevant parties **BEFORE** any change in supports starts.*

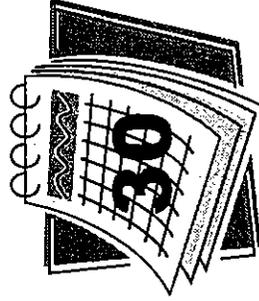
NOTES FOR PEOPLE HELPING WITH THE ISA:

Each time a significant change is made to your Individual Support Agreement there must be documentation of that change. DDS has a suggested form you can use; however, any form may be used as long as it contains the following information:

- Your name and the term of your ISA.
- The date the change will happen.
- Your new (or changed) expectations from supports.
- Descriptions of how you and others will know when your expectations are being met.
- Description of what supports you expect from support people (answers to who, what, when, where and how.)
- Description of what information people need so they can tell if supports are working and how often they get the information, and how they document the effects of supports. Name the support person responsible for documenting this information.
- Any changes to when each of your expectations are reviewed or when your ISA is reviewed and by whom.
- Indications of approvals to the ISA changes as follows:
 - Yours
 - Your guardian's (if you have one)
 - The signature of approval of a QDDP
 - The signature of any agency providing services

VI. EXTENDING YOUR ISA

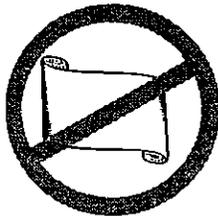
You and your guardian (if you have one) must agree to any extensions of your Individual Support Agreement. **No extension, however, may exceed thirty (30) calendar days.** An indication of your approval must be documented as well as your guardian's (if you have one), your QDDP, and any agencies providing services. Basically, everyone who approved the original ISA must indicate approval of an extension.



Everyone who indicated his/her approval of the original ISA, must also indicate their approval, in writing, to any change to the person's ISA.

Everyone who indicated his/her approval of the original ISA, must also indicate their approval, in writing, to an extension of the person's ISA.

VII. TERMINATING YOUR ISA



The Individual Support Agreement process is designed to be something that you and others important to you work out together. It is where support decisions are reached by consensus; everyone agrees to the decisions. Each person's approval on the ISA means they agree. There may be times when, once begun, one or more people disagree with all or part of the ISA. The person who disagrees should try to solve any disagreements through changes to the ISA – by consensus. If differences cannot be resolved, you or any other person who signs may end the agreement.

What you should know: Any party to the agreement, except the DA, has the right to end the ISA. The agreement may be stopped, in whole or in part, at any time before the "ISA end date" provided the party who wants to end the ISA notifies all other parties, in writing, of their intent to terminate. If a provider wants to terminate its involvement, this notification must happen sixty (60) calendar days before its part of the ISA is terminated. This notification must be in writing. During this period, supports must remain in place as negotiated by all involved parties.

If you receive services through a provider that is different from your Designated Agency, they must cooperate with you and your Designated Agency to provide all reasonable assistance in continuing your supports and to help transfer your supports to a different provider throughout the transition period (60 days).

NOTES FOR PEOPLE HELPING WITH THE ISA:

It should be explained to the person that termination of the ISA means that services will stop. Prior to reaching this level of disagreement between the person and the provider, it is important that the person is given information about how to file a complaint (see DDS video and written materials).

As required by Vermont law and regulation, the Designated Agency must provide or arrange to provide services and supports to an individual in its region. Therefore, if a different agency/individual decides to stop providing services, the DA is obligated to either directly provide the services or assist the individual to find another provider.

