



# FOSTER CARE INDIVIDUAL SUPPORT PLAN

Name of Individual \_\_\_\_\_ County \_\_\_\_\_  
 Child  Adult  Date: \_\_\_\_\_

<b>SERVICES NEED OR ISSUE</b>	<b>Describe Type &amp; Frequency of Supports/Training to be Provided</b>	<b>Responsible Person(s)</b>
<b>FAMILY &amp; FRIENDS INVOLVEMENT</b> Visits/Activities/Issues:		
<b>COURT ORDERS/ RESTRICTION</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Describe: _____		
<b>Juvenile Court Commitment:</b>		
<b>PSRB:</b> Contact: _____ Phone: _____ Expiration date: _____		
<b>Civil Court Commitment:</b> Date of commitment: _____ Expiration date: _____		
Parole/Probation Officer:		
Phone: _____		

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<b>COMMUNICATION:</b> How does this person communicate Needs? _____		
Equipment Used: Yes <input type="checkbox"/> No <input type="checkbox"/> Describe: _____		
Consultant Used: Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>EMPLOYMENT</b> <input type="checkbox"/> <b>COMMUNITY INCLUSION</b> <input type="checkbox"/> <b>SCHOOL</b> <input type="checkbox"/> <b>OTHER:</b> _____	Schedule from: _____ to _____, on the following days _____ Average, week or daily hours will be _____	
Plan attached: Yes <input type="checkbox"/> No <input type="checkbox"/> Agency: _____ Site Contact Person: _____	Agreed upon foster care provider responsibilities: _____	
Phone: _____ Address: _____	Transportation plan/action: _____	
<b>OTHER:</b> _____		

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<b>MISSING PERSON PLAN</b>	<p>If missing from the home or other destinations for _____ minutes, _____ hours, the Foster Care Provider will do the following:</p> <p>(Check all that apply)</p> <p><b>Immediately search the area. If the individual is not found contact the</b></p> <p><input type="checkbox"/> Vocational or <input type="checkbox"/> School/Day program provider</p> <p><input type="checkbox"/> Transportation provider and the</p> <p><input type="checkbox"/> Guardian/family.</p> <p><b>If the individual still cannot be located call 911 and the case manager.</b></p> <p>Other action:</p>	
Describe concerns/issues or provider information: (If applicable)		

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<p><b>FINANCIAL PLAN</b></p> <p><b>Need to open account</b>                      Yes <input type="checkbox"/> No <input type="checkbox"/>                      Name of Bank &amp; Branch: _____</p> <p><b>Check resources available.</b>                      SSI <input type="checkbox"/> SSB <input type="checkbox"/> Wages <input type="checkbox"/>                      Other <input type="checkbox"/> Source _____</p> <p><b>Regular expenses:</b>                      R &amp; B \$ _____                      Service Contribution: \$ _____                      Other: \$ _____                      Total: \$ <u>0.00</u></p> <p>Who is responsible for reporting wages/offsets?                      _____                      _____</p> <p><b>Representative Payee:</b>                      Name _____</p> <p><b>Is a change in payee needed?</b>                      Yes <input type="checkbox"/> No <input type="checkbox"/>                      If yes describe action needed: _____</p> <p><b>This person has a conservator:</b>                      Yes <input type="checkbox"/> No <input type="checkbox"/>  <b>Other Financial Needs:</b>                      Describe: _____</p>	<p><b>Supports-Training needed for bill paying, purchases, other:</b></p> <p>This person is totally independent with their finances <input type="checkbox"/>                      Describe: _____</p> <hr/> <p>This person needs assistance. <input type="checkbox"/>                      Describe: _____</p> <hr/> <p>This person needs total support. <input type="checkbox"/>                      Describe: _____</p> <hr/> <p>The individual will have access to \$ _____ daily <input type="checkbox"/>, weekly <input type="checkbox"/>, monthly <input type="checkbox"/> in personal spending, per ISP team approval.</p> <p>Purchases over \$ _____ Requires ISP-Team approval.</p>	

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<p style="text-align: center;"><b>MEDICAL</b></p> <p>Self administration of medication  <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/></p>		
<p style="text-align: center;"><b>MEDICAL</b></p> <p><b>Chewing/Swallowing Choking</b>  Describe: _____</p>		
<p>Medications/Treatments:  <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/></p> <p>Protocols needed:  <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Completed</b> <input type="checkbox"/></p> <p>Follow Up needed:  <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/></p> <p>Consultant Used:  <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/></p> <p><b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/></p>		
<p style="text-align: center;"><b>Neurology/Seizures</b></p> <p><b>Seizure:</b>  <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/></p> <p>Seizure documentation located  where? _____</p> <p>Medications/Treatments:  <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/></p> <p>Protocols needed:  <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/> <b>Completed</b> <input type="checkbox"/></p> <p>Follow Up needed:  <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/></p> <p>1:1 staffing needed:  <b>Yes</b> <input type="checkbox"/> <b>No</b> <input type="checkbox"/></p>		

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<b>VISION</b>		
Describe: _____		
Medications/Treatments:		
Glasses/Other:		
Yes <input type="checkbox"/> No <input type="checkbox"/>		
Follow Up needed:		
Yes <input type="checkbox"/> No <input type="checkbox"/>		
Protocols needed:		
Yes <input type="checkbox"/> No <input type="checkbox"/> Completed <input type="checkbox"/>		
1:1 staffing needed:		
Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Diet/Nutrition</b>		
<b>Special diet? Yes <input type="checkbox"/> No <input type="checkbox"/></b>		
Describe: _____		
Menu needed:		
Yes <input type="checkbox"/> No <input type="checkbox"/>		
Food intake documentation needed		
Yes <input type="checkbox"/> No <input type="checkbox"/>		
Fluid intake documentation needed		
Yes <input type="checkbox"/> No <input type="checkbox"/>		
Medications/Treatments:		
Yes <input type="checkbox"/> No <input type="checkbox"/>		
Protocols needed:		
Yes <input type="checkbox"/> No <input type="checkbox"/> Completed <input type="checkbox"/>		
Follow up needed:		
Yes <input type="checkbox"/> No <input type="checkbox"/>		
Weight documentation needed:		
Yes <input type="checkbox"/> No <input type="checkbox"/>		
Consultant used:		
Yes <input type="checkbox"/> No <input type="checkbox"/>		
1:1 staffing needed:		
Yes <input type="checkbox"/> No <input type="checkbox"/>		

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<p style="text-align: center;"><b>MOBILITY</b></p> <p><b>Ambulation &amp; Positioning</b> Describe: _____</p> <p><b>Equipment:</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Describe: _____</p> <p>Protocols needed: Yes <input type="checkbox"/> No <input type="checkbox"/> Completed <input type="checkbox"/></p> <p>Follow up needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Consultant used: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>1:1 staffing needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p style="text-align: center;"><b>HEARING:</b></p> <p>Describe: _____</p> <p>Medications/Treatments/Aids: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Follow up needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Protocols needed: Yes <input type="checkbox"/> No <input type="checkbox"/> Completed <input type="checkbox"/></p> <p>1:1 staffing needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p style="text-align: center;"><b>DENTAL:</b></p> <p>Describe: _____</p> <p><b>Sedation needed:</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Medications/Treatments/Dentures: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Follow up needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Protocols needed: Yes <input type="checkbox"/> No <input type="checkbox"/> Completed <input type="checkbox"/></p> <p>1:1 staffing needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p>		

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<p><b>BOWEL/CONSTIPATION</b>            Describe: _____</p>		
<p>Documentation Needed:            Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Medications/Treatments:            Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Protocols needed:            Yes <input type="checkbox"/> No <input type="checkbox"/> Completed <input type="checkbox"/></p> <p>Follow up needed:            Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>1:1 staffing needed:            Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p><b>OTHER MEDICAL</b>            Describe: _____</p>		
<p><b>RN SUPPORT</b>            Is nursing care plan needed?            Yes <input type="checkbox"/> No <input type="checkbox"/> Completed <input type="checkbox"/></p> <p>If completed where will care plan            be kept:</p>		

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<b>PSYCHIATRIC MENTAL HEALTH</b>		
Diagnosis:		
Last psychiatric hospitalization:		
Follow up needed: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Describe: _____		
Are medications taken for Psychiatric conditions? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Frequency of blood levels: _____		
<b>IS A RISK ASSESSMENT</b>		
N/A    Needed    Completed		
FIRE <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
SEXUAL <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
SUICIDAL <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
OTHER <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		
Location of Assessment & Plan:		

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<p style="text-align: center;"><b>BEHAVIORS MENTAL HEALTH</b></p> <p>Are medications taken for Behavioral issues: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Describe: _____</p> <p>Frequency of blood levels: _____</p>		
<p style="text-align: center;"><b>Recent History of Behaviors Important To Know</b></p> <p>Note year of occurrence</p>		
<p style="text-align: center;"><b>BEHAVIOR(S) NEEDING SUPPORTS &amp;/OR INTERVENTIONS</b></p> <p>Location of Functional Assessment &amp; Behavior Support Plan _____</p> <p><b>New Behaviors or on-going concerns to be addressed:</b></p> <p>Describe behaviors</p> <p>Targeted Behavior: _____</p> <p>1:1 staff? _____</p> <p>Targeted Behavior: _____</p> <p>1:1 staff? _____</p> <p>Targeted Behavior: _____</p> <p>1:1 staff? _____</p> <p>Targeted Behavior: _____</p> <p>1:1 staff? _____</p>		

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<b>SAFETY</b>		
<b>Home Safety:</b> _____		
Assistance needed: Yes <input type="checkbox"/> No <input type="checkbox"/>		
1:1 staffing needed: Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Night Time Safety:</b> _____		
Assistance needed: Yes <input type="checkbox"/> No <input type="checkbox"/>		
1:1 staffing needed: Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Fire Exiting:</b>		
Assistance needed: Yes <input type="checkbox"/> No <input type="checkbox"/>		
1:1 staffing needed: Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>Water Temperature Adjustment</b>		
Assistance needed: Yes <input type="checkbox"/> No <input type="checkbox"/>		
1:1 staffing needed: Yes <input type="checkbox"/> No <input type="checkbox"/>		

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<p style="text-align: center;"><b>COMMUNITY SAFETY</b></p> <p>Assistance needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>1:1 Staffing needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Describe:</p>		
<p style="text-align: center;"><b>DAILY ACTIVITIES OF LIVING</b></p> <p><b>Bathing:</b> Assistance needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>1:1 Staffing needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p><b>Hygiene</b> Assistance needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>1:1 staffing needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p><b>Dressing</b> Assistance needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>1:1 staffing needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p><b>Toileting</b> Assistance needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>1:1 staffing needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p><b>Accessing Food Water/Fluids</b> Assistance needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>1:1 staffing needed: Yes <input type="checkbox"/> No <input type="checkbox"/></p>		

