

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
 Division of Developmental Disabilities
 INDIVIDUAL SUPPORT PLAN (ISP)
RIGHTS, HEALTH AND SAFEGUARDS

INDIVIDUAL'S NAME (*Last, First, M.I.*)

DATE

This form is required for persons residing in a licensed residential setting (*e.g. group homes, CDH's, ADH's*), and optional for Individual Support Plan Teams to use in other settings.

1. May the person have access to bodies of water (*swimming pools, irrigation ditches, fish ponds*) without constant staff supervision?

Yes Please describe restrictions/safeguards, if any _____

No If no, why not _____ List restrictions/safeguards, if any _____

2. Does the person of legal drinking age wish to drink alcoholic beverages and have guardian consent (*if one has been appointed*)?

Yes Please describe restrictions/safeguards, if any _____

No If no, why not _____

NA

3. Does the person of legal age wish to use tobacco and have guardian consent (*if one has been appointed*)?

Yes Please describe restrictions/safeguards, if any _____

No If no, why not _____

NA

4. Does the person have any special transportation needs or requirements (*medical, safety, behavioral*)?

Yes Please describe (*medical and behavioral concerns require a Prevention/Risk Assessment, DDD-1309AFORNA*) _____

No

NA

5. Does the person require assistance with personal care (*dressing, bathing, toileting, menses care*)? If so, indicate the responsible person's choice regarding the gender of staff to provide such assistance (*check only one*).

Female staff only

Male staff only

No Preference

N/A

6. If the person lives in a Licensed Residential Setting, does the person have a skin integrity concern?

Yes If, yes, a Nursing Assessment is required with the plan of care completed for the provider.

No

7. Does the person have access to unlocked toxic substances (*e.g., cleaning supplies, pesticides*)?

Yes

No If no, why not _____

8. Does the person have access to unlocked medication (*prescribed, over-the-counter*)

Yes Comments _____

No If no, why not _____

9. Are there any reasons preventing this person from sharing a bedroom (*age, medical concerns, behaviors*)?

- Yes Describe reasons _____
- No

10. Does the person have limits to the amount of money he/she can carry?

- Yes How much? _____ Reasons for restriction _____
- No

11. Does the person have unsupervised time in the community?

- Yes Duration _____ Conditions _____
- No If no, why not? _____

12. Does the person have unsupervised time within their residence?

- Yes Duration _____ Conditions _____
- No If no, why not? _____

13. Does the person have:

- a. A history of life threatening behavior within past three years (*ingesting foreign objects, assaultive behavior*)?
- b. A medical or behavioral health issue that could jeopardize quality of life (*frequent falls resulting in fractures, seizure disorder*)?
- c. One or more Serious Incident Report(s) in one year? (The nature of the serious incident and need for a Prevention/Risk Assessment will be determined by the Team.)
- d. Other life events (*e.g., death of close relative, diagnosis, diabetes*)? (The nature of the serious incident and need for a Prevention/Risk Assessment will be determined by the Team.)
- e. Residence in a Licensed Residential Setting?
 - Yes (*A Prevention/Risk Assessment, DDD-1309AFORNA, is required to address each risk identified.*)
 - No

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