CUYAHOGA COUNTY
Board of Developmental Disabilities

INDIVIDUAL PLAN (SERVICE)

INDIVIDUAL NAME: _____ PROVIDER: _____ SITE LOCATION: _____

SPAN DATES: _____ IMPLEMENTATION DATE: _____ MEDICAID #: _____ SUPPORT ADMINISTRATOR: _____

FREQUENCY OF IMPLEMENTATION: _____ DURATION: _____ GROUP SIZE / ACUITY: _____ SUPERVISOR: _____

MONTH/YEAR: _____

Date	Initials	Comments

Mandatory monthly summary:

_____
Signature / Date

Rev. 9/2012

INDIVIDUAL NAME: _____ MONTH/YEAR: _____

Support Services (1): Area: _____ Frequency: _____ Duration: _____

Support Services (2): Area: _____ Frequency: _____ Duration:

Support Services (3): Area: _____ Frequency: _____ Duration: _____

Support Services (4): Area: _____ Frequency: _____ Duration: _____

Support Services (5): Area: _____ Frequency: _____ Duration: _____

Support Services (6): Area: _____ Frequency: _____ Duration: _____

FOR SUPPORT SERVICES: + = PROVIDED - = NOT PROVIDED (Give explanation) A=Absent C=Closed H=Holiday R-Refused (Give Explanation)

OBJECTIVE			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
*If additional trials are required, use additional Individual Plan documentation sheet *All goals will continue to the first of the month following annual meeting date for ICFMR	Service 1	+/-																															
		Initials																															
	Service 2	+/-																															
		Initials																															
	Service 3	+/-																															
		Initials																															
	Service 4	+/-																															
		Initials																															
	Service 5	+/-																															
		Initials																															
	Service 6	+/-																															
		Initials																															

STAFF SIGNATURE _____ INITIALS _____ STAFF SIGNATURE _____ INITIALS _____

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