DD-220-2-FF (3-05)

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 ______ 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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