Day Services
Plan of Service

Date of Plan:_____

Section I

Name:_____ Date of Birth:_____

Address *(include zip code)*:_____

Primary Contact:_____

Address *(include zip code)*:_____

Phone:_____ Email Address:_____

Emergency Contact:_____

Phone:_____ Email Address:_____

Critical Information:

Type and Frequency of Supervision to be provided:

Medical Information:

Medication taken and common/likely side effects:

Description of assistance to be provided with taking medications:

Any other medical interventions to be provided or for which assistance is needed?:

Adaptive Equipment used:

Behavior Support:

Is there a plan to be implemented? ☐Yes ☐No If yes, the plan must be attached.

Transportation:

Describe the person's transportation to and from Day Services:

Name/Title of Person Completing this section:_____

Signature of the Person/Legal Guardian:_____

Section II

Authorized Service *(select one)*:

☐Career Preparation ☐Community ☐Day Activity ☐Support Center

The time the unit(s) of the service will be provided *(check one)*:

☐A.M. ☐P.M. ☐A.M. and P.M. (two units)

This service will be provided as follows:

☐5 days/week ☐Other – Specify:_____

Funding Source:

☐Community Supports Waiver ☐HASCI Waiver ☐ID/RD Waiver ☐State Funding
☐Other (Private Pay, etc.)

Goal:

Objective/Intervention:

Method/Strategy:

Projected Completion Date:_____

Objective/Intervention:

Method/Strategy:

Projected Completion Date:_____

I participated in the development and agree with this plan.

Signature of the Person/Legal Guardian:_____

Name/Title of Person Completing this section:_____/_____

Date of Section *(required only if Section I is a Preliminary Plan)*:_____

General Instructions

Except for ICF/ID residents, the Day Plan of Service should be used to document the services to be provided to those who participate in a DDSN funded Day Service. These services include Day Activity, Career Preparation, Community Services, and Support Center Services.

For ICF/ID residents, the Individual Program Plan (IPP) required by CRF § 483.440 will document the services to be provided. Day Services providers will be expected to participate in the development of the IPP as specified by the Qualified Intellectual Disabilities Professional (QIDP) and in accordance with governing regulations.

For non-ICF/ID residents (e.g., those whose Day Services are funded by the Intellectual Disabilities/Related Disabilities Waiver, the Community Supports Waiver, the Head and Spinal Cord Waiver, or DDSN State dollars) the Day Plan of Service must be completed as specified in the service standards (Day Activity Services Standards, Career Preparation Services Standards, Community Services Standards, and Support Center Services Standards).

Service standards require that a **preliminary plan** be implemented at the time of admission/entry into the service. **Section I** of the Day Plan of Service will serve as the preliminary plan for the person. For those newly admitted to the service, only Section I will be completed as the preliminary plan and will be dated to reflect its completion prior to or at the time of admission/entry into the service. If transferring from another service, Section I of the existing plan should be reviewed. If accurate, Section I should be signed and dated to reflect the date it was reviewed and implemented until Section II is completed. If determined by review to not be accurate, Section I can be amended and signed and dated accordingly or re-written.

Within 30 days of admission, Section II of the Day Plan of Service must be completed.

Per service standards, planning must occur **annually**. Annual planning is defined as a plan that is completed within 365 days of the last plan. For those newly admitted, the annual plan must be completed within 365 days of the completion of Section II of the initial plan.

For annual planning, Section I and Section II of the Day Plan of Service must be completed and should be dated the same date.

Section I

Enter the person's name and Date of Birth (DOB)
Enter the person's address.

Enter the name, address, phone number and email address of the person's primary contact. Include all phone numbers.

Enter the name, phone number and email address of the person to be contacted in the event of an emergency.

Enter any CRITICAL INFORMATION about the person. Critical Information is information that is necessary for support staff to know about the person. Example of the kinds of information that may be critical for support staff to know include allergies, conditions like epilepsy and diabetes, behaviors that are extreme and harmful.

Enter the Type and Frequency of supervision to be provided. This should be determined and documented in accordance with DDSN Directive 510-01-DD: Supervision of People Receiving Services.

Enter appropriate medical information. List all medications taken and the common side effects of those medications. If medications are to be taken by the person while Day Services are being provided, describe the assistance to be provided by staff with medication taking. Describe any other medical interventions to be provided/assisted with by staff. Some examples might include, but are not limited to, assistance with checking blood sugar levels, emptying a leg bag, checking blood pressure.

Enter information about any Adaptive Equipment used by the person while he/she receives Day Services. Examples include, but are not limited to, eyeglasses, hearing aides, walkers and wheel chairs.

Indicate if the person has a Behavior Support Plan (BSP) or Behavior Guidelines to be implemented while receiving Day Services. If so, the BSP or Guidelines must be attached to the Day Service Plan.

Describe how the person will be transported to and from the Day Services facility. Of primary importance is an explanation of who is responsible for transportation. Examples: might include family/person is responsible for transportation to the facility; the Day facility is responsible for transportation from the facility to the person's home; Apple CTH-II staff are responsible for transportation to and from the facility.

The staff person completing this section must sign and include his/her title.

SECTION II

Select the service that has been authorized by the Case Manager. Select only one. If more than one service has been authorized, a Section II page(s) must be added to the plan for each service authorized. For example, if someone needs and has been authorized to receive Day Activity - one (1) unit per day/five (5) days per week and Community Services –one (1) unit per day/five (5) days per week, then that person's plan will include one (1) Section I page, and two (2) Section II pages.

Indicate if the service will be provided during the morning, afternoon or both morning and afternoon. Indicate the number of days per week the service will be provided. This must match the authorization from the Case Manager.

Indicate the funding source for the day service.

Indicate the goal to be achieved through the provision of this service.

Indicate the specific objectives or interventions to be provided that will help this person achieve the goal noted above.

Indicate the methods or strategies to be employed by staff when providing instruction or applying the intervention.

The date by which it is anticipated that the objective will be met or the intervention will have been successful.

Enter the name of the person completing the plan and his/her title.

The person and/or his/her legal guardian must sign the plan, or an explanation of why they did not sign the plan must be noted on or near the signature line. There must be evidence that the person and/or his/her legal guardian participated in the development of and agrees with the plan.