



“The ISP process, led by the Supports Coordinator (SC), is the most critical activity to help people envision a good life and to develop strategies to achieve the life they want. It is a process to help people explore the experiences, opportunities and resources available to them through family, friends and the community, and it is also the process to identify what services can enhance those resources and opportunities. ...

Philosophies and concepts including “what is important to people?” in Everyday Lives: Values in Action, person-centered approaches, the principles of Positive Approaches, and the LifeCourse tools are the foundation for completing a plan with the individual and family.”

“ODP utilizes a multifaceted assessment process to drive initial and ongoing ISP development in order to gain and capture person-centered information to determine the individual’s needs and risk factors...The Supports Intensity Scale-Adult™ (SIS-A™) and PA Supplement are the primary statewide standardized needs assessments tools used by ODP. The SIS-A™ and PA Supplement are administered by an independent contractor, and the results are available to team members in the form of the SIS Family Friendly Report located in SIS Online. The SC is responsible for distributing the SIS Family Friendly Report to the individual, people who participated in the completion of the SIS-A™ and PA Supplement assessment, and ISP team members.

The SIS-A is designed to be used for individuals ages 16 through 72; however, ODP with permission from American Association of Intellectual and Developmental Disabilities (AAIDD), selected to use the tool for individuals as young as age 14 and older than 72 years of age.”

From the 2/23/18 Commonwealth of PA Department of Human Services Office of Developmental Programs (ODP) Individual Support Plan (ISP) Manual...

Learn more about the SIS-A™ and PA Supplement at alleghenycounty.us/dhs/ODS

The Individual Support Plan (ISP):

- Is a comprehensive summary of planned services and supports for each individual receiving Intellectual Disability/Autism (ID/A) Services in Allegheny County.
- Is an integrated plan.
- Includes the values of Everyday Lives, Person Centered Planning and Self Determination.
- Must ensure that all services and supports that are provided with public dollars match assessed needs and reflect the participants preferences.
- Assists in ensuring quality within the system while promoting individual choice and control.

What information is included in the ISP?

The individual, their family, and people who support and know the person best will provide information to be included in the ISP, such as:

- Individual Preferences, This includes what is important to the individual and desired activities.
- Medical, Includes current health status and any medical concerns as well as medications and supplements and health evaluations.
- Health And Safety, Including knowledge of safe practices associated with cooking / use of appliances and traveling in the community. Also an explanation of what supports are needed for health and safety, for example, assistance needed in the event of a fire
- Functional Information
- Financial, resources, information and management.

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▪ Services and Supports

- Communication - including how the individual communicates with others
- Supervision - how much supervision is needed when the individual is at home and when they are in the community and when they are receiving services
- Information from each current service provider

Who completes the ISP?

The Supports Coordinator (SC) coordinates the completion of the ISP. To help everyone prepare for the ISP meeting, a copy of the ISP can be obtained with input from the individual and their team. The team can include family, friends, other case management staff, providers and anyone else the individual would like to include. To obtain a blank ISP form contact your Supports Coordinator.

When is the ISP developed?

The first ISP is developed as soon as a Supports Coordinator is provided to the individual. For people already working with a Supports Coordinator the SC is responsible for coordinating, reviewing, and updating the ISP at regularly scheduled reviews and when changes occur. The information provided in the ISP is comprehensive and multiple meetings or contacts between the person, the family, others who know the person and representatives from provider agencies are essential to gather the information for a thorough ISP. The plan should also be revised as necessary during the plan year to accurately reflect the person's needs and desires.

What is an Outcome?

The information in the completed ISP will help identify what a person should work on to maintain current skills, to develop new skills and to develop Outcomes. Outcomes will reflect:

- What they would like to maintain in their life
- The changes they would like to see for themselves
- The changes that people that support them would like to see happen
- The priorities which are identified by the person and people that support them
- Skills that are currently important for them to work on or to maintain
- Formal and informal assessments and information gathering
- Links to appropriate informal and formal supports and services

Outcomes are linked to qualified providers, family, community or other non-traditional supports. Service providers who are paid through public funds must assist in ensuring the health and safety of the individual and/or their continued involvement within the community and must have an outcome.

For more information about ISPs, including the ISP Manual, visit the PA DHS website and www.MyODP.org (PA DHS Office of Developmental Programs)



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For more information regarding ODS, including additional Fact Sheets visit alleghenycounty.us/dhs/ODS