

# POLICIES AND PROCEDURES MANUAL

KEYSTONE COMMUNITY RESOURCES, INC.

KEYSTONE INDEPENDENT LIVING, INC.



**Policy Title:**

The Annual Service Plan

**Chapter:**

**Effective Date:**

7/1/1992

**Revision Date:**

11/25/2008

**Policy Number:**

**Executive Director**

## SCOPE:

- Chapter 6400 – Community Homes For Individuals With Mental Retardation

## INTRODUCTION:

1. The Annual Service Plan is the written plan of services to be provided to a consumer. There are several reasons why the service plan is needed and considered an important document. The Service plans provide:
2. An organized plan to follow, letting all of us know what services are being given and who is giving them.
3. Accountability, consumers have the right to a written plan and we, as service providers, have a responsibility to provide them. Service plans also provide recognition for consumer and staff efforts and are also required by the regulations which govern community MR facilities.
4. A permanent record of a consumer's accomplishments based on the services provided.
5. Benefits to consumers by assisting them to participate in decisions which affect them, to be productive and useful members of society, and to increase their independence and control in daily life in both small and big ways.
6. The Annual Service Plan (ASP) is developed by the interdisciplinary team (IDT) which is a group of people working together to develop, monitor, and revise the service plan, The team members include the consumer, who is considered to be the most important member of all, as well as other professionals and non-professionals.
7. The members of an individual's team varies according to the services (s) he requires. The staff person who knows the consumer best is a significant member of the team. Because (s) he can best report on the persons likes, dislikes, progress and changing

needs. Also important to the team are the Program Specialist and Residential Manager, parents, guardians, case managers, medical staff, behavioral consultants and service staff from other settings. The common basis for the team's work is their common goal of serving the consumer.

8. The process of developing the ASP has a basic structure for guiding the activities of the interdisciplinary team. The steps of this process include:

- Assessment – assess the means to evaluate. In the goal planning process, assessing the consumer's skills is the first step in determining areas for skill development. Assessments may be formal or informal. Formal assessments are standardized and give a score. Information assessments are used frequently and include any other means for evaluating, such as talking with the consumer or someone who know him/her well, reviewing records, and observing. The results of the assessments are discussed at an initial meeting and a list of general strengths, needs and wishes is developed. This List includes all important and relevant information about the person's abilities and provides an accurate picture for the next step.
- Prioritize – Prioritize means to establish precedence, based on need. Decisions about what to address first, second, third, etc. are made formally at the ASP meeting, Each IDT member, however, needs to think about these in advance in order to be well-prepared and avoid wasting time at the ASP meeting. Things to consider in prioritizing service needs for a include:
  - What does the person want and want to learn?
  - What are the person's strengths and abilities?
  - What are the characteristics of the person's environment?
  - Does this person have any special concerns i.e. medial, behavioral which may need to take priority?

9. Developing the Plan – Once priority based on the assessment, has been established, specific goal areas can be selected and the plans developed.

- Areas for goal development include: Personal Care, Financial Management, Homemaking, Health/Medical, Socialization, Behavior, Academic/Education/Vocation, Sensory/Motor, Personal Safety/Community Awareness, Communication and Recreation/Leisure.
- In our agency, the ASP including the service goal plans, are by the Program Specialist. The Program Specialist is also responsible for providing copies of the plan to IDT members.

10. Training – This step refers to the actual carrying out of the written plans. The Program Specialist is responsible for teaching staff how to carry these out and ensuring that necessary materials are available to do so. The training step is a critical step in the entire process because it involves so many details. The written plan contains all for the information needed to implement, monitor and evaluate progress.

11. Evaluation – Evaluation means to judge or appraise. The evaluation step is necessary in deciding whether or not a goal has been accomplished. Generally, this is done by checking staff documentation against the criterion or standards which is determined by the wording of the goal plan. The Evaluation process also helps to identify developing or existing problems. The Program Specialist is responsible for evaluating progress, and documenting this on a monthly basis. The Program Specialist also makes any needed revisions.
12. Maintenance – Maintenance refers to the consumer remembering the skills (s) he has learned. Maintenance can be planned for by specifying in the plan how opportunities for maintenance will occur.
13. Generalization – Generalization refers to the consumer using the skills (s) he has learned in other settings. Generalization can be planned for by specifying in the plan how opportunities for generalization will occur.
14. There are many important factors to keep in mind when developing a program to meet a person's needs. Consider the Ten Qualities of Good Programs listed here in evaluating the quality of the existing goal plans at your facility.
  - **Integration** – does the program ensure that the individual will have opportunities to interact with community members? Will it provide opportunities to go to and use the community setting?
  - **Age Appropriate** – If the individual is an adult, does the program use adult activities? If the individual is a child, does the program use children's activities?
  - **Functional** – Does the program teach a useful skill in the person's environment? Is it a skill needed frequently by the person? Does the skill enable the person to function more effectively in the environment?
  - **Future Oriented** – Does the program consider (and train) for future needs of the person in the future environment?
  - **Participation** – Does the program increase the individual's participation in community life, home life, work life, social life?
  - **Productivity** – Does the program provide opportunities for the person to do something productive and worthwhile?
  - **Independence** – Does the program decrease the person's reliance on others? Does the program assist the person to be more self-sufficient?
  - **Effective** – Does the program work? Does it do what it is supposed to do? Teach what it is supposed to teach?
  - **Involved** – Does the program involve significant other people – parents, friends, family, work staff, residential staff? Does it involve more than one group of these?
  - **Comprehensive** – Does the program cover all aspects of functioning related to that goal, or does it only teach a "piece" of a larger skill?

## DISCUSSION:

Persons served under NJDDD shall have their ISP completed as outlined in NJDDD Circular #35 attached. **Double click on image below to view full text**

DIVISION CIRCULAR #35

DEPARTMENT OF HUMAN SERVICES  
DIVISION OF DEVELOPMENTAL DISABILITIES

EFFECTIVE DATE: March 1, 2006

DATE ISSUED: March 1, 2006

(Rescinds Division Circular #35, "Individual Habilitation Plan", issued January 21, 2001).

I. **TITLE:** SERVICE PLAN

II. **PURPOSE:** To establish policies which assure that each individual who is eligible for and receives services from the Division of Developmental Disabilities (DDD) participates in the development and completion of an annual Division approved Service Plan. The Service Plan is a tool for the planning and implementation of generic and specialized services designed to achieve personal outcomes that are appropriate to the individual's interests, strengths, needs and preferences.

III. **SCOPE:** This circular applies to all components of the Division and agencies and entities under contract with the Division or regulated by the Department, who provide services to Division eligible individuals.

IV. **GENERAL STANDARDS:**

A. **Definitions** - for the purpose of this circular, the following terms shall have the meaning defined herein.

1. "Assessment" means the process of identifying the strengths, needs, and preferences of an individual served, barriers to and recommendations for the provision of services.
2. "Behavioral Objective" means one in a series of short-range steps developmentally sequenced and directed toward the