Employment/Day Services
Plan of Service
Date of Plan: _____

Section I

Name: _____ DOB: _____
Address: _____
_____
_____

Primary Contact: _____
Address: _____
Phone: _____

Emergency Contact:_____
Phone:_____

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?
If yes, the plan must be attached.

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

Name/Title of Person Completing this section: _____

Signature of the Person/Legal Guardian: _____

SAMPLE

Employment/Day Services
Plan of Service

Section II

Authorized Service (select one):

_____ Day Activity _____ Community
_____ Career Preparation _____ Support Center
_____ Employment (Group Placement)

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

_____ A.M. _____ P.M. _____ A.M. & P.M. (two units)

This service will be provided as follows:

_____ 5 days/week
_____ Other – Specify: _____

Funding Source:

___ MR/RD Waiver ___ Community Supports Waiver ___ State Funding

___ Other (Private Pay, etc.)

Goal:

Objective/Intervention:

Method/Strategy:

Projected Completion Date:

Objective/Intervention:

Method/Strategy:

Projected Completion Date:

Name/Title of Person Completing this section: _____

Signature of the Person/Legal Guardian (optional): _____

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

SAMPLE

SC Dept. of Disabilities & Special Needs
Employment/Day Plan of Services
Instructions

General Instructions

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

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

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

Service standards require that a **preliminary plan** be implemented at the time of admission/entry into the service. **Section I** of the Employment/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 Employment/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 12 months of the last plan. . For example, if a plan were completed on December 1, 2008, the next plan must be completed by December 31, 2009; a plan completed January 31, 2008 must be completed by January 31, 2009. For those newly admitted, the annual plan must be completed within 12 months of the completion of Section II of the initial plan. For example, <u>if</u> someone was admitted on December 1, 2008 <u>and</u> Section I completed on December 1, 2008 <u>and</u> Section II of the plan was completed on December 28, 2008, <u>then</u> the annual plan must be completed no later than December 31, 2009.

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

SAMPLE

Section I

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

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

Enter the name 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.

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 Employment/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 Employment/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 Employment/Day Services. If so, the BSP or Guidelines must be attached to the Employment/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.

The person or his/her legal guardian may sign the plan. Signature by the person/legal guardian is OPTIONAL and not required for the plan to be considered complete.

SAMPLE

SECTION II

Select the service that has been authorized by the Service Coordinator. 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 or during the afternoon. Indicate the number of days per week the service will be provided. This must match the authorization from the Service Coordinator.

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 or his/her legal guardian may sign the plan. Signature by the person/legal guardian is OPTIONAL and not required for the plan to be considered complete.

SAMPLE