Arizona Department of Health Services

Office for Children with Special Health Care Need

Individual Service Plan (ISP) TBI ☐ SCI ☐ CYSHCN ☐

Date:	**Service Plan:** ☐ Initial ☐ Semi-Annual ☐ Annual			
Last Name:	**First Name:**	**Middle Initial:**	**Birth Date:**	**Gender:** M ☐ F ☐
Address:	**City:**	**State:**	**Zip:**	
Phone:	**County:**	**School District:**	**School:**	
Current Residential Setting:	**Medical Home**	☐ **Yes** ☐ **No**	**Other Agencies Involved:**	
Race/Ethnicity:	**Tribe:**	**Reservation:**	**Language of the home:**	
Date of Injury/ Illness:	**Type of Injury/Illness:**			
Primary Care Provider:	**Phone:**	**FAX:**		
Address:	**City:**	**State:**	**Zip:**	
Insurance Coverage: ☐ **AHCCCS** ☐ **KidsCare** ☐ **ALTCS** ☐ **IHS** ☐ **Private** ☐ **Military** ☐ **Other** ☐ **None**				
Health Plan/Company Name:	**ID#:**	**Name of Insured:**		
Other Insurance:	**ID#:**	**Name of Insured:**		
Immunizations Current: ☐ **Yes** ☐ **No** ☐ **Refused** ☐ **Exempt**				
Responsible Person(s):	**Relationship:**	**Phone:** *(Home & Cell)*		
Contractor:	**Family Resource Coordinator:**	**Phone:**	**Fax:**	

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Medical Information/Professional Evaluations

NAME (*Last, First, M.I.*)	**DATE**

EVALUATIONS & DATES	RESULTS & RECOMMENDATIONS
PHYSICAL Evaluator: Date:	None at this time ☐
OTHER MEDICAL Evaluator: Date:	None at this time ☐
AUDIOLOGY Evaluator: Date:	None at this time ☐
VISION Evaluator: Date:	None at this time ☐
DENTAL Evaluator: Date:	None at this time ☐
PSYCHOLOGICAL Evaluator: Date:	None at this time ☐

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Medical Information/Professional Evaluations *(Continued)*

NAME (*Last, First, M.I.*)	**DATE**

EVALUATIONS & DATES	RESULTS & RECOMMENDATIONS
PHYSICAL THERAPY Evaluator: Date:	None at this time ☐
SPEECH THERAPY Evaluator: Date:	None at this time ☐
OCCUPATIONAL THERAPY Evaluator: Date:	None at this time ☐
TYPE Evaluator: Date:	
TYPE: Evaluator: Date:	
TYPE: Evaluator: Date:	

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Medical Information/Professional Evaluations *(Continued)*

NAME (*Last, First, M.I.*)	**DATE**

ADAPTIVE EQUIPMENT: None at this time ☐	**SPECIAL INSRSTRUCTIONS** (if any)
☐ Feeding tube ☐ Oxygen ☐ Wheel Chair ☐ Hearing aids ☐ Walker ☐ Prosthesis ☐ Brace / Orthotics ☐ Eyeglasses ☐ Shower Chair ☐ Commode ☐ Ventilator ☐ Stander ☐ Crutches ☐ Aug. Comm. ☐ Tracheotomy ☐ Utensils ☐ Dressings ☐ Other _____	
NUTRITION: None at this time ☐	**SPECIAL INSRSTRUCTIONS** (if any)
☐ Formula ☐ Nutritional Supplements ☐ TPN ☐ Special Diet ☐ IV ☐ Special Food	
TESTS/EVALUATIONS: None at this time ☐	**RESULTS:**
PROCECURES/SURGERIES: None at this time ☐	**RESULTS:**

MEDICATION: None at this time ☐	**DOSE:**	**REASON FOR MEDICATION:**

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Assessment Summary

NAME (*Last, First, M.I.)*	**DATE**

Key points of discussion under each domain. Record present level of function and the family's concerns and recommendations

STRENGTHS AND RESOURCES	CONCERNS AND OBJECTIVES/RECOMMENDATIONS
HEALTH AND PHYSICAL	**HEALTH AND PHYSICAL** No concerns at this time ☐
FINE AND GROSS MOTOR SKILLS	**FINE AND GROSS MOTOR SKILLS** No concerns at this time ☐
COGNITIVE ***(Problem solving, ability to learn and perform tasks)***	**COGNITIVE** ***(Problem solving, ability to learn and perform tasks)*** No concerns at this time ☐

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Assessment Summary *(Continued)*

NAME (*Last, First, M.I.*)	**DATE**

STRENGTHS AND RESOURCES	CONCERNS AND OBJECTIVES/RECOMMENDATIONS
COMMUNICATIONS SKILLS	**COMMUNICATIONS SKILLS** No concerns at this time ☐
SOCIAL SKILLS	**SOCIAL SKILLS** No concerns at this time ☐
SELF-HELP SKILLS	**SELF-HELP SKILLS** No concerns at this time ☐

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Assessment Summary *(Continued)*

NAME (*Last, First, M.I.*)	**DATE**

STRENGTHS AND RESOURCES	CONCERNS AND OBJECTIVES/RECOMMENDATIONS
FAMILY/RELATIVES/FREINDS	**FAMILY/RELATIVES/FREINDS** No concerns at this time ☐
COMMUNITY/CHURCH/RELIGIOUS	**COMMUNITY/CHURCH/RELIGIOUS** No concerns at this time ☐
EDUCATIONAL/VOCATIONAL	**EDUCATIONAL/VOCATIONAL** No concerns at this time ☐

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Preferences

NAME (*Last, First, M.I.)*	**DATE**

Things that work for the person -- i.e., things that create **motivation, interest,** and **success**. Things that do not work for the person -- i.e., things the person dislikes, or that create boredom, frustration, or upsets.

What Works for the Person	What Does NOT Work for the Person

Transitions

No transition needs at this time ☐ Transition To: _____ From: _____

Individual Transition Plan completed ☐

Summary:

_____

_____

_____

_____

_____

_____

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Service Plan/Objectives

NAME (*Last, First, M.I.)*	**DATE**

Service	Units	Objective	Provider/Person Responsible	Time Frame *(Start & End w/ISP Date)*

Behavioral Health

BEHAVIORAL HEALTH AGENCY/CLINIC None at this time ☐	
ADDRESS (No. Street, City, State, Zip	Phone NO. *(Office & Fax)*
QUALIFIED BEHAVIORAL HEALTH PROFESSIONAL (QBHP) None at this time ☐	Phone NO. *(Office & Fax)*
FREQUENCY OF MEDICATION REVIEWS None at this time ☐	
BEHAVIORAL HEALTH PRESENTING PROBLEMS None at this time ☐	
BEHAVIORAL TREATMENT PLAN ☐ Yes ☐ No [If yes, list objective(s) outcome(s) from the Behavioral Health Treatment Plan, the Psychiatrist's notes or other treating professional's notes]	

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Comments

NAME (*Last, First, M.I.)*	**DATE**

Use this space to record additional information necessary for a complete plan.

FAMILY RESOURCE COORDINATOR'S SIGNATURE	DATE

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Signatures

NAME (*Last, First, M.I.)*	**DATE**

A signature indicates participation in the development of this Individual Service Plan (ISP). Service decisions may require further approval, subject to funding. A service provider may review client files for any relevant treatment, historical, and behavioral information. All team members must have a copy of the ISP mailed to them within fifteen (15) business days.

TEAM MEMBER'S NAME ***(Print)***	**RELATIONSHIP TO MEMBER**	**TEAM MEMBER'S SIGNATURE**	**DATE**