IOWA HHS

Iowa Department of Health and Human Services

Individual Service Plan

Program:

Member's Name	SID #	Date of Plan

Assessment Date of Home Visit

INTRODUCTION:

Name:	DOB:
Address:	
Phone number:	Marital status:
Resides with:	Employment:
Income:	Source:
Insurance:	Drives: ☐ Yes ☐ No
Interpreter needed: ☐ Yes ☐ No Name:	Phone #:
POA: ☐ Yes ☐ No Name:	Phone #:
Emergency contact: Name:	Phone #:

MEDICAL INFORMATION:

Diagnosis:

Physicians/Providers	How Often Seen

Medications:

Who sets up: Self: ☐ Other:

Comment:

Hospitalizations since last service plan:

Critical incidents since last service plan:

Have you had any recent injuries due to your medical condition? ☐ Yes ☐ No

Explain:

LEVEL OF CARE (if applicable):

Date of last LOC certification:	LOC determined:

HEALTH STATUS/ADLS:

Assistance required:	☐ Yes	☐ No	If yes, explain:
Dressing:	☐ Yes	☐ No	If yes, explain:
Bathing:	☐ Yes	☐ No	If yes, explain:
Meals:	☐ Yes	☐ No	If yes, explain:
Feeding self:	☐ Yes	☐ No	If yes, explain:
Toileting:	☐ Yes	☐ No	If yes, explain:
Transfers:	☐ Yes	☐ No	If yes, explain:
Minor wound care:	☐ Yes	☐ No	If yes, explain:
Finances/scheduling:	☐ Yes	☐ No	If yes, explain:
Transportation:	☐ Yes	☐ No	If yes, explain:
Medication management:	☐ Yes	☐ No	If yes, explain:
Housekeeping:	☐ Yes	☐ No	If yes, explain:
Laundry:	☐ Yes	☐ No	If yes, explain:

Communication:	☐ Yes	☐ No	If yes, explain:
Shopping:	☐ Yes	☐ No	If yes, explain:
Assistive devices:	☐ Yes	☐ No	If yes, explain:

ADDITIONAL COMMENTS:

Please use this section for any additional information that is pertinent to the care of this member that is not stated elsewhere.

Comments:

TEAM COMMUNICATION:

All services were mutually agreed upon by all parties. Service worker will communicate eligibility/activation of specific services as well as any modifications to the service plan with all parties and providers.

1.	**Goal:**		
	Objective:		
	Action Steps	Start Date	Complete Date
2.	**Goal:**		
	Objective:		
	Action Steps	Start Date	Complete Date
3.	**Goal:**		
	Objective:		
	Action Steps	Start Date	Complete Date
4.	**Goal:**		
	Objective:		
	Action Steps	Start Date	Complete Date

SAFETY AND CRISIS PLAN:

Phone available at all times:	☐ Yes	☐ No
Capable of contacting 911:	☐ Yes	☐ No
Caretakers capable of assisting:	☐ Yes	☐ No
Knows what to do in case of a fire, tornado, earthquake, or other natural emergency:	☐ Yes	☐ No
Capable of getting out of the home unassisted:	☐ Yes	☐ No
Home is handicapped accessible:	☐ Yes	☐ No
Barriers during emergency situations:	☐ Yes	☐ No
Explain:		

Service (formal and informal)	Funding Source	Name of Provider and Number (any pay source):	Service Frequency (units, days per month)	Rate	Service Effective Dates Where Applicable
					From: To:
					From: To:
					From: To:
					From: To:

Natural supports:

Responsibilities

Provider Individual and/or Agency:

Member and Family:

Iowa Department of Health and Human Services:

Signatures

I certify that the above information is true and correct to the best of my knowledge.

Worker's Name	Supervisor's Name
Worker's Signature	Date
Supervisor's Signature	Date

Please check: ☐ I agree ☐ I disagree

Member's Signature	Date

Service Plan Review

Pursuant to Iowa Administrative Code 441-177.7(1)(b), the IHHRC Service Worker will review the Service Plan every 90 days. The Service Plan will be updated as necessary.

I certify that I have reviewed the Service Plan on the following dates:

Date of Review	IHHRC Service Worker Signature
Notes:	
Date of Review	IHHRC Service Worker Signature
Notes:	
Date of Review	IHHRC Service Worker Signature
Notes:	