Individual Program Plan Guide for Regional Centers

Department of Developmental Services

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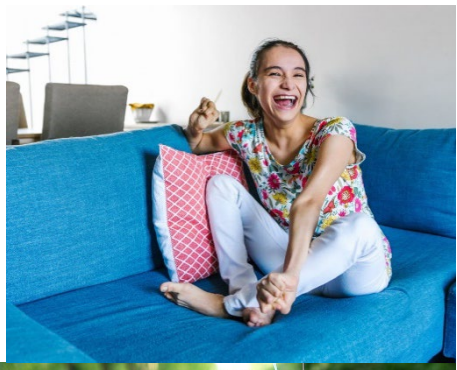

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SECTION 1: Introduction

1:1 Background

In September 2023, the State's Budget Trailer Bill for developmental services, SB 138 (Chapter 192, Statutes of 2023), added Welfare and Institutions (W&I) Code section 4435.1, requiring the establishment by June 30, 2024, of a standardized individual program plan (IPP) template and standardized procedures that are consistent with person-centered services planning requirements. Person-centered services planning requirements are described in the Federal Medical Home and Community-Based Final Rules (42 Code of Federal Regulations 441.301(c)(1-3).

Starting January 1, 2025, regional centers will use the new standard IPP template for all new IPP meetings, amendments, reviews and renewals. In the instance of biennial or triennial IPPs, individuals and families will have the option to transition to the new IPP template. If selecting the new IPP, regional centers must accommodate the request. By the end of 2027, all IPPs will transition to this new IPP template.

1:2 Overview of the Individual Program Plan (IPP)

For the purposes of this guide, the Individual Program Plan (IPP) is the document that outlines the goals and supports necessary to meet an individual's needs. This document is developed through a person-centered planning process, involving the individual and their planning team. The IPP should be based on the individual's strengths, capabilities, preferences, lifestyle, and cultural background.

Person-Centered planning, a fundamental approach to supporting individuals with disabilities, has evolved significantly in California over the years. Rooted in the principles of empowerment, choice, and dignity, person-centered planning prioritizes the unique needs and preferences of each individual, ensuring their active participation in decision-making processes related to their care and support.

The IPP is a detailed document tailored to an individual's needs and preferences. It is designed to ensure that supports and services are aligned with what is most important to and most important for the person and their goals.

An IPP should:

- Showcase a person's strengths and preferences
- Be self-directed
- Include people the individual wants involved in the process
- Use easy to understand language and writing styles
- Keep culture and communication preferences in mind
- Respect an individual's comfort level with sharing details of their life

This guide for regional centers will walk through the steps to completing an IPP in a person-centered way. It includes information about what is required in an IPP and provides regional center staff with “things to think about” throughout the IPP process.

SECTION 2: Principles of Person-Centered Planning

2:1 What is Person-Centered Planning?

Person-centered planning is an approach aimed at ensuring that individuals are at the forefront of decision-making processes regarding their own lives. This framework of planning is a dynamic, individualized approach used to help people plan their futures and achieve their personal goals. The approach emphasizes the unique preferences, strengths, and aspirations of the individual.

The key principles of person-centered planning include:

1. **Individual Focus**: It places the individual at the center of the planning process, recognizing their unique preferences, strengths, needs, and aspirations.

2. **Respectful:** Valuing the individual's perspective, culture, and communication preferences.

3. **Collaborative Process**: It involves collaboration among the individual receiving support, their parents, family members, friends, caregivers, and professionals from various disciplines to create a comprehensive plan.

4. **Self-Directed**: It aims to empower the individual by promoting self-determination in making choices that affect their life.

5. **Whole-Person Approach**: It considers all aspects of the individual's life, including social, emotional, physical, and psychological well-being.

6. **Flexible and Evolving**: Plans are flexible and can evolve over time as the individual's circumstances, goals, and needs change.

7. **Outcome-Oriented**: The focus is on achieving meaningful outcomes that enhance the individual's quality of life and promote their inclusion in their community.

2:2 Important To and Important For

"Important to" and "important for" are two perspectives used in person-centered planning and are key to understanding and addressing an individual's needs and preferences.

Important To

"Important to" refers to the things that matter most to an individual, the aspects of their life that bring them satisfaction, comfort, and happiness. These are the personal preferences, values, relationships, activities, and routines that are significant to the person's quality of life. Examples include:

- Valuing the role they play in their family
- Having a daily routine that they prefer
- Knowing co-workers have respect and confidence in them
- Going on a vacation that they saved up for
- Celebrating the holidays the way they want to celebrate them
- Building a relationship with a pet
- Volunteering at a place where they feel welcome and included

Important For

"Important for" refers to the elements necessary for an individual's health, safety, and overall well-being. These are often related to medical needs, safety measures, and practical supports that ensure the individual's welfare. This can also include an individual's experience as a valued member of their community. Examples include:

- Getting consistent physical exercise
- Making food choices that positively affect their health and well-being
- Being aware of our surroundings when walking around town
- Self-advocating for their rights to privacy, physical safety, and equal access to the community

Achieving a balance between "important to" and "important for" ensures that individuals not only remain safe and healthy but also lead fulfilling and satisfying lives. This approach underscores the essence of person-centered planning, which respects and honors individual preferences while meeting essential health and safety requirements.

In many sections of the IPP, you will be prompted to include what is important to and important for the individual in the narrative. Throughout this guide, you will find examples of how to describe important to and important for as well as things to think about while you gather this information from the individual and their family.

SECTION 3: Process for Developing the IPP

3:1 Getting Ready for the IPP Meeting

Person-centered planning provides an opportunity to engage directly with individuals to discuss their needs, and plan how they can achieve the best possible outcomes. Through a process of discovery in advance of an IPP meeting, conversations can be had about what is important to someone, important for someone and how best to support them.

Below are some example steps on how to prepare for an IPP meeting before the actual meeting.

1. Establish communication
   - Communicate with the individual and their support network to understand their preferences, goals, and specific needs. Outline for everyone the purpose and objectives of the upcoming IPP meeting

2. Gather information
   - Collect information about the individual's strengths, accomplishments, challenges, and goals that they want to achieve now and in the future
   - Review past records, reports, assessments, evaluations, and service plans to gain insights into what has been done in the past for the individual
   - Identify what has worked well and what hasn't

3. Gather an inclusive team
   - Have a conversation with the individual and /or their representative about who they would like to invite to participate in the planning process
   - Promote active participation and ensure everyone on the team are heard and valued

4. Provide Resources
   - Provide handouts, tools or workbooks to the individual in advance of the meeting so that they can start the discovery process and identify the areas of their life to set goals.

3:2 Conducting an IPP Meeting

The primary goal for the meeting is to assist the individual in the development of a plan that will support the individual's ability to achieve the life they want to lead. Below are some examples of steps to assist you to get started with an IPP meeting.

Facilitate Collaborative Discussions
Use person-centered planning techniques and tools to guide the discussion, discover insights about the person served, and inform the decision-making process. Encourage open dialogue, active listening, and mutual respect among all team members to ensure that measurable goals can be captured.

Develop a Comprehensive IPP

Based on the information gathered and discussions held during the meeting, collaboratively develop an individualized plan that reflects the individual's goals and preferences. Make sure the plan is realistic, achievable, and flexible enough to adapt to changing needs and circumstances. Discussion should be centered around:

- What is the goal or action?
- Who is responsible to follow through for each goal?
- When the goal should be completed?
- Information on how the goal will be accomplished.
- How will you measure if the goal has been accomplished?

Discuss Services

- The planning team should have conversations around what types of services and supports might help the individual make progress toward their goals.
- Determine the use of natural supports, generic resources or regional center funded services to support the individual.

Empower and Advocate

- Empower the individual and their support network to advocate for their rights and preferences.
- Provide information, resources, and support to help them navigate the service system and make informed decisions.

Document and Evaluate

- Keep thorough records of all meetings, discussions, and service plans.
- Regularly evaluate services and progress towards goals, revisit the plan as necessary, and make revisions to enhance effectiveness and alignment with the individual's evolving needs and preferences.

Foster Continuity and Follow-Up

- Maintain ongoing communication and collaboration with all circles of support.
- Follow up regularly to ensure the individual's needs are being met and address any emerging issues or concerns promptly.

3:3 Discussing Types of Services

Based on the desired outcomes, the planning team should have conversations about what types of services and supports would best meet that individual’s needs. Examples of these services may include educational supports, behavioral therapies, residential services, vocational training, respite care, medical services, transportation assistance, and more, depending on the individual’s requirements.

It is important to start the conversation with information about how an individual can receive services. Services may be offered by vendored service providers or through self-directed services.

The individual, with guidance from the regional center, can select from a pool of vendored service providers. The regional center ensures that chosen providers deliver the required services effectively and in accordance with the IPP.

Self-Direction

California's commitment to self-directing services through the Self-Determination Program (SDP) and Participant-Directed Services (PDS) marks a significant step toward empowering individuals and their circle of support. By promoting personal choice, flexibility, and control, these programs aim to enhance the quality of life for participants, enabling them to live more independently and integrate more fully into their communities. Regional center service coordinators play a vital role in communicating with individuals about self-direction, including the SDP and PDS. Effective communication strategies are essential to ensure that individuals and their families understand these programs and feel empowered to make informed decisions. Here are some key approaches:

1. **Use Plain Language**: Avoid jargon and use simple, clear language to explain concepts. For example, instead of saying "budget authority," say "you can decide how to spend your money on services you need."

2. **Focus on Individual Goals**: Begin discussions by talking about the individual's goals, preferences, and dreams. Frame the information about SDP and PDS in the context of how these programs can help achieve their personal goals and what services are available.

3. **Visual Aids**: Use charts, pictures, and videos to illustrate how SDP and PDS work. Visual aids can make complex information more accessible and easier to understand.

4. **Step-by-Step Explanation**: Break down the information into small, manageable steps. Explain each part of the program one step at a time, ensuring understanding before moving on.

5. **Encourage Questions**: Create an open environment where individuals feel comfortable asking questions. Answer questions patiently and encourage them to express any concerns or uncertainties.

6. **Offer Written Materials**: Provide brochures, fact sheets, and guides that individuals can take home and review with their families or support network.

7. **Connect to Other Resources**: Provide information on resources available to the individual if they are interested in pursuing self-direction, such as where to take an SDP orientation, how to locate supports to help the individual transition into the program or where to locate a Financial Management Service.

3:4 Things to Keep in Mind

Throughout the IPP process there are important concepts and requirements to keep in mind. This guide will highlight four important considerations that the planning team should take into account. Each of the four considerations will be identified by a specific icon. See Appendix B for a description of each icon.

 Culture	 Self-Direction
 Exceptions To Settings Requirements	 Home and Community-Based Services Waiver Eligibility

SECTION 4: Required Components of a IPP Narrative

4:1 Individual Information

The first section of the IPP captures important individual information related to the plan. Information included is the individual's:

- Legal Name
- Preferred Name (this is the name the individual wants to be referenced as throughout the IPP document)
- UCI Number
- Date of Birth
- Meeting Date
- Amendment Date (If Applicable)
- Next Review Date

4:2 Type of IPP Document

Based on the individual preferences and planning team conversations the IPP may be set for a period of one year, two years, or three years. Regardless of the determined length of the IPP, an annual review of the IPP and assessed needs must be completed. The IPP type should be selected as an Initial, Annual, Biennial, or Triennial. The type of plan may be used to determine the "Next Review Date" in the required Individual Information section.

Individuals and planning teams may amend the IPP at the request of the individual or as needed. Some examples of when an IPP might be amended could include:

- New or changing assessed need
- New or changing goal(s)
- New or changing services
- Other significant life events
- Transition periods

The Individual Program Plan may be written using first person or third person at the request of the individual served. A first person IPP is written from the perspective of the individual served and can be used when the person plays and active role in writing the plan or a section of the plan. While a third person IPP is still reflective of the individual's input into the plan, it is written from the perspective of the author of the document. Planning teams should have conversations around how the individual would like to record their IPP.

4:3 Introduction

The introduction section of the IPP is an opportunity to introduce the individual in a positive and person-centered way. The information captured in this section can be gathered through a discovery process and focuses on important things to know about an individual, what people like and admire about the individual, and the successes the individual would like others to know about.

Things to Think About:

- Culture and cultural identity
- Preferred Name
- Pronouns
- Interests
- Spirituality
- Preferred Language

This section includes three prompts:

- Things you should know about [Name]:
- What people like and admire about [Name]:
- Successes [Name] wants others to know about:

Culture often plays a large role in how we identify ourselves. When an individual introduces themself, providing information about their culture may be important to them and for others to understand their background. Always ask before assuming anything about an individual's background, culture, or ways they identify.

4:4 How This Plan Was Developed

In planning for the IPP meeting, it is important to consider the preferences and needs of the individual and their circle of support. A circle of support typically includes people chosen by the individual or their parents. This may include family members, friends, caregivers, teachers, mentors, neighbors, and professionals. The circle members should be committed to the well-being and development of the individual. IPP meetings should be conducted in a place and at a time that is comfortable for the individual. The IPP meeting should be an opportunity for the individual to decide who provides input into their plan and what type of information is provided. For young children or individuals who may have difficulty sitting through a long meeting, how the planning team captured the wants, needs and preferences should be indicated here.

This section includes three prompts:

- Where did the meeting happen?
- What part did [Name] choose to play in making this plan?
- Who also helped with the plan?

4:5 Vision for the Future

As young children, many of us are asked to entertain the question of "what do you want to be when you grow up?" From an early age, planning for the future shapes our experiences and how we live our lives. This section offers an opportunity to lift the voices of the individual and their circle of support in sharing their short and long-term goals. This section might focus on one area of an individual's life where they want to see changes or have goals, while other or different areas of life for someone else. It may also include objectives for those individuals or those who's caregivers are aging and how to plan for the future.

Things to Think About:
Short Term:

- Tasks that the individual may want to learn
- Activities that the individual may want to participate in
- Time limited goals the individual might have

Long Term:

- Vision for lifestyle or the way the individual lives their life
- Long term goals around things such as education, career, community, living and relationships etc.
- Planning for transitional stages in life (entering or exiting school, moving into a new home, anticipated changes in natural supports etc.)
- For those individuals whose caregivers are aging, what are the long-term plans to support those who may benefit from assistance in areas of daily living, community or lifestyle

4:6 Communication

Introduction to Section:
Communication is a critical piece of all our lives and an absolutely critical (and required) piece to include in the IPP.

The conversation will likely involve others in the individual's support network. Like any of us, it's often the people who know us best that know what a certain look or tone of voice means that we may not be aware of ourselves.

A Note on Preferred Language:
The IPP Meeting and the written IPP must be facilitated and provided in the individual's preferred language and/or the preferred language of a parent, supporting family member, conservator, or a legal representative. Keep in mind that speaking and understanding English does not make it the preferred language by default. For an individual or parent who speak a language other than English, it is important for the service coordinator to initiate a conversation on preferred language. The individual or family may not be comfortable offering that information unprompted.

Things to Think About:

- What communication methods does the individual use (verbal, communication device, facial expressions, behavior, etc.)? Which of these does the individual prefer or default to most often?
- How does the individual prefer others communicate with them? Do they understand others better with visual supplements or with additional time for processing? Are there other ways they can be supported with comprehension?
- What do others need to do/know to understand the individual's communication?
- What paid supports, if any, does the individual use or need related to communication? Assistive technology, speech therapy, social skills group, etc.?
- For individuals that have support from parents, family members or others to communicate, what can they share about how the individual communicates/understands?

There are two sections in this category of the IPP:

- How [Name] communicates with others:
- Important things you should know about how to communicate with [Name]:

4:7 Decision-Making

Introduction to Section

We each face decisions every day, such as where we spend our time, what we eat for dinner or the clothing we choose to dress in. For some, decisions are made easily, while others may benefit from support in making choices and decisions. Some decisions, regardless of our lives may lead us to seek advice or support from others, such as where we want to go to school or choosing one job over another. In seeking the advice and support of others for small and big decisions, having people the individual trusts and feels comfortable with may help to make decisions with and for the individual.

For minors, while there may be decisions that a parent or responsible person makes on behalf of the child, conversations around the role the individual plays in those decisions may be important to highlight for planning teams. For example, while the parent of a young child may make all decisions around medical or educational services for their child, it may be that as a family they collectively make decisions about where in the family spends time in their community based on the preferences of the individual and other family members. Additionally, the IPP team should have conversations for those transition age youth who are moving into adulthood and how to support them in their decision-making process in the future.

Things to Think About:

- What decisions does the person make for themselves?
- Could they benefit from support from others in making decisions?
- Could they make informed decisions (on their own)?
- Could they benefit from supported decision-making (help from others regarding options and impact of choices)?
- Are there any decisions that require substituted decision-making (authorized representatives/others deciding for them)? These might include:

    - Representative Payee
    - Power of Attorney
    - Guardianship
    - Limited Conservatorship
    - Educational Decision maker
    - Parent
- Does the individual you are supporting want any more information about any of the above legal roles?
- Does the individual experience a combination of informed, supported, and substituted decision-making?

The planning team should discuss which life area(s) the individual or parent may want to include in this section and may include as many life areas as applicable or desired.

There are two prompts to answer in this section:
- When making decisions about [select a life area], [Name] gets support from others in this way:
- The people who assist with decisions are:

4:8 Emergency Planning

Emergencies happen in all our lives. It could be a natural disaster, loss of ability for an individual or their caregiver to provide appropriate level of supports, death of a caregiver, loss of access to critical health care services. While everyone is at risk for and will likely experience some kind of emergency in their lives, some of us may be more likely to experience a specific kind of emergency than others. Someone who relies on others for mobility to get in and out of bed or in and out of their home is more likely to have an emergency if those people are suddenly not available.

We all live with the risk of an emergency and face the choice of whether we think the risk is high enough that we need to have a plan in place should it occur. While different for everyone, we all have a threshold at which point a risk feels like an unacceptable threat to safety. Someone living in a wildfire risk area likely has emergency supplies ready in case of evacuation and someone who lives on their own with limited mobility likely thinks about what they would do if the usual people they call for assistance can't be reached.

The purpose of this section of the IPP is to describe the risks in an individual's life that may lead to an emergency and that the individual and planning team agrees a specific emergency plan is appropriate. This section also describes what that emergency plan entails, including information about specific steps in an emergency or examples if beneficial to that individual.

There are three prompts to answer in this section:
- What is the emergency preparedness plan for [Name]?
- Who should be contacted in case of an emergency?
- Important things to know and do to support [Name] in an emergency.

SECTION 5: Life Areas

5:1 Overview of Life Areas Sections

In addition to the required components of the IPP, individuals may choose to include other important information about themselves. Planning teams should have conversations about areas that an individual (or parent of a minor) may choose to include in their IPP based on the individual's preferences and supports. Individuals may choose as many or as few additional categories to include in their IPP and present them in an order that they would like. Life Areas include:

- Choice/Advocacy
- Community Participation
- Education/Learning
- Employment
- Healthcare/Wellness
- Home Life/Housing
- Income/Finances
- Personal/Emotional Growth
- Relationships
- Safety Considerations
- Supports at Home
- Transportation/Getting Around

When a service or support is funded by the regional center, including those that are self-directed, a corresponding section should be completed. In aligning the types of services with the additional category, the individual's goals, personal wants, and needs should be considered.

A few examples of a regional center service and the corresponding sections may be:

Service Type	Possible Life Area (Not Exclusive)
Respite	Supports in the Home, Health and Wellness, Safety
Social Recreation	Relationships, Community Participation, Health and Wellness
Behavior Services	Homelife and Housing, Community Participation, Personal/ Emotional Growth
Community Living Supports (Self-Determination Program Service)	Homelife and Housing, Relationships, Income/ Financing

Each additional category has five questions to complete:

- What is the desired outcome?
- What is currently happening?
- What is important to [Name]?
- What is important for [Name]?
- What needs to be done?

Information about progress on previous outcomes for an IPP should be captured in the appropriate life area under “What is currently happening”. It is also important to capture information related to natural supports and generic resources that an individual may rely on under the life area. The information may be highlighted under what is currently happening, important to or important for depending on the relationship and type of support provided.

Natural supports refers to resources, relationships, and assistance that naturally exist within an individual's community and social environment. They are crucial in promoting independence, inclusion, and quality of life for individuals with developmental disabilities. Examples of natural supports include:

- Family
- Friends
- Neighbors
- Community members
- Other people that provide unpaid support

Generic resources are the services that are provided by other agencies, that have a legal responsibility to fund them. State law says that regional centers cannot pay for services for which another agency has responsibility. Examples of “Generic Resources” include:

- California Children’s Services
- City, County, and State Housing Services
- Community Legal Services
- County Medical Clinics
- County Mental Health and/or Behavioral Health Services
- Department of Rehabilitation
- Education System (Private and/or Public)
- Family Resource Centers
- Health Care Insurance (Private and/or Public)
- In-Home Supportive Services

The following descriptions of the Life Areas provide a framework and guidelines on the specific information to include in each section. Each description includes “Things to Think About” to assist service coordinators as you gather information related to each unique individual. These questions are NOT intended to be used as a list of questions for every individual and/or family. Conversations about any of the individual Life Areas must take into consideration careful framing of questions to demonstrate respect and honor each individual’s culture, background, and beliefs.

For individuals enrolled in the Home and Community-Based Services (HCBS) Waivers, goals and desired outcomes that link to a specific service purchased by a regional center must also link to an identified need.

5:2 Choice and Advocacy

Being known and valued in one's community gives a person a sense of worth and of being a contributor and good citizen, not just someone who needs assistance. Learning to make choices, set goals, and knowing how to speak up for wants and needs leads to being more self-determined in life and is essential for the individual to become an advocate for themselves or others. This section highlights the choices and decisions that individuals make for themselves, or with the support of those they trust. Examples of different types of advocacy include self-advocacy, peer advocacy and supported decision making.

5:3 Community Participation

Feeling connected in our communities promotes feelings of belonging and value. How someone spends time in their community can vary based on their preferences, culture, geographic location, and interests. When identifying opportunities for community participation it is important to determine what is important to someone and important for them to promote that connection.

Community participation could include activities that someone likes to engage in, hobbies that may interest them, or being around people they like. This section should include information about an individual's interest, hobbies, activities, and places they enjoy spending their time. It may also include activities that an individual participates in within their community, such as volunteering, social recreation, or day program activities.

Things to Think About:

- What are some of their interests? What do they like to do for fun?
- Who do they like to spend their time with? How often?
- Do they see their friends outside of typical daytime activities?
- What supports do they have?
- How do they feel about their current activities?
- What are some options they've considered when it comes to enriching their life?
- What strategies might be helpful for individuals to learn how to get involved in their communities?
- Is the individual interested in learning more about socialization and recreational resources?

Self-Directing services can be a way for individuals to have more flexibility in how they spend their time in the community and with who they choose to spend their time with.

5:4 Education/Learning

The education system plays a large role in the lives of many children, young adults, and lifelong learners. This section may be used to describe the educational goals, settings, and supports that are important to the individual. For those individuals who are under the age of 22 and receive services through a school district, information regarding the types of classroom settings, educational plans or specific supports may be important to include. For those who pursue higher educational goals, this section may be used to highlight educational successes, areas of support, or continued educational goals.

Equally important to the learning that happens in a formal setting is the lifelong learning that happens outside of school systems. Including information related to an individual's personal goals in learning may offer opportunities to reflect on that individual's desire to learn new hobbies, explore community classes, or gain new skills.

Things to Think About:

Education in a Formal Setting

- Does the individual participate formally in school? If so, what does that look like?
- Does the person have an educational plan or supports provided by their school?
- How does the school address the individual's unique communication needs?
- What are their educational goals?
- What do they like about their educational setting? Is there anything they would like to change?
- What type of transitional plan does the individual want when they exit the school district?

Lifelong Learning

- What new skills do they want to learn, or existing skills they want to expand?
- Are there new hobbies, activities, or classes they would like to participate in?
- What opportunities exist in their community for continued learning?
- Are there any supports that may be beneficial for the individual to have so that they can meet their learning goals?

5:5 Employment

The State's Employment First Policy, established in the Lanterman Developmental Disabilities Services Act (Act), is designed to further the availability of services and supports for persons to achieve more independent and productive lives, and support integration into community life.

At the IPP meeting for a person 16 years of age or older, service coordinators must provide information about the Employment First Policy, options for competitive integrated employment, and services and supports, including post-secondary education. This information is available to enable the individual to transition from school to work and to achieve the outcomes of obtaining and maintaining competitive integrated employment. Starting no later than age 16, talk with the individual you are supporting, and their family, about the advantages they can gain from employment, beyond earning wages.

Some of those advantages could be:

- Employment is important to the overall health and stability of any individual.
- Employment offers wages, benefits, status, and opportunities to make connections with coworkers and the community as a whole.
- Employment affords the community at large an opportunity to experience first-hand the capabilities and contributions made by individuals with developmental disabilities.
- Employment offers a life with income rather than public benefits.
- Employment empowers an individual to dream of and create a fulfilling career.
- Through work individuals develop relationships and gain self-esteem. They are not just in the community, but they become a part of the community.
- Employment offers all people access to other community citizens, a path out of poverty, and independence from service systems.

Things to Think About:

For Those Employed:

- What type of job do they have? How long have they had it?
- What are their wages, if they're comfortable sharing
- What is their schedule and how do they get to and from work?
- What types of supports do they have at their job?
- Are there opportunities for advancement in their job or other types of work they would like to explore?

For Those Considering Employment:

- What are they interested in/good at?
- What is their dream job?
- What are the educational and experience-based requirements for their preferred job?
- What are their thoughts about working and earning money after they finish school?
- Are there any resources or supports needed to be eligible for employment?
- What supports do they need to obtain and maintain a job?
- What concerns do they have around social security benefits and working?
- What is their desired outcome for employment?

If the Individual is Not Interested in Employment:

- Why not and what does the individual do during a typical day?
- How much control do they have over what they do and where they go?
- What level of access do they have to their community and to other people?
- Does the individual have opportunities to spend time with people who do not have identified disabilities (other than staff)?
- How does the individual seem to feel about employment? Assess current satisfaction as well as prior experience with employment.
- If the individual is retired, how do they fill their days now?

Regional center employment specialists may be able to help guide planning team conversations around resources.

5:6 Healthcare/Wellness

If agreed to by the individual, a parent of a minor child, or a legally responsible party, a review of the general health status including medical, dental, and mental health needs should be completed. This section should include a summary of the individual's relevant medical information and any significant changes, including age-related health issues. Additionally, this review shall include a discussion of current medications, any observed side effects, and the date of the last review of the medication. Access to medical services or referrals necessary should be discussed as part of the IPP as necessary.

A few examples of information that might be included in this section: review of weight, use of adaptive equipment if applicable, speech and/or language, hearing, and/or vision, sensory processing/ sensitivities, seizure status, recent major surgeries or illnesses, allergies or dietary restrictions, and hospitalizations. Note: this list is not all inclusive.

Any health status issues or conditions which are critical to the individual's health and safety should be discussed. However, everyone has the right to privacy and individuals may request that some information not be publicly discussed.

Things to Think About:

- What does health and wellness mean to the individual?
- What information are they comfortable sharing?
- Is there information that others may benefit from knowing to support that individual?
- How do they stay active?
- Are there any health issues or conditions that suggest a plan for the future may be needed?
- When an individual decides not to share information related to their health status, proceed respectfully by following these steps:
    - Acknowledge the decision and respect the individuals privacy regarding their health information.
    - Clarify understanding by politely asking if there are specific reasons or concerns, they have about sharing the information. This can help the individual feel heard.
    - Create a supportive and non-judgmental environment to encourage open communication and assure the individual that their decision will not impact the quality of support or services provided.
    - Focus the conversation on understanding the individual's current needs, goals, and preferences for services or support. Emphasize that the IPP aims to meet their unique needs effectively.
    - Explore alternative ways to gather necessary details if certain health information is crucial for providing appropriate support. This could involve discussing symptoms or general concerns without delving into specific medical history.
    - Document, in a respectful manner, the individual's preference and decision regarding the disclosure of health information.
    - Respect and maintain professional boundaries and avoid pressuring the individual into disclosing information they are not comfortable sharing.

- Provide information about available resources or support services that could be beneficial to them based on the information they are willing to share.
- Establish open channels of communication and schedule regular reviews of the IPP to ensure that the individual's needs and preferences are continually respected and addressed appropriately.

By proceeding with sensitivity and respect for the individual's autonomy and privacy, service coordinators can maintain trust and effectively support individuals in accordance with their preferences and needs.

5:7 Home Life/Housing

Whether a person may spend some of their time going to work, school, daycare, or other places in their community, home is where many people spend the majority of their time. How people define their home may vary based on a variety of cultural, financial, societal, or personal differences. A home is where many look to find their comforts and safety. It is important to ask questions around an individual's living situation to understand if it is reflective of their wants, needs and desires. For those who's living arrangements may not be meeting their preferences, the planning team should have conversations around what is working and not working and what types of supports may be beneficial to that individual and family.

Things to Think About:

- Where do they live? Are there things they like about it or things they wish could change?
- Who do they live with? What role do those that live with them play in their life?
- Who takes care of their home? How do they contribute to the home? Who helps within their home?
- Do they feel safe, valued, and comfortable in their home? What are the things in the home that make them feel this way? If they do not feel this way, what types of supports or arrangements would get them closer to that feeling?
- What would they like their future living situation to be? Would they like to live alone, with others, in a group setting or with their family? What are things they do not want in their home? What types of skills would they like to learn now to get them closer to their future goals?
- Are any changes anticipated for the future that suggest a plan may be needed?
- Do they have adequate supports to remain in their home if they or their caregivers are aging? Is there equipment they may need in their home to remain safely and independently?
- Is the person interested in learning more about available housing services to either remain in their existing home or explore alternative options?

Privacy is another important feeling that people may look for in their home. Privacy can look different from one person to another and may be reflective of that person's age, individual values, culture, or situation. A person's desires for privacy should be respected and confirmed. Planning teams should have conversations around what privacy looks like for someone, such as the information they share with others about themselves and who has access to their space.

When planning teams have conversations related to making exceptions to the HCBS Settings Requirements, it is important to document it within the IPP. See Appendix B.

5:8 Income/Finances

Discussing income and finances with others is an important, however sometimes sensitive subject. When discussing income and finances during the IPP meeting, the understanding that people's relationships with money may differ based on their personal experiences is important. For individuals who receive financial benefits such as Social Security Insurance (SSI), discussions can be had around the level of supports they may benefit from to maintain their benefits. Discussing wages, for those who are employed, can offer opportunities to discuss career growth and job opportunities that promote competitive integrated employment. How individuals manage their money is another topic that can be meaningful to include in the section such as identifying coins and bills, using a debit card to make purchases, budgeting funds, or contributing to savings. For those who benefit from assistance in money management, consider what supports are available to them to help them gain independence in this area.

Things to Think About:

- How do they manage their finances? Paying bills?
- Do they have a representative payee?
- Do they have a Special Needs Trust, CalAble account, or 529 savings plan?
- What is their current awareness of financial risk and potential for financial exploitation?
- Is the individual interested in learning more about managing their own finances?

5:9 Personal/Emotional Growth

Our emotional well-being and mental health is just as important as physical health. For individuals that choose to include this category, information might include an individual's personal and emotional growth as it relates to their thoughts, feelings, or actions. When discussing personal and emotional growth it is important to look through a culturally sensitive and person-centered lens. The thoughts, feelings, and actions of one individual varies from another, and can sometimes lead to unintended stigmas and reputations.

We all have good days and bad days but what defines that day is often different based on our preferences, desires, and needs. How we react to having a tough day may also vary. In the discovery process to gather information in this section, considering what makes someone have a good day versus a bad day can provide information related to what is important to and for them. For individuals who express how they are feeling through behavior, there may be an overlap in information in this section with that of the communication section.

Things to Think About:

- What happens in a day that causes them to feel they had a good day?
- What in their day causes them to feel successful?
- What can they or others do for them to have more successful days?
- What happens in a day that causes them to feel they had a bad day?
- What in their day causes them to feel stressed?
- What can they or others do for them to be less challenged in their day?
- How do they communicate their feelings with behavior?
- What do they want you to do to support them when they communicate their needs with behavior?
- Is the individual interested in counseling or mental health resources?

5:10 Relationships

Feelings of belonging are largely driven by who we spend our time with and the relationships we build. For many individuals, parents, family members, significant others, friends, teachers, co-workers, or support staff are who they may spend the most time with and who may play a significant role in their lives. The relationships that we have with people and their characteristics often define the amount of time we like to spend with them, situations we prefer to be in with them, or shared experiences we embark on together. Trust, respect, and compatibility are extremely important factors. This section may include important relationships in an individual's life, including their circle of support. Additionally, it may speak to the characteristics of people that the individual prefers to surround themselves with, which may change based on the setting or situation.

Things to Think About:

- Who do they feel close to in all the settings of their life?
- Who they enjoy being with at home, school, work, day program, church, shopping, eating out, going for a walk?
- Do they have friends, relatives, roommates, co-workers, a coach, pastor, support staff, etc. that play an important role in their lives?
- What are the characteristics of people who support them best?
- What interests do they enjoy sharing with others?
- Is there a need for any future planning around aging caregivers who play a large role in the individual's relationships?
- Does the individual want new experiences to develop relationships?

5:11 Safety Considerations

Historically, our service system has been based on a medical model that has engrained health and safety into the work done in the field. Safety considerations should be discussed with the individual and planning team as appropriate. How safety is defined may vary based on a variety of factors such as an individual's age, medical diagnoses, living situation, community participation or level of support required. A young child may always need direct supervision regardless of disability, whereas individuals above a certain age may vary based on their specific individual needs and supports.

Things to Consider:

- What level of supervision does the individual benefit from?
- Does the individual live alone or with others? Do they spend time by themselves?
- What is their level of knowledge related to safety skills at home or in the community?
- What safety skills do they want to learn or improve?
- Is the individual interested in learning more about public safety and awareness?

5:12 Supports at Home

With much of our time spent in our homes, for many that is where the daily tasks and activities occur. We each have our own routines, which can vary based on our own individual preferences. Daily living might include cooking, cleaning, chores, eating, using the restroom, showering, getting dressed or other ways that we care for ourselves or others. This section may include information about support that others assist with while in the home, this might include support from family, roommates, paid supports or assistive devices.

Things to Think About:

- What does their morning or evening routine look like?
- Are there things that they need to have a successful day?
- Are there skills that they would like to learn to be more independent in their home?
- Are there tasks that they benefit from having someone help with?
- Is the individual interested in or expressed a need for training or supports provided in home?

5:13 Transportation/Getting Around

Reliable access to transportation is an important factor in community participation and being able to access resources. This section can be used to describe the ways in which individuals get around. It may include private transportation such as having a driver's license or car, transportation provided by parents, family, friends and staff, or the use of public transportation or ride shares. Some individuals may choose to live in cities where resources may be accessed within walking distance, biking or buses, whereas others may live in remote areas and rely on paid transportation or family to get where they need to go.

Things to Think About:

- How do they get to where they need to go?
- Do they benefit from support for accessible transportation?
- Do they have a driver's license? Learner's permit? Car insurance?
- Have they had any travel training?
- What do they like/dislike about their current mode of transportation?
- How do they pay for transportation? How much is it?
- Is the individual interested in learning more about public transit or other available transportation resources?

SECTION 6: Required Components of IPP Agreement and Signature Form

6:1 Individual Information and Type of Plan

Complete this section of the Agreement form by filling in the areas including:

- First and Last Name
- UCI Number
- Date of Birth
- Federal funding source and type
- Date the review occurred
- Date of next review
- If the meeting was remote or in person
- Language the individual would like to receive a copy of their IPP in
- Type of plan, including reason for amendment if applicable.

6:2 Services and Supports

The IPP Agreement Form must be completed at the time of the meeting, whether written or electronic. This is an important form and ensures everyone leaves the IPP meeting knowing the desired outcomes and the service/support connected to that outcome. This section should be completed for each of the identified outcomes in the IPP and include the following information for each service support listed:

- Who will be providing it. This could be a regional center vendor or a generic resource.
- When it will start, if known.
- When it will end, if applicable. Some services continue until something changes in the individual's life, but some services are time limited. If there is an identified end date, it needs to be documented on the agreement form.
- How much will be provided. What number of hours or days will be indicated in the authorization? Or will it be a monthly or session unit?
- How often it will be provided. Per month, quarter, or year?
- The funding source. If the service/support is paid, indicate if it is funded by regional center, Department of Rehabilitation, IHSS, health insurance, etc.

A desired outcome should meet these criteria (SMARTIE):

- **Specific**. What is the desired result?
- **Measurable.** How will the planning team know if the outcome has been achieved or if progress is being made?
- **Achievable**. Is this a realistic outcome within the timeframe of the plan?

- **Relevant**. Does the outcome relate to what is important to the individual? It may or may not relate to what is important for the individual, but it should always reflect what is important to the individual.
- **Timebound.** When does the individual anticipate or want to achieve the outcome?
- **Inclusive.** Did the individual drive the conversation of their goals with support from their team as needed?
- **Equitable.** Is the goal fair and reflective of the individual's wants and needs?

6:3 Agreement of Services

This section is used to document if the individual or parent/legal representative agrees with the services and supports. There are two options to choose from: agreement on all services or agreement on some services.

Agreement on all services:
This option should be selected if all services were agreed upon by the planning team.

Agreement on some services:
This option should be selected if only some services were agreed upon by the planning team. Select the service(s) where the planning team did not come to an agreement.

Additional Requests:
When agreement on some services is selected, the individual may request additional actions. Those include holding another IPP meeting within 15 days, or later, and/or request a Notice of Proposed Action (NOPA). This should be sent in their preferred language.

Exceptions to Settings Requirement:
If the individual's team has discussed and agreed that modifications to the HCBS settings rules are necessary, it must be documented in the agreements section. In addition, the individual or their representative must indicate they are aware of the exceptions to their rights under the HCBS settings rule, and service coordinator should indicate which Life Area documents the justification for the modification. See Appendix B for further instructions.

Any modifications to the community settings rules for provider owned or controlled settings must document exceptions in the appropriate Life Area. See Appendix B.

6:4 Acknowledgements

This section of the agreement form verifies that the service coordinator has provided all required information to the individual and their family, if applicable, at the time of the IPP meeting. If you are unsure of what is indicated in these acknowledgements, it is important to get this information from a

colleague or manager prior to the meeting. You may need to have specific documents or information packets available whether electronically or as a paper copy.

These sections include:

- Statement of services and supports
- Needs in the future
- Frequency of IPP meetings
- Format to receive the IPP
- Self-Direction
- 4731 Complaint
- Whistleblower Policy
- Employment First Policy
- National Voter Registration Act
- Transportation Access Plan

Additional Notes:
This is a place to capture information that is still pending. This can also be used to capture any feedback from the individual or the planning team.

6:5 Signatures

The IPP must be signed by:

- The individual whose plan it is, if an unconserved adult
- The conservator, if conserved
- The parent or legal representative of a minor individual receiving services
- The regional center service coordinator

6:6 IPP Survey
At the end of the IPP, there is a link/QR code for the individual to provide feedback on their IPP meeting. This survey is voluntary and is anonymous. Only DDS will receive the results.

SECTION 7: Summary

A well-developed IPP serves as a comprehensive roadmap for achieving the personal goals and improving the quality of life of the individual. Upon completion of the IPP, it is imperative that the IPP undergoes thorough, periodic review and approval, followed by diligent implementation. Continuous monitoring, regular reviews, and open communication among all IPP team members are critical to its success. Providing necessary training and support, evaluating outcomes and making timely adjustments further enhance the IPPs effectiveness. By adhering to these steps, the IPP can successfully guide and support the individual's development and well-being.

APPENDIX A

Federal and State Requirements: Quick Reference

This Appendix is provided as a quick reference summary of current federal and state requirements directly related to the Individual Program Plan (IPP) and IPP Services Plan Agreement Form templates. Citations to federal and state requirements are linked and paraphrased for ease of reading. The Department strongly encourages you follow the links to view the full requirements. Some citations are referenced multiple times as there may be more than one area in the IPP where the requirements are applicable. All references to individuals below includes the role of, if appropriate, the individual's parents or legally appointed guardian of a minor or the legally appointed conservator of an adult, the individual's legal guardian or conservator, or other authorized representative.

Revised June 27, 2024

Individual Program Plan (IPP) Template	Federal Requirements/Reference	Lanterman Act Requirements/Reference
Name/UCI/Date of Birth		
Meeting Date/Amendment Date/Next Review Date	42 CFR 441.301(c)(3) – The plan must be reviewed at least every 12 months.	WIC §4646(c) – An IPP shall be developed for any person who, following intake and assessment, is found to be eligible for regional center services. These plans shall be completed within 60 days of the completion of the assessment. WIC §4646.5(b) – For all active cases, IPPs shall be reviewed and modified by the planning team, as necessary, in response to the person's achievement or changing needs, and no less often than once every three years.
Type of Plan	42 CFR 441.301(c)(3) – The plan must be reviewed, and revised upon reassessment of functional need as required by § 441.365(e), at least every 12 months, when the individual's circumstances or needs change	WIC §4646(c) – An IPP shall be developed for any person who, following intake and assessment, is found to be eligible for regional center services. These plans shall be completed within 60 days of the completion of the assessment.

Individual Program Plan (IPP) Template	Federal Requirements/Reference	Lanterman Act Requirements/Reference
	significantly, or at the request of the individual.	WIC §4646.5(b) – For all active cases, IPPs shall be reviewed and modified by the planning team, as necessary, in response to the person's achievement or changing needs, and no less often than once every three years.
Introduction • Things you should know about [Name] • What people like and admire about [Name] • Successes [Name] want others to know about	42 CFR 441.301(c)(2)(ii) – The plan must reflect the individual's strengths and preferences. 42 CFR 441.301(c)(1)(iv) – The planning process reflects the cultural considerations of the individual.	WIC §4646(a) – The IPP and the provision of services and supports by the regional center system is centered on the individual and the family of the individual and takes into account the needs and preferences of the individual and the family, if appropriate. WIC §4646.5(a)(1) – The planning process for the IPP shall include gathering information and conducting assessments to determine the life goals, capabilities and strengths, preferences of the individual.
How this plan was developed • Where did the meeting happen? • What part did [Name] choose to play in making this plan? • Who also helped with the plan?	42 CFR 441.301(c)(1)(i) – Includes people chosen by the individual. 42 CFR 441.301(c)(1)(iii) – Occurs at times and locations of convenience to the individual.	WIC §4646(b) – The individual shall have the opportunity to actively participate in the development of the plan. WIC §4646(d) – IPPs shall be prepared jointly by the planning team. WIC §4512(j) – "Planning team" means the individual with developmental disabilities, one or more regional center representatives, including the designated regional center service coordinator, any

Individual Program Plan (IPP) Template	Federal Requirements/Reference	Lanterman Act Requirements/Reference
		individual, including a service provider, invited by the consumer.
Vision for the Future • [Name]'s short and long-term visions	42 CFR 441.301(c)(2)(iv) – Includes individually identified goals and desired outcomes.	
Communication • How [Name] communicate with others • Important things you should know about how to communicate with [Name]	42 CFR 441.301(c)(2)(vii) – Be understandable to the individual and the individuals important in supporting them.	
Decision-Making • When making decisions about [Life Area], [Name] gets support from others in this way • The people who assist [Name] with decisions are	42 CFR 441.301(c)(1)(ii) – The planning process provides necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions. 42 CFR 441.301(c)(1)(vii) – The planning process offers informed choices to the individual regarding services and supports they receive and from whom.	
Life Areas • Choice/Advocacy • Community Participation • Education/Learning • Employment • Healthcare/Wellness • Home Life/Housing • Income/Finances • Personal/Emotional Growth	42 CFR 441.301(c)(1)(ii) – The planning process provides necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions. 42 CFR 441.301(c)(1)(iv) – The planning process reflects the	WIC §4646(b) - The IPP and provision of services and supports by the regional center system is centered on the individual and the family of the individual and takes into account the needs and preferences of the individual and the family, if appropriate, as well as promoting community integration, independent, productive, and

Individual Program Plan (IPP) Template	Federal Requirements/Reference	Lanterman Act Requirements/Reference
• Healthcare/Wellness • Personal/Emotional Growth • Relationships • Safety Considerations • Supports at Home • Transportation/Getting Around	cultural considerations of the individual. 42 CFR 441.301(c)(1)(vii) – The planning process offers informed choices to the individual regarding services and supports they receive and from whom. 42 CFR 441.301(c)(2) – The plan must reflect the services and supports important for the individual to meet the needs identified through an assessment of functional need, as well as what is important to the individual with regard to preference for the delivery of such services and supports. 42 CFR 441.301(c)(2)(i-vii) – The plan must: reflect the individual's strengths and preferences; the clinical and support needs as identified through an assessment of functional need; include individually identified goals and desired outcomes; reflect the services and support (paid and unpaid) that will assist the individual to achieve their identified goals; reflect risk factors and measures in place to minimize them; and be understandable to the individual. 42 CFR 441.301(c)(2)(xiii) – The plan must document any modifications to the settings requirements.	normal lives, and stable and healthy environments. It is the further intent of the Legislature to ensure that the provision of services to individuals and their families be effective in meeting the goals stated in the IPP, reflect the preferences and choices of the individual, and reflect the cost-effective use of public resources. WIC §4646.5(a)(2) – A statement of goals, based on the needs, preferences, and life choices of the individual, and a statement of specific, time-limited objectives for implementing the person's goals and addressing the person's needs. These goals and objectives should maximize opportunities for the individual to develop relationships, be part of community life in the areas of community participation, housing, work, school, and leisure, increase control over the individual's life, acquire increasingly positive roles in community life, and develop competencies to help accomplish these goals.

Individual Program Plan (IPP) Template	Federal Requirements/Reference	Lanterman Act Requirements/Reference
Emergency Planning • What is the emergency preparedness plan for me? • Who should be contacted in case of an emergency? • Important things to know and do to support me in an emergency.	42 CFR 441.301(c)(2)(vi) – The plan reflects risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.	

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IPP Services Agreement and Signature Form	Federal Requirements/Reference	Lanterman Act Requirements/Reference
Name/UCI/Date of Birth		
Federal Funding		
Date Review Occurred/Next Review Date/Remote Meeting	42 CFR 441.301(c)(3) – The plan must be reviewed at least every 12 months.	WIC §4646(c) – An IPP shall be developed for any person who, following intake and assessment, is found to be eligible for regional center services. These plans shall be completed within 60 days of the completion of the assessment. WIC §4646.5(b) – For all active cases, IPPs shall be reviewed and modified by the planning team, through the process described in Section 4646, as necessary, in response to the person's achievement or changing needs, and no less often than once every three years.
Preferred Language	42 CFR 441.301(c)(2)(vii) – The plan must be understandable to the individual receiving services and supports, and the individuals important in supporting them.	WIC §4646(j)(3) – The preferred language of the individual or the consumer's family, legal guardian, conservator, or authorized representative, or both, shall be

IPP Services Agreement and Signature Form	Federal Requirements/Reference	Lanterman Act Requirements/Reference
		documented in the individual program plan.
Type of Plan		WIC §4646(c) – An individual program plan shall be developed for any person who, following intake and assessment, is found to be eligible for regional center services. These plans shall be completed within 60 days of the completion of the assessment. WIC §4646.5(b) – For all active cases, individual program plans shall be reviewed and modified by the planning team, through the process described in Section 4646, as necessary, in response to the person's achievement or changing needs, and no less often than once every three years.
List of Agreed Upon Services and Supports • Desired Outcome • Funding Source • Service/Support • Supported By • Start/End Date • How Much • How Often	42 CFR 441.301(c)(2)(iv) – The plan includes individually identified goals and desired outcomes.	WIC §4646(b) - The provision of services to individuals and their families must be effective in meeting the goals stated in the IPP, reflect the preferences and choices of the individual, and reflect the cost-effective use of public resources. WIC §4646(d) – Decisions concerning the individual's goals, objectives, and services and supports that will be included in the IPP and purchased by the regional center or obtained from generic agencies shall be made by agreement between the regional center representative and the individual. WIC §4646.5(a)(5) – A schedule of the type and amount of

IPP Services Agreement and Signature Form	Federal Requirements/Reference	Lanterman Act Requirements/Reference
		services and supports to be purchased by the regional center or obtained from generic agencies or other resources in order to achieve the IPP goals and objectives, and identification of the provider or providers of service responsible for attaining each objective, including, but not limited to, vendors, contracted providers, generic service agencies, and natural supports. The IPP shall specify the approximate scheduled start date for services and supports and shall contain timelines for actions necessary to begin services and supports, including generic services.
Agreement of Services • Agreement is achieved • The team does not agree (list services) • Exceptions to the settings requirements? (list areas)	42 CFR 441.301(c)(2)(ix) – The plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation. 42 CFR 441.301(c)(2)(xiii) – The plan must document any modifications of the settings requirements.	WIC §4646(g) – The regional center shall sign the list of agreed-upon services and supports at the time of the meeting. The individual shall sign the list of agreed-upon services and supports prior to its implementation. WIC §4646(h) – If a final agreement regarding the services and supports to be provided to the individual cannot be reached at a program plan meeting, then a subsequent program plan meeting shall be convened within 15 days, or later at the request of the individual. WIC §4646(i) – The regional center and the individual shall sign the individual program plan and the list of the agreed-upon

IPP Services Agreement and Signature Form	Federal Requirements/Reference	Lanterman Act Requirements/Reference
		services and supports prior to its implementation. If the individual does not agree with all components of the IPP, the individual may indicate that disagreement on the plan. Disagreement with specific plan components shall not prohibit the implementation of services and supports agreed to by the individual. If the individual does not agree with the plan in whole or in part, the individual shall be sent written notice of their appeal rights, as required by Sections 4701 and 4710.
Acknowledgements • Individual has been provided statement of regional center purchased services and supports in the last year. • Individual has discussed and shared information about their needs. • Service Coordinator is responsible to monitor the plan. • Individual can have a planning team meeting at any time.	42 CFR 441.301(c)(1)(viii) – The planning process includes a method for the individual to request updates to the plan as needed. 42 CFR 441.301(c)(2)(viii) – The plan identifies the individual and/or entity responsible for monitoring the plan. 42 CFR 441.301(c)(3) – The plan must be reviewed, and revised upon reassessment of functional need as required by § 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.	WIC §4646(g) – The regional center shall provide, in written or electronic format, a list of the agreed-upon services and supports, and, if known, the projected start date, the frequency and duration of the services and supports, and the provider. WIC §4646(d) – IPPs shall be prepared jointly by the planning team. Decisions concerning the individual's goals, objectives, and services and supports that will be included in the IPP and purchased by the regional center or obtained from generic agencies shall be made by agreement between the regional center representative and the individual at the program plan meeting. WIC §4647(a) – Service coordination shall include those activities necessary to implement an IPP, including, but not limited

IPP Services Agreement and Signature Form	Federal Requirements/Reference	Lanterman Act Requirements/Reference
		to, participation in the IPP process; assurance that the planning team considers all appropriate options for meeting each IPP objective; securing, through purchasing or by obtaining from generic agencies or other resources, services and supports specified in the person's IPP; coordination of service and support programs; collection and dissemination of information; and monitoring implementation of the plan to ascertain that objectives have been fulfilled and to assist in revising the plan as necessary.
Copy of the IPP	42 CFR 441.301(c)(2)(x) – The plan must be distributed to the individual and other people involved in the plan.	WIC §4646.5(a)(6) – Each regional center shall offer, and upon request provide, a written copy of the IPP to the individual within 45 days of their request in a threshold language, as defined by paragraph (3) of subdivision (a) of Section 1810.410 of Title 9 of the California Code of Regulations.
Self-Direction	42 CFR 441.301(c)(2)(xi) – The plan must include those services, the purpose or control of which the individual elects to self-direct.	
4731 Complaint		WIC §4731 – Any individual who believes that any right to which they are entitled has been abused, punitively withheld, or improperly or unreasonably denied by a regional center, state-operated facility, or service provider, may pursue a complaint.
Whistleblower Policy		Whistleblower Policy – Whistleblower complaints are

IPP Services Agreement and Signature Form	Federal Requirements/Reference	Lanterman Act Requirements/Reference
		defined as the reporting of an improper regional center or vendor/contractor activity.
Employment First		WIC §4646.5(a)(4) – In developing an IPP for a transition age youth or working age adult, the planning team shall consider the Employment First Policy
National Voter Registration Act (NVRA)		The NVRA requires that public agencies such as Regional Centers provide people the opportunity to register to vote.
Transportation Access Plan		WIC §4646.5(a)(7) – The planning process for the IPP shall include the development of a transportation access plan when certain conditions are met.
Additional Notes		

APPENDIX B

Things to Keep in Mind

Throughout the Individual Program Plan(IPP) process, there are additional considerations the planning team should take into account, such as the setting that the individual receives services in, funding related to federal waivers, or how someone desires to receive their services. Though these may not be a specific section in the IPP, it is important to weave these concepts throughout the required and additional categories. Keep this page handy as a reference sheet when developing the IPP.

Respecting a Person's Culture

Speaking about an individual's culture in their IPP is important for the following reasons:

- Respect and Inclusion:
  Acknowledging and incorporating an individual's cultural background shows respect for their identity and fosters an inclusive environment. This recognition helps the individual feel valued and understood.

- Tailored Support:
  Culture influences various aspects of an individual's life, including their values, beliefs, customs, communication styles, and preferences. Understanding these cultural factors allows caregivers and support teams to provide more effective and personalized services.

- Enhancing Communication:
  Cultural competence improves communication between the individual and their support network and helps avoid misunderstandings and ensures that the individual's needs and preferences are accurately conveyed and addressed.

- Building Trust:
  When an individual's cultural background is recognized and respected, it builds trust between them and their support team. Trust is essential for effective collaboration and for the individual to feel safe and supported.

- Improving Outcomes:
  Person-centered plans that incorporate cultural considerations are more likely to be successful. They align better with an individual's worldview and lifestyle, leading to higher satisfaction and better outcomes.

- Promoting Equity:
  Addressing cultural aspects in person-centered planning promotes equity by making services more accessible and appropriate for individuals from diverse backgrounds which helps reduce disparities in care and support.

Integrating culture into person-centered planning enhances the relevance, effectiveness, and quality of the support that is provided, leading to a more inclusive and respectful approach to care and support.

Self-Direction

Self-Direction offers individuals a way to receive services in a way in which they have flexibilities in the services and supports they receive, including who they hire to work with and how that service is provided. By promoting personal choice, flexibility, and control, these programs aim to enhance the quality of life for participants, enabling them to live more independently and integrate more fully into their communities.

Individuals may choose to self-direct for a variety of reasons such as:

- Flexibility in the supports provided to reach their goals
- Use of vendored and non-vendored services
- Ability to locate providers and hire employees who might:
  - Speak their language
  - Understand their culture
  - Provide services when and where they want
  - Offer services not available through another provider

As part of the process of developing the IPP, individuals and their families should be informed about services they may choose to self-direct through Participant-Directed Services or the Self-Determination Program. This conversation should occur regardless of their age, disability, level of supports required or living situation and confirmation that the information has been provided to the individual should be documented into the IPP.

Participant-Directed Services
Participant-Directed Services (PDS) provides individuals the option to exercise more authority over how, and by whom, their services are provided. PDS offers a more flexible approach compared to traditional services by allowing participants to direct and manage certain aspects of their care.

With participant direction, individuals have employer authority and responsibilities including choosing, scheduling, and supervising workers.

Examples of PDS include:

1. **Personal Assistance Services**: Participants can hire, supervise, and manage their own personal assistants. This includes the ability to select individuals who are a good fit for their personal needs and preferences.

2. **Respite Services**: Families can arrange for respite care that fits their schedules and needs, providing temporary relief from caregiving responsibilities.

3. **Social Recreation and Camping Services**: Participants can have a financial management service provider pay for the social recreation, camping and non-medical therapies instead of needing to be a vendor of the regional center.

4. **Supported Employment Services**: Participants can choose and direct services that help them find and maintain employment. This includes job coaching and other supports tailored to their employment goals.

5. **Independent Living Skills**: Participants can select services that help them develop skills necessary for independent living, such as cooking, budgeting, and transportation training.

Self Determination Program

The Self-Determination Program (SDP) is grounded in five key principles:

1. **Freedom**: Participants have the freedom to plan their lives and choose the services that best meet their individual needs.

2. **Authority**: Participants have authority over a budget to purchase services and supports that are tailored to their specific requirements.

3. **Support**: Participants can choose their own supports, including hiring their own staff or using traditional service providers.

4. **Responsibility**: Participants take responsibility for managing their budget and making decisions that will help them achieve their goals.

5. **Confirmation**: Participants are recognized as critical contributors to the community and are supported in their efforts to lead more independent lives.

The SDP allows participants both budget and employer authority. The SDP offers participants and their families flexibility and choice for their services along with increased responsibility. The participant and their IPP team develop a budget and spending plan that is used to purchase services and supports needed to implement their IPP outcomes. In the SDP, participants must use an FMS to help manage budgets, hire and pay staff, verify skills of staff, and comply with both federal and California employment and tax laws.

Exceptions to Settings Requirement

Individuals receiving Home and Community-Based Services (HCBS) must be offered choice in who and where services are provided, have opportunities to access the community, control their personal resources and schedules, and have support in seeking competitive and integrated employment if they choose. A full list of the federal settings requirements can be found on the DDS website: https://www.dds.ca.gov/wp-content/uploads/2023/08/HCBS-Handout_Final-Rule-Requirements-with-Modifications.pdf.

For individuals receiving residential services in provider-owned and/or controlled settings, there may be circumstances where an exception to the federal settings requirements is necessary. For example, there may be a reason an individual cannot have access to food at any time due to a specific diagnosis. In this case an exception, or sometimes called a modification, to that setting requirement is needed to keep that individual safe. The decision to implement a modification to the settings requirements is made amongst the planning team, and the individual must give informed consent. The IPP must support and justify the specific and individualized assessed need which requires the exception, documenting:

- The positive interventions and supports used prior to any modifications
- Less intrusive methods of meeting the need that have been tried but did not work
- A clear description of the condition that is directly proportionate to the specific assessed need
- Regular collection and review of data to measure the ongoing effectiveness of the modification
- Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated
- An assurance that interventions and supports will cause no harm to the individual

This information should be reflected in each category where an exception to the settings requirement is supported and justified by a specific assessed need. Categories that might be common include, but are not limited to: Healthcare/Wellness, Homelife and Housing, Relationships, Safety Considerations, and/or Supports at Home.

The agreement form will reflect what categories contain the above justification for an exception to the settings requirements and will also document the individual's consent to any exceptions.

Home and Community-Based Services Waiver Eligibility

An individual is eligible for the 1915c Home and Community-Based Services (HCBS) waivers, both traditional services and for the Self-Determination Program, if they have two moderate to severe support needs derived from the assessment completed on the CDER. These needs should be identified on the CDER and summarized on the DS 3770 and re-evaluated for recertification annually. These needs are not required to be listed in the IPP as conditions, but information should be discussed in terms of the needs the person has and should be reflected in the IPP that notes what these needs look like and what supports are in place (paid, unpaid and/or generic) to address those needs. If IPPs are completed biennially or triennially, an annual review of the IPP is required using the Standardized Annual Review Form. The annual review should assess the individuals, health, needs and progress.

Any individual, who has Medi-Cal and is not on the HCBS Waiver, can be added to the 1915i State Plan Amendment (SPA). For the SPA, there is no requirement for the individual to have a minimum of two support needs.

There are certain components that are required relating to the IPP for both the 1915c waivers as well as the 1915i SPA.

- IPP should address health and safety needs and include any special healthcare requirements identified in the CDER
- All IPPs should address the assessed needs of the individual and should have their needs addressed in the IPP along with the identification of services and supports
- All individuals on a waiver should be receiving at least one waiver eligible service and the type and amount of this service should be reflected in the IPP