**WNYCCP 2005 Indicators of Person Centered Planning**

**The person's activities, services and supports are based upon his or her dream, interests, preferences and strengths.**

1. The person's (enrollee's) interests and strengths drive activities, services and supports (QOLSA and ISP)
   Examples include:
   - Quality of life areas that the person wants on the service plan are included in the ISP, and
   - ISP goals, activities (services and supports) reflect the person's interests and strengths, and
   - ISP goals and activities are a balance of important to the person and important for the person.

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| The ISP does not reflect interests and strengths at all. | Interests and strengths are noted but do not drive goals or activities. | One to two activities are important to the person, but the ISP's focus is what's important for the person. | ISP goals & activities are well balanced between what is important to & what is important for the person. |

Comments:____________________________________________________________

2. Services and supports are individualized. (ISP).
   Examples include:
   - See supportive language such as "explore", "work out", "negotiate"
   - Not using "police language" such as "will comply"
   - When reviewing several ISPs, they are not the same

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| ISP is not personalized, i.e. goals and services are standardized. | ISP goals are personalized, but activities are not (standard services and supports.) | Both ISP goals and activities are personalized | ISP goals and activities are personalized and adjusted with circumstances. |

Comments:____________________________________________________________

**Activities, supports and services foster skill to achieve personal relationships, community inclusion, dignity and respect.**

3. The person has a presence in a variety of typical community places. Segregated services and locations are minimized (ISP).
   Examples include:
   - Items such as "community education", various generic (non-mental health) clubs, volunteer work etc. and
   - ISP demonstrates empowerment

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| Activities, supports and services focused solely within the Behavioral Health community | There are some non-segregated activities not moving towards any new ones. | Planning is moving towards non-segregated environments consistent with the person's needs & desires | Individual is supported in non-segregated environments consistent with the person's needs & desires |

Comments:____________________________________________________________

**Planning is collaborative, recurring and involves an ongoing commitment to the person, as evidenced by:**

4. Planning activities occur periodically and routinely. Lifestyle decisions are revisited (QOLSA, ISP).
   Examples include
   - There are modifications to the ISP at significant events that impact on the person and;
   - See evidence on the ISP review that there has been progress, not all goals are continuations, and there have been changes in the plan.

| 1 | 2 | 3 | 4 | Not Applicable |
|---|---|---|---|---|
| ISP is not reviewed at the required intervals or is reviewed at the required intervals without updating goals and supports | ISP updates show revisiting of goals and supports. | Change in goals and supports reflect changes in what the person thinks are most important | ISP goals and supports are updated at significant events or when barriers are encountered. Change in goals and supports reflect what the person thinks are most important | Only one service plan is available and the person has been in Care Coordination less than 6 months in the review period. |

Comments:_____________________________________________________________________

5. A group of people who know, value and are committed to the person remains involved (ISP).
   Examples include
   - ISP review indicates feedback from other providers;
   - Signoff on the ISP by an individual external to the Care Coordination program and;
   - ISP review indicates feedback from non-providers i.e. family, landlords etc.

   Note: all collaboration needs to be with the person's consent

| 1 | 2 | 3 | 4 |
|---|---|---|---|
| ISP is reviewed at the required intervals and planning is between the person and the care coordinator only | Providers are notified of the plan. | Other providers are and significant others are consulted in the plan or the service plan update | Planning shows an ongoing collaborative approach between the clients, the care coordinator, and the significant individuals in the person's life |

Comments:_____________________________________________________________________

**The person is satisfied with his or her activities, supports and services, as evidenced by:**

6. There are steps towards tangible changes in areas where the person is dissatisfied (QOLSA, ISP).
   - ISP review shows attention to goals or goal attainment
   - Reflects hope

| 1 | 2 |
|---|---|
| Service planning does not address dissatisfaction with life situation. | Service planning does address dissatisfaction with life situation. |

Comments:_____________________________________________________________________