pennsylvania
DEPARTMENT OF HUMAN SERVICES

OLTL INDIVIDUAL SERVICE PLAN

Name:	Date:

Participant Information

Name of Participant (Last, First, Middle)				Date
Address (Street, City, State)			Zip Code	County
Telephone Number	Birth Date	Sex	Social Security Number	Recipient Number (MA ID)
Race:	Email:		OLTL HCBS Waiver/Program:	

Directions to Participant's Residence

Individual Back-Up Plan (support plan for unexpected disruption in service)

Individual's Name/Agency Name	Telephone Number/Email

Emergency Back-Up Plan (Emergency Preparedness Plan)

Representative Contact(s)/Relationship	Telephone

Primary Language or Way of Communication

Long Term Goals:

Short Term Goals:

Participant Strengths (including existing supports and resources):

Household Composition (name of persons)	Relationship to Participant and Age

pennsylvania
DEPARTMENT OF HUMAN SERVICES

OLTL INDIVIDUAL SERVICE PLAN

Name:	Date:

List identified needs:	Met:	Partially met:	How is met?	Unmet:

Community Resources (Is the participant utilizing any community resources to assist with independence?):

List informal supports:

TPL (please list any other types of insurance(s):

If the participant is receiving any services that are not funded through OLTL waiver/program, please list below.

NON-WAIVER / PROGRAM SERVICES

Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences

Frequency/Duration (Hours/Days):	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Total Hours/Week:	Any Barriers/Risks:	Mitigation Strategy:	Agree/Disagree:
0			

Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences

Frequency/Duration (Hours/Days):	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Total Hours/Week:	Any Barriers/Risks:	Mitigation Strategy:	Agree/Disagree:
0			

Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences

Frequency/Duration (Hours/Days):	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Total Hours/Week:	Any Barriers/Risks:	Mitigation Strategy:	Agree/Disagree:
0			

pennsylvania
DEPARTMENT OF HUMAN SERVICES

OLTL INDIVIDUAL SERVICE PLAN

Name:	Date:

OLTL WAIVER / PROGRAM SERVICES

Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences

Frequency/Duration (Hours/Days):	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Total Hours/Week:	Any Barriers/Risks:	Mitigation Strategy:	Agree/Disagree:
0			

Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences

Frequency/Duration (Hours/Days):	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Total Hours/Week:	Any Barriers/Risks:	Mitigation Strategy:	Agree/Disagree:
0			

Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences

Frequency/Duration (Hours/Days):	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Total Hours/Week:	Any Barriers/Risks:	Mitigation Strategy:	Agree/Disagree:
0			

Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences

Frequency/Duration (Hours/Days):	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Total Hours/Week:	Any Barriers/Risks:	Mitigation Strategy:	Agree/Disagree:
0			

Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences

Frequency/Duration (Hours/Days):	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Total Hours/Week:	Any Barriers/Risks:	Mitigation Strategy:	Agree/Disagree:
0			

pennsylvania
DEPARTMENT OF HUMAN SERVICES

OLTL INDIVIDUAL SERVICE PLAN

Name:	Date:

OLTL WAIVER / PROGRAM SERVICES

Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences

Frequency/Duration (Hours/Days):	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Total Hours/Week:	Any Barriers/Risks:	Mitigation Strategy:	Agree/Disagree:
0			

Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences

Frequency/Duration (Hours/Days):	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Total Hours/Week:	Any Barriers/Risks:	Mitigation Strategy:	Agree/Disagree:
0			

Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences

Frequency/Duration (Hours/Days):	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Total Hours/Week:	Any Barriers/Risks:	Mitigation Strategy:	Agree/Disagree:
0			

Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences

Frequency/Duration (Hours/Days):	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Total Hours/Week:	Any Barriers/Risks:	Mitigation Strategy:	Agree/Disagree:
0			

Goal (Desired Outcome)	Identified Need	Action Step/Service	Provider/Responsible Party	Preferences

Frequency/Duration (Hours/Days):	Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Total Hours/Week:	Any Barriers/Risks:	Mitigation Strategy:	Agree/Disagree:
0			

pennsylvania
DEPARTMENT OF HUMAN SERVICES

OLTL INDIVIDUAL SERVICE PLAN

Name:	Date:

HAVE YOU ADDRESSED ALL OF YOUR NEEDS AND RISKS IN THE SERVICE PLAN? IF NO, COMPLETE THE NEXT SECTION.

☐ YES ☐ NO

Unaddressed Needs/Risks/Barriers identified during the assessment process:
Mitigation Strategy (How are barries being addressed/reduced?)
Additional Supports (Are additional supports needed?)
Discussion of Mitigation Strategies (Do you agree/disagree with the mitigation strategies?)

Service Plan Type:	Initial:	Annual:	Revision:	Date Completed:

	Your signature acknowledges that you received, reviewed and discussed the following information:
	NOTIFICATION OF SERVICE DETERMINATION AND THE RIGHT TO APPEAL (Given only when services are being denied, reduced, terminated, or suspended.)
	PROVIDER CHOICE FORM
	FREEDOM OF CHOICE FORM
	TOLL FREE PARTICIPANT HELPLINE PHONE NUMBER
	HOW TO REPORT INCIDENTS OF ABUSE, NEGLECT/EXPLOITATION
	EMERGENCY BACK-UP PLAN (Emergency Preparedness Plan)
	INDIVIDUALIZED BACK-UP PLAN
	AVAILABLE SUPPORTS (BOTH WAIVER/PROGAM AND NON-WAIVER/PROGRAM)
	MY INDIVIDUALIZED SERVICE PLAN
	I HAVE BEEN INFORMED OF, UNDERSTAND AND ACCEPT THE RISKS IDENTIFIED IN MY SERVICE PLAN
	PARTICIPANT INFORMATION MATERIALS

Date:	Participant signature:
Date:	Representative signature designated by participant:
Date:	Signature of others who participated in developing the plan:
Date:	Signature of others who participated in developing the plan:
Date:	Care Manager/Service Coordinator signature:
Date:	Care Manager/Service Coordinator Supervisor signature: