**MA DDS Autism Division**

**AUTISM SUPPORT PLANNING DOCUMENT**

**Autism Waiver Program**

**Demographics**

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| --- | --- |
| Child’s Name: | Date of Birth: |
| Parent/Guardian Name(s): | |
| Address: | |
| School Program: | Date of Autism Support Plan: |
| Lead Autism Support Center: | Primary Language of Family:  Is an interpreter required?  Yes  No |

**Individual Profile**

1. Who are the members of the planning team and people involved in the implementation of the program? (include responsible adults home during sessions, etc.). Please check for responsible adult(s)/release on file.

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| --- | --- | --- |
| Name | Relationship | Checkmark with solid fill |
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2. Who lives in the home and have there been any changes in the last year?  Yes  No

(information is included in the CCA) Please check for responsible adult(s)/release on file.

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| --- | --- | --- |
| Name | Relationship | Checkmark with solid fill |
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| Notes: | | |

3. Are there other people who provide support to the child who live outside of the family home? (information included in the CCA)

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| --- | --- |
| Name | Relationship |
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4. What are the current supports and services the child receives? (ex. MH ABA, 766 Program, DCF, DPH, Personal Care Assistance, food stamps, fuel assistance, SLT, OT, PT, etc.). Please check for release on file.

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| --- | --- | --- | --- |
| Type of Support | Total Number of Hours Per Week | Name/Contact Information | Checkmark with solid fill |
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5. Describe the child’s strengths (these are things the child enjoys or does well that may help in developing strategies to address objectives).

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6. Describe the child’s challenging issues (these are things the child does that make day-to-day living difficult for you and your other family members.

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7. Team conducted an assessment and reviewed the following needs/concerns. If any answers are yes, please describe below and note steps taken to access other funding sources.

* Are there current safety concerns? (ex. child trying to leave the home or tries to climb out windows)  Yes  No
* Need for home or vehicle modification? (ex. getting out of seatbelt or opening windows or doors)  Yes  No
* Need for assistive technology? (review outside evaluations from school or insurance providers. Ex. sensory item identified by SLT/OT)  Yes  No
* Need for individual goods and services? (must increase functioning, increase safety, and decrease dependence on Medicaid services. ex. adaptive swim lessons)  Yes  No

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8. What are the goals that you would like your child to achieve from the supports available in this Autism Waiver Program?

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| 1. |
| 2. |
| 3. |
| 4. |
| 5. |

9. What are the child’s learning styles the support person must understand in implementing supports? (ex. quiet environment, low distractions, small groups, visuals, etc.)

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10. Are there family concerns that affect the support to the child? (ex. risk of losing home, medical needs of the primary caregiver, etc.)

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11. What is your plan in case of emergency? Do you have other people that could assist with care of the child? (ex. medical emergencies)

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12. What are the supports necessary for the family to self-direct waiver services? (ex. supports to be able to hire, fire, supervise, complete time sheets, etc.)

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13. What services do you think will help reach those goals that you would like to see addressed through the waiver program? What are the objectives (incremental steps) to help reach that goal? (objectives must be written in measurable terms in order to track progress toward meeting criteria).

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| **Goals:** | **Objective:** | **Provider Type:**  (Ind/Agency/Vendor) | **Waiver Service:**  *For Expanded Hab, Education list type (Ex: ABA, Floor Time, RDI, etc.), Family Training, etc.* | **Frequency/**  **Duration** |
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Signature Date

14. Are there any specific training (to be provided by the Caregiver) that staff will need to work with the child (ex: child has severe allergy and has EpiPen that must be delivered in emergency situations)

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| 1. |
| 2. |
| 3. |

15. Describe any additional trainings staff must complete prior to working with child (record information on training document).

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| 1. Mandated Reporter Training |
| 2. Incident Reporting Training |
| 3. Emergency Plan Training- What to do if there is an emergency in the home |
| 4. HIPPA |

16. Important Emergency and other information for employees working in the home:

Form is attached to the plan:  Yes  No

17. Supporting Documents: (the following documents were reviewed and are on file)

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| **Document** | **Reviewed**  **Y/N** | **On File**  **Y/N** |
| Individual Education Plan (IEP) |  |  |
| Individual Flexible Family Support Plan (IFSP) |  |  |
| Any current behavior plans |  |  |
| CCA |  |  |
| Vineland Summary |  |  |
| Physical | Date: |  |
| Dental | Date: |  |
| Other documents (e.g., in home ABA treatment plans, SLP, OT, PT assessments, other school-based assessments): |  |  |

**Autism Support Broker please initial:**

      I have given the parent/guardian access to the Provider Website (https://fms.publicpartnerships.com/maasd) and/or provided with a list of approved providers relevant to the services in this plan.

**Parent/Guardian please initial:**

      I have been given access to the Provider Website (https://fms.publicpartnerships.com/maasd) and/or provided with a list of approved providers relevant to the services in this plan.

      I understand that I have access to an interpreter if English is not my native language.

      I have been informed how to report abuse, neglect, exploitation, and unexplained deaths.

      I give permission for my child’s picture to be used on the emergency fact sheet.

**The following people have reviewed the plan:**

**Family Member/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Support Broker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Autism Division Designee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**