INDIVIDUALIZED SERVICE PLAN

RESIDENT'S NAME:_____ **NAME OF ALF:** _____

Description of needs is based upon the (i) UAI; (ii) medical reports; (iii) interview with the resident; (iv) fall risk rating, if appropriate; (v) assessment of psychological, behavioral and emotional functioning, if appropriate; and (v) any additional information necessary to meet the care needs of the resident.

For a facility licensed for residential living care only, if the resident lives in a building that houses 19 or fewer residents, does the resident need to have a staff member awake and on duty at night? ☐ **Yes** ☐ **No**

Description of Needs and Date Identified	Description of Services to be Provided	Persons Who will Provide Services	When and Where Services will be Provided	Expected Outcomes and Time Frame	Date Outcomes Achieved

RESIDENT'S NAME: _____

Description of Needs and Date Identified	Description of Services to be Provided	Persons Who will Provide Services	When and Where Services will be Provided	Expected Outcomes and Time Frame	Date Outcomes Achieved

SIGNATURES:

I. DEVELOPMENT OF PLAN:

Staff Person Who Developed Plan	**Date Plan Completed**	**Resident or Resident's Legal Representative**	**Date**
Other, if any, Involved in Plan Development (Specify Title/Relationship to Resident)	**Date**	**Other, if any, Involved in Plan Development (Specify Title/Relationship to Resident)**	**Date**

II. SUBSEQUENT REVIEW/UPDATE OF PLAN:

Staff Person Who Reviewed/Updated Plan	**Date Reviewed/Updated**	**Resident or Resident's Legal Representative**	**Date**
Other, if any, Involved in Plan Review/Update (Specify Title/Relationship to Resident)	**Date**	**Other, if any, Involved in Plan Review/Update (Specify Title/Relationship to Resident)**	**Date**

NOTE: Any time changes are made in the plan, the place where the change is made should be initialed and dated by the staff person making the change and by the resident/legal representative. In addition, the staff person and the resident/legal representative must sign in Part II above.