

**PRODUCTIVE LIVING BOARD  
INDEPENDENT SUPPORTED LIVING ASSISTANCE (ISLA)  
ISLA INDIVIDUAL SUPPORT PLAN**

- Prior to the implementation of services, the PLB must review and approve the Individualized Support Plan for any new consumer the lead agency is proposing to support.
- This plan can be denied by the PLB should it not comply with the Funding Manual – Service Guidelines and Policies.
- Please attach a copy of the individual’s outcomes/goals from his/her Person Centered Plan (as they should relate to the need for ISLA services).
- **This plan must be submitted prior to any commitment to the individual or his/her family in order to avoid unnecessary disappointments.**

Date: \_\_\_\_\_  
Consumer name: \_\_\_\_\_  
Current address: \_\_\_\_\_  
Date of birth: \_\_\_\_\_  
SSN: \_\_\_\_\_  
Projected Start Date: \_\_\_\_\_

**Complete Diagnosis (ISLA provider must have a copy on file prior to beginning services and submit consumer eligibility information to PLB)**

Agency Name: \_\_\_\_\_  
Project Number: \_\_\_\_\_  
Agency Contact: \_\_\_\_\_  
Contact number: \_\_\_\_\_  
Email: \_\_\_\_\_  
Referral Source: \_\_\_\_\_  
SLRO Service Coordinator: \_\_\_\_\_  
Contact number: \_\_\_\_\_  
Email: \_\_\_\_\_  
Date Service Coordinator was contacted: \_\_\_\_\_

Has this person previously been accepted into the PLB ISLA program?  Yes  No  
If “Yes”, are they currently being supported by another agency?  Yes  No  
Who has been contacted at this agency and what plans have been made to transition the consumer?  
\_\_\_\_\_  
\_\_\_\_\_

Does the individual have children living in the home?  Yes  No  
Please provide first & last names & ages: \_\_\_\_\_  
\_\_\_\_\_

Does the individual choose or need a housemate?  Yes  No  
Housemate’s name (If a housemate needs to be identified, what is the process to find a suitable housemate):  
\_\_\_\_\_  
\_\_\_\_\_

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Does the housemate currently receive ISLA supports?

Yes  No

Does the housemate currently receive DMH waiver?

Yes  No

Does the housemate currently receive DMH ISLA supports?

Yes  No

The proposed budget should be based on the agency's best projections of total income & total expenses on a line item basis. Include sources of income, as well as an accountable strategy for assisting the individual in obtaining necessary sources of revenue to meet the needs stated in the body of the Individual Support Plan.

Sources of Income	Amount
Salary	\$
SSI/SSDI/SSA	\$
Food Stamps	\$
Family Assistance	\$
Other Sources:	\$
	\$
Total Monthly Income	\$

Monthly Expenses	Amount
Rent	\$
Utilities	\$
Insurance	\$
Food	\$
Entertainment	\$
Telephone	\$
Other:	\$
	\$
Total Monthly Expenses	\$

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Identify and describe, in detail, the need for ISLA Supports for the categories listed below. Include the supports needed by the individual to live in his/her home and participate in the local community, as well as, the natural and paid supports (include funding source) which will be needed. All areas must be addressed even if it is anticipated supports will not be needed in a particular area.

**Preparing Meals:**

Units targeted for first month	Units targeted @ 12 months

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**Personal Hygiene:**

Units targeted for first month	Units targeted @ 12 months

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**Access to Transportation:**

Units targeted for first month	Units targeted @ 12 months

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**Finances:**

Units targeted for first month	Units targeted @ 12 months

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**Shopping:**

Units targeted for first month	Units targeted @ 12 months

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**Laundry:**

Units targeted for first month	Units targeted @ 12 months

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**Housework:**

Units targeted for first month	Units targeted @ 12 months

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**Home and Community Safety Needs** (include emergency response):

Units targeted for first month	Units targeted @ 12 months

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**Medical:**

Units targeted for first month	Units targeted @ 12 months

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**Community Participation:**

Units targeted for first month	Units targeted @ 12 months

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**Community Interaction:**

Units targeted for first month	Units targeted @ 12 months

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**Natural Supports:**

Units targeted for first month	Units targeted @ 12 months

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**SIGNATURES:**

_____	_____
Person to receive ISLA Support	Date
_____	_____
Guardian/Family Member	Date
_____	_____
Representative of lead agency to provide ISLA Support	Date
_____	_____
SLRO Service Coordinator	Date
_____	_____
Representative of previous agency providing ISLA Support (if applicable)	Date

**FOR PLB USE ONLY:**

Approved                       Not Approved

_____	_____
OPLS Program Staff Review	Date