

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

**INDIVIDUAL SUPPORT PLAN/INDIVIDUALIZED FAMILY SERVICE PLAN
INDIVIDUAL ATTRIBUTES CHECKLIST**

INDIVIDUAL'S NAME <i>(Last, First, M.I.)</i>		DATE
FOCUS ID NO.	ELIGIBILITY <input type="checkbox"/> ALTCS <input type="checkbox"/> TSC <input type="checkbox"/> Foster Care <input type="checkbox"/> DDD <i>(only)</i> <input type="checkbox"/> AZEIP	DATE OF BIRTH

- List the service(s) at the top of each column. If there are more than 5 services, attach another checklist.
- In each column, provide requested information and check the attributes that must be considered when receiving the service(s).
- The service amount identified on this document does not constitute approval.
- All those individual characteristics/provider expertise marked with (*) are electronically matched to qualified vendors who the individual/responsible person can select amongst.

	SERVICE	SERVICE	SERVICE	SERVICE	SERVICE
Service Amount					
Service need date					
Qualified vendor	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Independent provider	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Auto Assign	<input type="checkbox"/> Yes <input type="checkbox"/> No				
List days and time you are available to receive the service.					
Who will contact potential providers to confirm availability?					
Cross streets, community and/or city where you are located.					
If you have identified the service provider in advance, please specify.					
INDIVIDUAL CHARACTERISTICS:					
Autism					
Cognitive Disability					
Cerebral palsy					
Epilepsy					
At risk					
Movement limitations					
Vision limitations					
Hearing limitations					
Communication limitations					
Alzheimer's/dementia					
Non-ambulatory					
Location of service	<input type="checkbox"/> In-home <input type="checkbox"/> Out-of-home <input type="checkbox"/> No preference	<input type="checkbox"/> In-home <input type="checkbox"/> Out-of-home <input type="checkbox"/> No preference	<input type="checkbox"/> In-home <input type="checkbox"/> Out-of-home <input type="checkbox"/> No preference	<input type="checkbox"/> In-home <input type="checkbox"/> Out-of-home <input type="checkbox"/> No preference	<input type="checkbox"/> In-home <input type="checkbox"/> Out-of-home <input type="checkbox"/> No preference
*Assistive technology					
*Augmentative communication device					
*G-tube feeding/cleaning					
*Assistance with bowel and bladder care					
*Positioning					

INDIVIDUAL'S NAME (Last, First, M.I.)	DATE
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PROVIDER EXPERTISE:	SERVICE	SERVICE	SERVICE	SERVICE	SERVICE
*Positive Behavior Support					
*Client Intervention Techniques (CIT) Level 1					
*Client Intervention Techniques (CIT) Level 2					
Spanish speaking					
Sign language					
Other language (Specify)					
Gender preference requested by individual (Specify one)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> No preference	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> No preference	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> No preference	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> No preference	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> No preference
*Medication monitoring/administration					
Implementing/following therapy home programs					
*Lift up to/transfer 30 lbs.					
*Lift up to/transfer 40 lbs.					
*Lift up to/transfer 50 lbs.					
*Lift up to/transfer 50+ lbs.					

THERAPY PROVIDER EXPERTISE:

Mobility and gait training					
Oral motor/feeding/swallowing					
Neuro-developmental therapy					
Auditory integration					
Sensory integration					
Cranial sacral					
Home modification					
Tscharnuler Akademie for Movement Organization (TAMO)					

SUPPORT COORDINATOR'S NAME (Please Print)	SUPPORT COORDINATOR'S SIGNATURE	DATE
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COMMENTS

Equal Opportunity Employer/Program ♦ Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disability Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at (602) 542-0419; TTY/TDD Services: 7-1-1.