Newfoundland Labrador

Model for the Coordination of Services to Children and Youth
INDIVIDUAL SUPPORT SERVICES PLAN
TEAM MEMBERSHIP

NAME OF CHILD/YOUTH _____   DATE OF BIRTH _____

ADDRESS _____

TEL. NO. _____   COMMUNITY _____

SCHOOL _____   SCHOOL DISTRICT _____

REGION _____   ISSP MANAGER _____

DATE OF FIRST ISSP _____   DATE OF TODAY'S ISSP MEETING_____

NAME	POSITION	PHONE/FAX
NOTE: NAME OF ISSP MANAGER SHOULD APPEAR IN THE lIST		

TEAM MEMBER CONTRIBUTION

To be completed after an assessment/observation and to be brought to the ISSP team meeting, or forwarded to the Manager if member is unable to attend. This form may be kept by the team member in his/her own child/youth file.

CHILD/YOUTH _____ TEAM MEMBER _____

DATE _____

STRENGTHS	*NEEDS*

INDIVIDUAL SUPPORT SERVICES PLAN

(Strengths & Needs Agreed upon by the Team)

CHILD/YOUTH _____ **DATE** _____

STRENGTHS	*NEEDS*

INDIVIDUAL SUPPORT SERVICES PLAN
(Goals agreed upon by the Team)

CHILD/YOUTH _____

Annual Goals	To be implemented by	Environment (s)	Date of review

*Goals that have been met should be noted with an "a" and the date.
*Goals that have been discontinued are noted with a "d" and the date.

INDIVIDUAL SUPPORT SERVICES PLAN
Service Needs Required/Already Attained

CHILD/YOUTH _____

Description of Service Need *	Is service available to child (Yes or No)	Who will be responsible for requesting/obtaining service	Person/Agency Responsible for Implementation	Date Service Obtained	Review Date

* Services should be considered for all aspects of the child's/youth/s life. Areas for discussion could include but are not limited to: place of residence, (location and support needed); social; emotional; developmental; supportive services; health needs (physical needs, medications, procedures); equipment (personal, adaptive); materials and supplies; facilities; behavior; transportation; financial; family; vocational and career planning; recreation/co-curricular

INDIVIDUAL SUPPORT SERVICES PLAN
Comments/Signature

(This page is used to outline important decision/items not already listed in other parts of this form Minute taking is not required)

CHILD/YOUTH _____

COMMENTS:_____

_____

_____

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_____

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Team
Review Dates (s) _____

Signature _____
           parent (s)/guardian   **parent (s) guardian**

_____
    child/youth (if participant)   **ISSP**

_____

_____

_____

_____

January 2002

INDIVIDUAL SUPPORT SERVICES PLAN
MANAGER'S RECORD (OPTIONAL)

Individual Support Services Managers may contact members on/near the review date and record the contacts

CHILD/YOUTH'S NAME _____

Goal/Service Area	Notations	Date (component submitted)