Developmental Educational Assistance Program

2200 Box Elder, Miles City, MT 59301

Phone: (406) 234-6034, Fax: (406) 234-7018

SPECIALIZED SERVICE PLAN

FOR NURSING FACILITY RESIDENTS WITH DEVELOPMENTAL DISABILITIES

Name: _____ DOB: _____

Date of Plan: _____ SSN: _____

Facility: _____

City: _____

Specialized Services Coordinator: _____

Phone: _____

NF Social Services Contact: _____

Phone: _____

Developmental Disabilities Program Staff: _____

Phone: _____

Legal Guardian: _____ Address: _____

Phone: _____

Specialized Service Needs:

	Yes	No	Comments
Specialized Services Coordinator	☐	☐	_____
Additional Assessments	☐	☐	_____
Behavioral Management	☐	☐	_____
Skill Acquisition	☐	☐	_____
Assistive Technology	☐	☐	_____
Community Exposure/Training	☐	☐	_____
Specialized Leisure/Recreation	☐	☐	_____
Referral for Specialized Services	☐	☐	_____
Other	☐	☐	_____

Description of Specialized Services and Supports to be provided:

Individual Plan Objectives Attached: Yes ☐ No ☐

Individual Plan Objectives are included in the nursing facility plan of care for the resident: Yes ☐ No ☐

Signatures of Participants: Relationship or Agency:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

SPECIALIZED SERVICES PLAN

RESIDENT: _____ DATE: _____

Directions: List prioritized objectives. Include a condition, behavior and criterion for each objective as necessary.

_____

OBJECTIVE: _____

_____

_____

_____

Person Responsible: _____ Start Date: _____

Date Reviewed/Completed: _____

OBJECTIVE: _____

_____

_____

_____

Person Responsible: _____ Start Date: _____

Date Reviewed/Completed: _____

OBJECTIVE: _____

_____

_____

_____

Person Responsible: _____ Start Date: _____

Date Reviewed/Completed: _____

SPECIALIZED SERVICES PLAN

NAME: _____ DATE OF SSP: _____