Developmental **E**ducational **A**ssistance **P**rogram
2200 Box Elder, Miles City, MT 59301 Suite 151
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:

NAME: DATE OF SSP: