State of Vermont
Division of Disability and Aging Services
TBI Program

INDIVIDUAL SERVICE PLAN

Evaluation Due Date: _____ **Today's Date:** _____

Consumer Name: _____ **SSN:** _____

Address: _____

Guardian: _____

Guardian Phone Number: _____ **Alternate Phone Number:** _____

Guardian Address: _____

Program: ☐ Long Term *OR* ☐ Rehabilitation

DOB: _____ **Date of Injury:** _____ **Services Start Date:** _____

Provider Agency: _____

Case Manager: _____ **Phone Number:** _____

Other Insurance Information: _____

Date of Last Physical: _____ **Date of Last Vision Exam:** _____

Date of Last Dental Exam: _____ **Date of Last Tetanus Booster:** _____

Client Summary: (Include a discussion of strengths, needs, current environment, natural supports, etc.):

_____

Funded Services:

☐ Life Skills Aide ☐ Case Management ☐ Community Supports

☐ Respite ☐ Psych & Counseling Supports ☐ Employment Supports

Other Services: (Example: counseling, medication management, SLP, OT, PT, AA)

_____

Safety Precautions/Functional Activity:

☐ No restrictions	☐ Contract PRN
☐ Self Administration of Medications	☐ Suicide Precautions

☐ Constant Observation	☐ Restrict driving
☐ Transport to:	
☐ Other:	
☐ Supervision level:	

Diagnoses: _____

Medications and Dosage: (Attach additional sheet if necessary)

Medication	Dosage	Purpose	Prescribing Physician:

Allergies: _____

Advanced Directives: ☐ Yes *OR* ☐ No

Diet / Nutrition Needs: _____

Long Term Outcomes: (Refer to Independent Living Assessment for developing specific goals under each outcome)

Improved Physical Development and Mobility

-

Improved Communication / Cognitive Skills

-

Improved Eating Behaviors

-

Improved Food Preparation / Cooking Ability

-

Improved Personal Hygiene and Grooming

-

Improved Health and Safety Behaviors

-

Improved Social Behaviors and Leisure Time

-

Improved (ADL's) and Household Chores

-

Improved Budgeting and Numerical Skills

-

Improved Transportation and Travel

-

Vocational Skills:

-

Discharge Plan:

Consumer input:

Consumer: ___________________________________ Date:_____________

Guardian: ____________________________________ Date:_____________
(if applicable)

Case Manager: ________________________________ Date:_____________

All signatures are to be kept on file with the Provider Agency and available upon request. Copy of signature page is not required to be sent to the TBI Program.