Provider Implementation Plan (PIP) for Traditional and Self-Directed Services

Person's Name: _____

PIP Development Date: _____ PIP Revision Date: _____

Person-Centered Plan (PCP) Outcome (as identified in the PCP):

_____

Provider or Self-Directed Staff/Vendor: _____

DDA Funded Service(s): _____

Goal #1: _____

Goal Implementation Strategy (Clearly describe the processes, specific tasks, action plans and staff ratio(s) as applicable that will be used to support the person in achieving their goal):

☐ **Check this box if additional space is needed to describe this goal in the "Additional Goals and Information" section.**

Target Implementation Date: _____ Target Date for Completion: _____

Provider or Participant Self-Directing Services Staffing Plan: _____

Who will help me achieve this goal? ☐ Direct Support Professional ☐ Program Manager ☐ Other _____

Who will review my progress? ☐ Program Manager ☐ Other _____

How often will my progress be reviewed? ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly

Name of family member, relative, or legally responsible person as staff member:

_____

Issue date: 02.26.21

Goal #2: _____

Goal Implementation Strategy (Clearly describe the processes, specific tasks, action plans and staff ratio(s) as applicable that will be used to support the person in achieving their goal):

☐ **Check this box if additional space is needed to describe this goal in the "Additional Goals and Information" section.**

Target Implementation Date: _____ Target Date for Completion: _____

Provider or Participant Self-Directing Services Staffing Plan: _____

Who will help me achieve this goal? ☐ Direct Support Professional ☐ Program Manager ☐ Other _____

Who will review my progress? ☐ Program Manager ☐ Other _____

How often will my progress be reviewed? ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly

Name of family member, relative, or legally responsible person as staff member:

_____

Issue date: 02.26.21

Goal #3: _____

Goal Implementation Strategy (Clearly describe the processes, specific tasks, action plans and staff ratio(s) as applicable that will be used to support the person in achieving their goal):

☐ **Check this box if additional space is needed to describe this goal in the "Additional Goals and Information" section.**

Target Implementation Date: _____ Target Date for Completion: _____

Provider or Participant Self-Directing Services Staffing Plan: _____

Who will help me achieve this goal? ☐ Direct Support Professional ☐ Program Manager ☐ Other _____

Who will review my progress? ☐ Program Manager ☐ Other _____

How often will my progress be reviewed? ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly

Name of family member, relative, or legally responsible person as staff member:

_____

Issue date: 02.26.21

Goal #4: _____

Goal Implementation Strategy (Clearly describe the processes, specific tasks, action plans and staff ratio(s) as applicable that will be used to support the person in achieving their goal):

☐ **Check this box if additional space is needed to describe this goal in the "Additional Goals and Information" section.**

Target Implementation Date: _____ Target Date for Completion: _____

Provider or Participant Self-Directing Services Staffing Plan: _____

Who will help me achieve this goal? ☐ Direct Support Professional ☐ Program Manager ☐ Other _____

Who will review my progress? ☐ Program Manager ☐ Other _____

How often will my progress be reviewed? ☐ Daily ☐ Weekly ☐ Monthly ☐ Quarterly

Name of family member, relative, or legally responsible person as staff member:

_____

Issue date: 02.26.21

ADDITIONAL NOTES AND GOALS

Issue date: 02.26.21