POLICY

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Branch/ Division:	Disability Policy / Policy Programs and Legislation	**Applicable To:**	Community Living disABILITY Services
Responsible Authority:	Department of Families	**Next Review Date:**	To Be Determined
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1.0 Policy Statement

Individual planning is a holistic, intentional process to create an individual plan for every person receiving support services from the Community Living disABILITY Services (CLDS) program and assist them to identify the services and supports they may require to meet their needs and goals.

The individual planning process is dynamic and follows the principles of person-centred planning where the person, with the assistance of their support network, identify their personal strengths, needs, interests, and dreams and make choices, set goals and identify actions to achieve these goals.

2.0 Background

The Adults Living with an Intellectual Disability Act (ALIDA) is legislation that recognizes the rights of adults living with an intellectual disability to make their own decisions and receive advice, support or assistance, where necessary, in a manner that respects their independence, privacy and dignity.

Part 2 – Support Services of ALIDA identifies the legislative authority for the department to provide or arrange for support services for individuals as defined by ALIDA. The department provides these support services through the CLDS program.

Section 12 and Subsections 11(1), 11(2), and 15.1 of ALIDA contain requirements that regulate individual planning practices. Under ALIDA, the executive director (or delegate[1]):

- shall develop an individual plan for every adult who receives support services under Part 2 of ALIDA
- may review an individual plan and vary (i.e., amend) it
- shall take reasonable steps to ensure that every person and their substitute decision maker or committee, if any, can participate in the development of, and are informed of any decisions respecting, their individual plan
- shall make any decision concerning a dispute relating to the individual plan in writing and advise the person of the right to appeal the decision where applicable to the Social Services Appeal Board

[1] The Program Manager and CSW are responsible to ensure that the individual plan is developed.

3.0 Purpose

This policy establishes a planning process for developing an individual plan for every person eligible to receive support services from the CLDS program. It identifies and provides a reason for support services that may be provided by the CLDS program and other community-based supports, and it is guided by the principles of person-centred planning.

Scope and Flexibility

This policy applies to all individuals eligible to receive CLDS services, as well as their support networks, service providers, and departmental staff involved in case management. It is intended to be flexible and responsive to each person's unique needs and choices.

Overlapping Planning Themes

An individual plan is legislated under ALIDA. It is typically, but not always, focused on dreams, goals, and increasing independence. In contrast, a support plan is non-legislated and outlines how a person is supported in daily life. Only paid service providers are required to complete a support plan as a program expectation. A safety plan is a written document designed to mitigate risk and harm to a person. The individual plan does not replace the requirement to develop a support or safety plan as needed, or other plans required by the CLDS program. However, the individual plan may contain elements of these other plans for some people.

Flexible Planning Approach

The individual plan can include any mix of dream and personal, learning and skill-building, support, immediate need, or cultural and spiritual goals or other goals based on the person's direction with input from others involved in their life. Goals may be ambitious, modest, or even absent if that reflects the person's genuine choice.

This policy is not meant to prescribe a ridged universal planning approach for every person in the CLDS program. It is recognized that processes established in this policy may need to be adapted or modified for some persons. For example, some persons receiving CLDS experience multiple barriers, and planning may follow a modified framework based on the person's immediate needs, including planning to manage dangers and risks. In these cases, the plan may instead document important discussions focused on mitigating risks or developing strategies to support engagement with the person, rather than long-term goals.

4.0 Definitions

The Adults Living with an Intellectual Disability Act (ALIDA) refers to the legislation in Manitoba that recognizes, promotes and protects the rights of adults living with an intellectual disability who need assistance to meet their basic needs.

Community Living disABILITY Services (CLDS) means the Government of Manitoba program that provides support services to adults living with an intellectual disability as defined by ALIDA.

Community Service Worker (CSW) means a case manager, employed by the department, who is responsible for connecting persons and their support networks and assisting them with planning to access supports and services available in their community and the CLDS program.

Individual Plan means a plan for an adult living with an intellectual disability (i.e., person) under section 11 of ALIDA, developed following the principles of person-centred planning.

Person means an adult living with an intellectual disability as defined by ALIDA who receives or is eligible to receive support services through the CLDS program.

Person-Centred Planning refers to a process directed by the person and their support network, intended to identify the strengths, capacities, choices, needs and desired outcomes of the person. Person-centred values drive all individual planning activities for the development of all types of plans a person may require.

Planning Team Member means an individual typically chosen by the person to contribute to the development of the person's individual plan, which may include anyone who knows and supports the person or contributes to their care.

Service Provider refers to an agency, organization or person responsible for providing care or support services to persons funded through the Community Living disABILITY Services program, and it is inclusive of agency and private home share providers.

Service Provider Agreement means the Service Purchase Agreement between the Government of Manitoba and service provider for agency delivered services and the Agreement for Home Share Services between the Government of Manitoba and service provider for private home share providers.

Social Services Appeal Board (SSAB) means a board of individuals appointed by the Lieutenant-Governor in Council who provide an impartial appeal process for decisions relating to eligibility, design or implementation of the individual plan or support services from CLDS.

Substitute Decision Maker (SDM) refers to a substitute decision maker for personal care or property appointed in accordance with ALIDA.

Support Network means family, friends and/or community members who provide personal support and assistance with decision making, advocacy and/or help with monitoring services provided to the person and who have mutual relationships with the person.

5.0 Policy

Person-centred planning is based on the belief that all persons should have the opportunity to direct and lead a life that is personally satisfying, secure and meaningful. In keeping with these principles, the following three parts typically provide the basis for developing an individual plan:

1. Empowerment and Self Determination

Planning activities are based on the presumption that a person can make life decisions, unless shown otherwise. Planning activities therefore:

- ensure the person is included and involved in every meeting and participates to the best of their ability, unless they do not wish to participate in the process
- ensure the person is at the centre of all stages of the planning process to ensure they make the decisions impacting their life

- recognize that the person's wishes are important and are to be fully respected
- actively encourage the person to make informed choices, provide opportunities to exercise those choices and where necessary, change those choices over time. Informed choice requires the person to have enough information and experience to be able to make a choice. Where the person has not yet had this information or experience, efforts will be made to provide this to them.
- seek to enable the person to choose from a range of services and support that are practical and appropriate based on the individual and their supports needs
- recognize and support the person's right to dignity of risk

2. Holistic Orientation

Holistic (i.e., all-inclusive or total) planning methods provide for the consideration of every person as a whole person in a positive and combined way. Therefore, planning will address the person's health, safety and basic comfort needs and recognize and respond to each person's need for:

- respect, privacy and dignity
- communication
- friendships/relationships
- meaningful community presence and participation
- supports to be provided in the least limiting way possible
- employment/educational goals
- valued social roles

3. Cooperation and Collaboration

Planning activities build cooperation and collaboration between the person and their support network. They are based on the belief that:

- Planning team members contributions are equally valued
- Planning team members have equal opportunity to contribute to the process
- Developing connections and relationships within the person's community are essential to increasing the range of choices available to them and responding meaningfully to their personal and social needs

6.0 Core Supporting Standards, Procedures and Guidelines

6.1 Standards

Individual Plan Standards

The following standards apply to all individual plans:

- All planning aligns with ALIDA and person-centred principles.
- All planning ensures the participation of the person, unless they request not to be involved, and their support network as needed, and typically includes at least the following activities: selection of a facilitator, planning team members, planning method and scope.
- Persons receiving support from more than one service provider will be encouraged to include all service providers in planning (this leads to a more holistic support plan).

- If the person requests the involvement of multiple service providers in the development of the individual plan, the service providers will inform one another of this request and make efforts to engage the other service provider in the plan development[2].
- The individual plan, whether created formally or informally, typically contain these planning parts and activities[3] and are addressed during annual planning:

  Planning Parts
  - desired outcomes
  - goals
  - important/relevant assessed support needs, particularly those supports required to address safety concerns
  - specific support strategies
  - measurable support objectives
  - the person(s) responsible for implementing support strategies
  - timelines for review

  Planning Activities
  - knowing the person and their vision
  - goal planning
  - action planning
  - planning for accountability
- The planning team will identify one or more planning team members to invite all planning team members to the meetings, document the individual plan and share it with the person, their support network, other planning team members, all service providers and the CSW.
- The individual plan will be reviewed annually and updated or redeveloped as required.

CSW Standards

The CSW in their role as case manager for the person, shall:

- ensure the individual plan is developed by the service provider as may be required in their Service Provider Agreement and/or by the planning team (and updated or redeveloped as required) in accordance with person-centred planning principles
- ensure when immediate safety or short-term needs take priority over long-term goals, planning remains person-centered and is documented in place of long-term goal planning
- review the plan annually and ensure it is reviewed, updated or redeveloped by the service provider as may be required in their Service Provider Agreement and/or by planning team.
- monitor and ensure the implementation of any CLDS support services identified in the individual plan and approved by the CSW or department
- facilitate individual planning if no other planning team member agrees to fulfil this role

[2] If one or more of a person's service providers cannot attend a planning meeting(s), they may meet with the person and others separately as needed to contribute to the plan development. The planning team or facilitator ensures their contributions and perspectives are included in the person's individual plan.
[3] Planning for some persons may necessitate modifications to some of these planning parts and activities.

6.2 Procedures

The individual planning process occurs:

- when the person is assigned a CSW after deemed eligible for the CLDS program
- if the person's life goals have changed
- if the person is dissatisfied with their existing individual plan
- if the current individual plan does not meet department standards

6.2.1 Procedures: Beginning the Individual Planning Process

The person, their SDM (if applicable) or support network, service provider, or CSW may begin the individual planning process annually or at any time deemed necessary. The CSW will contact persons new to the program and their support network where appropriate upon receiving the person's file to become familiar with the person's strengths and support needs and explain the individual planning process and reason for developing an individual plan.

A facilitator, planning team members, method and scope will be selected when developing an individual plan. Information shared about the person in the planning process is confidential and must not be disclosed by planning team members outside of meetings without the person's knowledge and consent.

In some cases, individual planning may occur when people who know the person, including their CSW and service provider and community resource staff, come together to discuss the person's immediate needs. Selecting a facilitator, planning team members and individual planning methods may look different in these situations.

Selection of the Facilitator

The person will have the opportunity to invite someone to serve as the facilitator for the individual planning process. Some persons may wish to select their CSW to fulfil this role, while others may wish to select someone else (e.g., service provider staff or support network member).

In cases where the person does not identify someone to serve as the facilitator, support network members or service provider staff are encouraged to fulfil this role.

Selection of the Planning Team Members

The person will have the opportunity to choose the planning team members they want to invite to attend planning meetings. This may include anyone who knows and supports the person, such as:

- support network members (e.g., family, friends, advocates or other community members)
- current service provider staff, if applicable
- potential service provider staff, if known
- professionals with expertise in areas related to the person's care needs (e.g., physio, speech or occupational therapist, physician or psychologist)
- the person's CSW

Selection of the Individual Planning Method

The person will have the opportunity to select a planning method or agree with a method suggested by the facilitator, and the chosen method typically includes the following parts[4]:

- **knowing the person and their vision**, which identifies who the person is, their current situation and their present and future dreams, hopes and interests
- **goal planning**, which identifies and develops goals towards realizing a better quality of life for the person
- **action planning**, which identifies the activities required for goals to be realized and assigns responsibilities and completion timelines to specific planning team members, service providers and others.
- **planning for accountability**, which determines who on the planning team will be responsible for ensuring that specific actions identified during planning are completed

Selection of the Scope

The person is actively encouraged to determine the scope of the individual planning process by communicating with their planning team members. The scope may be reached by examining gaps and/or the desire for increased participation in a particular area of their life.

For examples of outcome areas to explore during the individual planning process, please refer to the accompanying resource document.

6.2.2 Procedures: Roles in Individual Planning Meetings

Individual planning activities typically occur after an initial meeting with the person to select the facilitator, planning team members, method and scope.

The roles of the planning team members are summarized below, and **Appendix A** contains further information on these roles and is shared by the CSW with the planning team members at the outset of the individual planning process so that they have a clear understanding of their respective roles and responsibilities in the process.

Role of Facilitator

The facilitator, shall:

- invite planning team members to attend the planning meetings, lead planning meetings and document and share the individual plan with other planning team members unless these tasks are assigned to someone else
- support the person to engage and participate in planning
- support planning team members to stay invested and engaged during meetings, assisting

[4] If the person does not want formal goal planning, the service provider(s) shall determine another method for gathering information from the person and their support network and documenting their wishes and supports they need (i.e., through informal discussions).

them to build consensus on the individual's plan and its implementation

- fulfil the requirements identified in the Service Provider Agreement if the facilitator is a service provider or service provider staff member (refer to Appendix A for more details)

Role of Person

The person is the reason for and focus of individual planning and will be included in every step of the process unless they opt not to attend or participate in planning meetings.

Role of CSW

In addition to what is stated under the standards section, related to planning meetings, the CSW shall:

- ensure the planning team members clearly understand person-centred planning principles and their respective roles and responsibilities in the individual planning process
- use their professional discretion to determine if their attendance at planning meetings that involve CLDS support services is required and are encouraged to make all attempts to attend the following type of individual planning meetings:
    - the first after being assigned as the person's CSW (the initial planning meeting)
    - that will result in a change to the person's support services
    - that relates to transition planning
    - when concerns are raised about the individual plan or a CSW attendance is requested
- gather information about the person's current situation and share it with the planning team members if the person chooses not to attend their individual planning meetings
- ensure that the planning team members have necessary information about the person to further the individual planning process prior to the meetings if the CSW is not attending
- inform planning team members that the individual plan is reviewed annually and updated as needed.

Role of Service Provider

Service providers play an important role in planning because support staff spend a lot of time with the person and know them well, and the services provided affect the person's choices and goals.

Service providers fulfil the individual planning (formerly person-centred planning) requirements identified in the Service Provider Agreement (refer to Appendix A for more details) and participate in developing and reviewing the person's individual plan annually (and updating and redeveloping it as required). Staff from the service provider may fulfill the role of facilitator.

Role of Support Network

The person's support network knows them best and can provide valuable information about their current situation, goals and desires and support them in planning meetings.

Role of Professionals

Professionals with expertise in areas related to the person's care needs (e.g., physician, speech therapist, occupational therapist, physician, psychologist etc.) can attend and participate in individual planning meetings or provide information to the planning team members ahead of the meetings if they are unable to attend.

6.2.3 Procedures: Parts of Individual Planning

Individual planning typically has these key parts and follows person-centred planning principles:

Knowing the Person and Their Vision

The first parts of the individual planning process seek to know the person and their desires in the area(s) that planning is to occur. The person is encouraged to describe their strengths, abilities and needs, as well as their past and present relationship with the community, people, places and activities. Planning team members may provide information verbally or share written reports that assist other planning team members in knowing the person.

As a principle of person-centred planning, understanding the ways a person communicates with others is very critical. Planning team members actively ask about, listen to and respond to the person's needs, ideas, and choices, whether communicating verbally or non-verbally.

Visioning is the active process of exploring the person's dreams, hopes and interests for the present and future and leads to goal development. Planning team members and the person are encouraged to express ideas without limitations and begin the visioning process once they understand the person's needs, ideas and choices.

Goal Planning

Goals can be documented in many different forms and focus on the person's abilities and can range from realistic attainable goals to ambitious goals. Planning team members encourage the person to identify the goals they wish to set for the immediate future and long-term. If planning occurs in several areas, there is a minimum of one goal for each area. These goal areas can be explored in individual planning:

Dream and Personal Goals focus on setting goals, aims and objectives based on the person's dreams or what they desire to do, where they want to be and what will make them most happy.

Learning and Skill Building Goals focus on developing skills that the person has identified as being important to them (e.g., learning how to cook or do the laundry).

Daily Support Goals focus on the person's day-to-day support needs and how to support the individual in achieving these goals identified through the individual planning process, and there may be some overlap with information set out in the person's support plan document, but duplication will be avoided or reduced.

Cultural and Spiritual Goals focus on planning to identify and support the person with their cultural and spiritual needs such as language, customs and traditions, beliefs and values, arts and music, food and cuisine, knowledge systems, recreation and leisure and community.

Immediate Need (including safety) Goals focus on planning to ensure that the person's most immediate needs are met and may include planning to help the person access shelter, meals, or medical treatment, or planning to mitigate risk and dangers to help ensure their safety.

Action Planning

Action planning is identifying activities through which goals are realized. Activities may include taking advantage of appropriate opportunities and resolving barriers. It may also identify the specific supports and resources needed to achieve a particular goal. This may include identifying new resources to develop or new and creative approaches to the provision of supports.

First, it must be determined if the person can accomplish a goal independently or require and desire support from a planning team member. Then, specific responsibilities and timelines for the required activities will be identified and assigned to the person or planning team members.

If the action plan calls for the implementation of CLDS-funded support services and the CSW supports them, the CSW is responsible for pursuing the services as needed and reporting back to the planning team by an agreed upon date.

Planning for Accountability

Planning team members identify the member(s) responsible for assisting the person implement their plan. Planning for accountability identifies someone to monitor all agreed upon activities to ensure they are carried out within the established timeframes.

The CSW or other planning team members may be designated to monitor some or all these activities. Service providers, the person, family members and members of the person's support network are encouraged to provide feedback to the CSW related to their agreed upon monitoring activities. The CSW will monitor the implementation of support services that may be provided by other service providers if these services are funded or arranged by CLDS.

6.2.4 Procedures: Documentation

Planning team members will document the goals and are encouraged to track the outcomes of the individual planning. The individual(s) responsible for transcribing, documenting and distributing the individual planning document will be identified at the beginning of the process.

The CSW files the individual plan document in the individual's case file and updates inFACT by writing in a case note that the plan was developed or updated and selecting the date it was updated under the Plan Information heading of the CLDS tab.

6.2.5 Procedures: Implementation

The person's plan can be put into action in the implementation phase after completion of goal planning and planning for accountability. This phase involves ensuring that responsibilities assigned to planning team members are carried out within the agreed time frames. The following actions may be undertaken by planning team members to assist the person reach their goals.

Referring to Appropriate Resources

Where the person's plan has not identified a specific resource to provide the required supports, the CSW informs the person and the planning team members of the person's Supports Budget Level and the CLDS resources that may be available. Wherever possible, multiple options will be provided to the person to identify and choose what is most appropriate for them. The CSW will present information about non-CLDS funded resources that is available and engage in discussion with planning team members about their capacity and availability to meet the person's needs.

The CSW, with the consent of the person, forwards a written referral to the identified service provider(s) where CLDS funded support services are identified.

For support services not provided by CLDS, designated planning team members may gather information about appropriate community resources and supports and make referrals as agreed upon by the person and their individual planning team.

Securing Funding

The CSW follows established processes to secure the funding approval if a service provider is identified to provide CLDS funded services to the person. The CSW informs the person and planning team members of the outcome of any funding decisions respecting CLDS-funded support services. The CSW continues to work with the person and planning team members to secure other suitable resources.

Implementing Services

The CSW will confirm the status of any funding requests with planning team members. The CSW or other designated planning team members are responsible for ensuring the service provider has enough information about the person to provide the services requested. Planning team members may aid and support the person in accessing these services.

Ongoing cooperation and communication between the person and their planning team members needs to occur throughout implementation of services to keep members apprised of:

- significant changes in the person's goals, dreams, health, well-being and living arrangements
- the overall progress with the implementation of the individual plan

Monitoring

Monitoring activities assists the person in reaching their goals and may include identifying and dealing with additional opportunities or barriers that arise. Planning team members monitor the provision of community resources/services in accordance with the planning for accountability measures identified in the person's individual plan.

The CSW monitors the implementation of support services by external service providers where these services are funded or arranged through CLDS. The CSW also monitors the implementation of any other services as designated in the individual plan (which may take the form of phone calls, reminders and follow up by the CSW).

Follow Up and Ongoing Planning

Where the person's plan involves the provision of support services funded through CLDS, the CSW contacts the person and their support network **at least once every year** to assess the person's level of satisfaction with the planning process and its outcomes.

The CSW engages with the person and their support network to discuss their satisfaction with the implementation and outcomes of the individual plan and the need for further planning efforts to ensure that the plan remains relevant. If the person and/or their SDM is satisfied with the current plan and does not wish to engage in further planning, the CSW enters a case note stating that contact occurred, and the plan has been updated or no updates are required.

6.2.6 Procedures: Resolving Individual Plan Concerns

Informal Solutions

If a person has a concern(s) about the design or implementation of their individual plan, they will first discuss and try to resolve their concern(s) with the planning team members including the service provider, seeking input and guidance from the CSW or Program Manager as needed. The planning team members and CSW or Program Manager (as needed) shall make their best efforts to resolve the concern(s), which may include modifying the plan or its implementation.

Social Service Appeal Board

If concern(s) about the individual plan or CLDS-funded support services remain after following the process in 6.2.6, the person may identify their concern(s) and proposed solution in writing to the CSW and Program Manager, copying the service provider.

The Program Manager will review the concern(s) and proposed solution, provide a written decision in response and advise the person of their right to appeal the decision to the SSAB. The person or SDM may appeal the Program Manager's written decision to the SSAB by filing a notice of appeal with the SSAB. The SSAB does not have jurisdiction to consider any decision for more support services funding or a change to support services regulations or policies.

Fair Practices Office

If the person or SDM feels they were treated unfairly during the development or revision of the individual plan, they should first try to resolve the issue with the CSW or Program Manager. If unresolved, they may contact the Fair Practices Office, which provides confidential and impartial assistance to Manitobans.

7.0 Policy Documents

- Individual Planning Meetings – Expanded Roles (Appendix A)

8.0 Resource Documents

- Refer to the Individual Planning Policy Accompanying Resource Document on the CLDS program website.

Appendix A
Individual Planning Meetings – Expanded Roles

Individual planning activities typically occur after an initial meeting with the person to select the facilitator, planning team members, method and scope but may start later. The following information will be shared with the planning team members at the outset of the individual planning process, so they have a clear understanding of their respective roles and responsibilities in the individual planning process.

Role of Facilitator

The facilitator, shall:

- invite planning team members to attend the planning meetings, lead planning meetings and document and share the individual plan with other planning team members unless these tasks are assigned to someone else
- support the person to engage and participate in planning
- support planning team members to stay invested and engaged during meetings, assisting them to build consensus on the individual's plan and its implementation
- fulfil the requirements identified in the Service Provider Agreement if the facilitator is a service provider or service provider staff member

During individual planning meetings, the facilitator's role is to:

- ask about and listen and respond to the person's needs, ideas and choices (whether communicating verbally or non-verbally)
- moderate and guide the discussion to ensure the meetings progress smoothly and productively
- encourage useful solutions in the event of disagreement

When a service provider agency assumes the role of facilitator for individual planning, per the terms of an agency's Service Provider Agreement, they must ensure that:

- an individual plan is developed to include the basic principles of action and person-centred planning
- the person and/or their substitute decision makers have an opportunity to make decisions about the scope of the plan, the planning method and the participants involved in the process
- reviews of the plan are facilitated at the request of the person and/or their substitute decision maker
- copies of original and revised individual plans are forwarded to the person and/or their substitute decision makers and the CSW within 20 working days of completion

Role of Person

The person is the reason for and focus of individual planning and is included in every step of the process unless they opt not to attend or participate in planning meetings.

During individual planning meetings the person chooses to attend, they (whether communicating verbally or non-verbally):

- describe their strengths, abilities and interests
- identify their hopes, dreams, goals, and vision for their future
- share their needs, struggles and concerns
- make choices and identify actions to achieve their goals

Role of CSW

In addition to what is stated under the standards section, the CSW shall:

- ensure that planning team members clearly understand person-centred planning principles and their respective roles and responsibilities in the individual planning process
- use their professional discretion to determine if their attendance at planning meetings that involve CLDS support services is required and are encouraged to make all attempts to attend the following type of individual planning meetings:
    - the first after being assigned as the person's CSW (the initial planning meeting)
    - that will result in a change to the person's support services
    - that relates to transition planning
    - when concerns are raised about the individual plan or their attendance is requested
- gather information about the person's current situation and share it with the planning team members if the person chooses not to attend their individual planning meetings
- ensure that the planning team members have necessary information about the person to further the individual planning process prior to the meetings if the CSW is not attending

During individual planning meetings that the CSW attends, they:

- share information about the person's current situation and desires, if they choose not to attend
- act as a resource for planning team members by sharing information about (including how to access) support services that may be provided by the CLDS program
- ask about and listen and respond to the person's needs, ideas, and choices (whether communicating verbally or non-verbally)
- ensure planning team members address the parts described in **6.2.3 Procedures: Parts of Individual Planning** in the portion of the individual plan that may involve the provision of CLDS support services and does not involve the provision of CLDS support services

Role of Service Provider

Service providers play an important role in planning because support staff spend a lot of time with the person and know them well, and the services provided affect the person's choices and goals.

- Service providers must fulfil the individual planning (formerly person-centred planning) requirements identified in the Service Provider Agreement and participate in developing and reviewing the person's individual plan annually (and updating and redeveloping it as required), including the following activities:
    - attend planning meetings
    - participate in establishing goals
    - implement responsibilities identified in the plan and support the plan developed for

each person
    - consult with the support network, professionals and resource persons as required to support individual planning
- Per the terms of their Service Provider Agreement, service providers will maintain records documenting each person's ongoing progress toward their goals and submit a service report with this information to the CSW as requested and at minimum annually.
- Service providers may assume or assign staff to fulfil the role of facilitator[5] (as needed and agreed to by the planning team members and service provider).

During individual planning meetings, service providers:

- share information about the support services and resources the service provider can provide to the person
- ask about and listen and respond to the person's needs, ideas and choices (whether communicating verbally or non-verbally)
- ensure that the required parts described in **6.2.3 Procedures: Parts of Individual Planning** are addressed in the process and in the individual plan

Role of Support Network

The person's support network knows them best and can provide valuable information about their current situation, goals and desires and support them in planning meetings.

During individual planning meetings, family members and members from the person's support network:

- provide emotional support and assistance to the person
- ask about and listen and respond to the person's needs, ideas and choices (whether communicating verbally or non-verbally)
- share information about the person's current situation, goals and desires
- share information about available supports and resources through the support network and family

Role of Professionals

Professionals with expertise in areas related to the person's care needs (e.g., physician, speech therapist, occupational therapist, psychologist etc.) can attend and participate in individual planning meetings or provide information to the planning team members ahead of the meetings if unable to attend.

During individual planning meetings, professionals:

- ask about and listen and respond to the person's needs, ideas and choices (whether communicating verbally or non-verbally)
- provide expert advice on the support needs required by the person to meet their goals and desires
- share information about, including how to access, available supports and resources

[5] The CSW typically assumes the role of facilitator when a person is supported by a private home share provider, but the private home share provider or another person chosen by the person may fulfil this role instead.