

# *A key to your future*



**UNDERSTANDING THE  
INDIVIDUAL AND FAMILY  
SERVICE PLANNING PROCESS:  
A RESOURCE FOR  
FAMILY MEMBERS**



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# Introduction

**ABOUT THIS BOOKLET.** This booklet is written for family members of the people who receive services from Harbor Regional Center (HRC). It provides basic information about the center and its operations. It also explains how regional centers help people with a developmental disability, as well as their families, get the kinds of services and supports they need to achieve their hopes and dreams.

The primary purpose of this booklet is to describe the Individual and Family Service Plan (IFSP) and explain how such plans are developed and carried out. The booklet contains helpful information about how to prepare for the meeting where the IFSP is developed, and it describes the process that is put in place to make sure that the plan is effective in helping the person with a disability and his family achieve their desired outcomes.

If your family member is a young adult or adult, there is a companion booklet about the IFSP written especially for him. It is called *Your Individual and Family Service Plan: A Book for Adults*. This booklet explains the IFSP process in terms that many adults with a disability are able to understand. You may request a copy of this booklet from the regional center.

## SECTION 1

# What is Harbor Regional Center

Harbor Regional Center is a private, non-profit agency that has a contract with the State of California to provide certain services for people with a developmental disability. HRC is not a state agency. Rather, it is a community-based organization. This means that its policies are set and its major financial decisions are made by a Board of Directors whose members are people from the local community. While the state makes many of the rules that determine how regional centers operate, the primary purpose of giving local control to a board is to make sure that the services provided through the center meet the special needs of the community where it is located.

The HRC Board of Directors has 17 members. Some of these people have a disability and some have a family member with a disability. Still other board members are involved with HRC merely because they are interested in helping people with a disability live the fullest lives possible.

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**THE REGIONAL CENTER HELPS  
OPEN DOORS FOR PEOPLE  
WITH A DISABILITY.**

**WHAT THE REGIONAL CENTER DOES.** The regional center's main activity is *service coordination*.

This is a process that involves planning and coordinating the delivery of services for people with a developmental disability. Service coordination is an ongoing activity through which regional center staff:

1. Give people with a disability opportunities to take charge of their lives by participating actively in making decisions about how they will live and do other things in the community.
2. Help people with a disability and their families gain access to the services and supports needed for the person to achieve his life goals.

**The HRC mission.** In many of the materials that it publishes, Harbor Regional Center describes itself as an agency that “makes things happen” for people with a developmental disability and their

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families. This particular phrase was chosen by the people at HRC to reflect their commitment to being strong and *active* advocates for people and their families. It means they work very hard to make sure people with a disability and their families have access to the services and supports they need to live their lives in the way they choose.

**Regional center goals.** Harbor Regional Center focuses its efforts on achieving two particularly important goals. The first is to *help people be active members of their community*. This means that people with a disability live, work, socialize, and are involved in recreational activities within the community, in natural environments and with non-disabled people. The second important goal is to *help people and their families make their own choices about how they live their lives*. In other words, people, often with support from their families, decide where they live, what they do during the day, what they do for fun, and with whom they spend time. The Individual and Family Service Plan (IFSP) process is the primary way that the person with a disability is helped to work toward these two critical goals.

## WHAT ARE THE REGIONAL CENTER'S

**RESPONSIBILITIES?** Regional center staff are responsible for helping the person and his family decide what kinds of services and supports will best help the family member with a disability achieve his desired outcomes. Desired outcomes are the things that a person would like to be true about his life in the near or more distant future. For example, he may want to have a job, live on his own in the community, learn a particular skill, stay in good health, or make new friends. Regional center staff are also responsible for identifying the source of services and supports that the person will need to achieve the outcomes, and for helping the individual and his family gain access to these resources.

The regional center directly provides service coordination and several other types of services and supports for people with a developmental disability. It also purchases a large number of services provided by independent professionals

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and agencies that contract with the center. Examples of such services are *independent living skills training* (to help people with a disability learn how to look after their own basic needs while living in the community), *respite* (providing occasional care for a consumer so his family members can take time away from home or just have time to themselves), and *behavior management* (to help parents deal more effectively with their child's challenging behaviors).

Some services, called “generic” services, are provided or paid through public sources, such as the federal, state, or local government (e.g., through MediCal, the Department of Rehabilitation, or the county mental health department). For school age children, services may also be provided by the school system (e.g., speech and hearing assessment, special education services).

**WHAT IS A REGIONAL CENTER COUNSELOR?** Every regional center client and family have a special relationship with a single staff member called a

Counselor. The Counselor is their main contact person within the center. He has the primary responsibility for organizing the team that works with the individual to develop the IFSP, and he participates in the development of the plan. (HRC has written a special booklet, called ***Making It Happen: Your Harbor Regional Center Counselor***, that contains a lot more information about Counselors. You may request a copy of this book from the center.)

The IFSP is developed by the team, each member of which has a special relationship with or special knowledge about the person with a disability. The Counselor is the person who actually writes the plan based on decisions made by the team, and he coordinates the delivery of services and supports described in the plan. He also keeps a check on how the plan is working and whether the person is making progress. Throughout the entire process, the Counselor is the staff person with whom the person with a disability and the family should communicate about getting help with services, asking for information or advice, or seeking assistance if there is a problem.

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# About the IFSP

The Individual and Family Service Plan helps the person with a disability answer two very important questions: *What future do I want for myself?*

*and How do I make my future happen?* The plan describes the preferred future in terms of outcomes that the person and his family wish to achieve. It also describes the way to the outcomes in terms of the services and supports needed to achieve them.

If the individual is an adult and can make his wishes known, he will have the main responsibility for choosing his preferred outcomes. If he is limited in his ability to communicate, the family may play a role in the process. If the person with a disability is a child or adolescent, the family will have the primary role in developing the plan.

**THE PLAN DESCRIBES DESIRED  
OUTCOMES AND HOW THEY  
WILL BE ACHIEVED.**

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## **WHY IS A PLAN NECESSARY?** One reason for having a

written plan is that it increases the likelihood that people with a disability will achieve their preferred future. It does this in a number of ways. Having a plan increases the likelihood that the services and supports provided to help people achieve their preferred future are coordinated, i.e., that these services work well together in helping the person. Having a written plan helps the team monitor the effectiveness of the various services and supports. And reviewing a plan at least annually provides a regular opportunity for the person himself to re-examine and modify his preferred future. Finally, a plan is necessary because California law requires every person who participates in the regional center program to have a written service plan which is reviewed and modified at least annually.

The document reflecting the decisions made at the IFSP meeting becomes the basis of the written plan. This plan then serves as a visible record of

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what everyone involved with the person has agreed to. The written plan promotes *accountability* by clearly specifying who is responsible for what aspects of the plan and what the outcome is expected to be. The written plan also helps assure that everyone is “on the same page” with regard to what the person wants to do in his life.

## A PERSON-CENTERED PLAN: NOT JUST A PIECE

**OF PAPER.** The most important thing about a plan is not the piece of paper it is written on, but rather, the **person** about whom the plan speaks. The phrase “person-centered plan” is used to emphasize the importance of the person behind the plan. And this is the person with a disability.

A person-centered plan involves a way of thinking about a person with a disability and helping that person lead a more fulfilling life. The approach requires a vision of a desired future, and a gathering together of all the resources necessary

for the person to achieve that future. Members of a person-centered team or “circle-of-support” participate in carrying out the plan by working to develop community connections, to invent and experiment with novel courses of action, and to stand by the person as any close friend would.

A set of values underlies the person-centered planning process. These include:

1. Service options based on personal choices, strengths, and needs rather than on a predetermined “menu” of available services;
2. Type and intensity of services that vary from time to time, as the person’s strengths and needs vary over time and across settings;
3. Access to resources that are available to everyone in the community rather than services developed specifically for people with a disability;
4. Services that are coordinated around individual needs rather than pre-programmed services designed for groups of people; and
5. Recognition that friends, families, and co-workers as well as professionals are able to teach new skills, model social behaviors, provide support, and develop relationships with the person.

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As is suggested by the last statement above, developing action plans using a person-centered approach is not just about finding and using professional services. It is also about identifying support and resources that already exist in the everyday life of the person with a disability and marshaling these resources toward the achievement of his desired outcomes.

## THE RELATIONSHIP BETWEEN THE IFSP AND

**OTHER PLANS.** People with a disability often have several different types of plans. For example, a school-aged person will usually have an Individual Educational Plan (IEP) that helps him, teachers, and other people know what help he needs to do his best in school. Adults involved in day activities have Individual Service Plans (ISP), outlining what the program will help each of them achieve through planned activities.

The IFSP is different from these plans in that it is more general, covering all areas of the person's life. It addresses all outcomes that are targeted in

the various plans and tells how these important activities fit into the total picture of the life of the person with a disability. The IFSP speaks to: family and other important people in the person's life; home; school, work, or day activity; social, recreation, or leisure activities; and personal health. One of the main purposes of the IFSP, then, is to ensure coordination of services provided through all plans relevant to the person's life.

## INPUT VERSUS OUTCOMES IN SERVICE

**PLANNING.** As discussed already, *outcomes* describe what the person with a disability and his family hope his life will be like or what he will be able to do in the immediate and more distant futures. Services and supports are the *inputs*, or means, intended to help the person with a disability achieve the desired outcomes.

There are often multiple ways to achieve any given outcome. Take as an example a child who does not speak or who speaks in a way that is not easily understood. The family's desired outcome

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for this child might be that he be able to communicate well enough to be understood by people outside the family. The means to achieve this outcome – the input – could be speech therapy. Other means to achieve this goal, however, might be for the child to learn to communicate using sign language or a communication device.

Under any of these three options, the desired outcome is the same (the child is able to communicate). At the same time, the input differs, depending on the family's preferences as well as judgments of professionals and other members of the team about what is likely to be the most successful approach. Furthermore, in this situation, the person providing the service would be held accountable for the outcome – helping the child develop improved communication skills – rather than for merely providing services.

This example illustrates the importance of focusing first on outcome and, secondarily, on the ways in which the outcome can be achieved. It also demonstrates why it would not be appropriate to write as a desired outcome for this child that he receive speech therapy. The outcome sought would be improved communication, and the service could be speech therapy or some other means for achieving this outcome.

# What's in a Plan?

A plan says a lot about a person. It deals with things such as what he would like to do now and in the future; what he does well or would like to do better; what makes him happy and sad; and what he likes to do for fun. It also considers what things get in the way of his doing what he would like to do.

## WHAT HELP OR SUPPORT DOES THE PERSON

**NEED?** A very important part of planning is making sure the help and support are available when they are needed. Sometimes a person may wish to learn a new skill to make him more independent. For example, a person who wishes to travel independently to his job might want to learn to ride the public bus. In such a case, the plan would include *development of this skill* as an outcome.

Another person might want to live independently in the community, in an apartment. This might require that he have someone come to the apartment periodically to assist in specific

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activities, such as money management or certain household chores. This person's plan, then, would include *ongoing support* in particular life areas.

Finally, in order to support a child with a disability in the home environment, the family may need regular relief from the pressures of taking care of a special needs child. This child's plan, then, could include respite services to allow the family members to take time away from the home or concentrate on other responsibilities or activities within the home. This is another example of ongoing support.

**THE PLANNING TEAM.** The team that helps the person with a disability develop the IFSP also plays a major role in supporting him in the pursuit of his goals. It is important, therefore, to bring onto the team as many people as possible who are directly involved in the person's life. If the person is an adult, he

may select team members, or he may do this with the help of his family. If the person with a disability is a child or adolescent, the family would normally select or help the person select team members.

The person with a disability is the most important member of the team. An HRC Counselor is also a member. If the person is a child, the family is part of the team, and if the person is an adult, family members participate if he wishes them to.

It is particularly helpful to have as team members parents of people living in licensed homes or supported living settings. Other members of the team may be extended family members, neighbors, and friends such as people from work or school, friends from church, or roommates. In addition, every effort is made to have the participation of key service providers such as the residential service provider or job coach.

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**THE IFSP MEETING.** The person with a disability (or family members, if the person is a child) should be in charge of the IFSP meeting. Therefore, even though the Counselor is there to help with the meeting, it is important for the individual and family to prepare for the meeting ahead of time. A good way to do this is to work through the tool called *Planning for Your Future*. This tool, included at the end of this booklet, helps the person and his family think about the issues to be discussed at the meeting. For example, it asks them to think about who will be in the circle of support. It asks them to describe the person with a disability (likes, dislikes, wishes and dreams), think about what the person would like his life to be like in 3-5 years, and think about the barriers that prevent him from getting where he wants to go.

The meeting should be scheduled far enough in advance to enable all members of the planning team to attend. It should also be held at a place and time that are convenient for the person and his family as well as other team members. The

Counselor plays the major role in helping to schedule and coordinate the IFSP meeting.

**WRITING AND REVISING THE IFSP.** Following the team meeting, the Counselor writes up the actual IFSP document. He makes sure that what he has written accurately reflects what was decided at the meeting, and he gives copies of the plan to the person with a disability, the family, and other team members as needed.

An IFSP is completed for all new regional center clients. Thereafter, the team gets together at least once a year to see how things are going and to make changes that the person or the family request or that team members agree should be made. At this annual meeting the team members ask the person and his family if they are happy with the plan, including the services and supports. They also evaluate whether the plan is really helping the person reach his goals and they decide as a group what, if anything, should be changed for the coming year.

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**Reviewing the plan.** For some people, the IFSP is reviewed more often than at the annual meeting. Counselors get together on a quarterly basis with people living in licensed homes and people living independently in the community with supports. These quarterly reviews focus on how things are working for the person. One of those quarterly meetings becomes the annual review for which the planning team is brought together.

If the person lives with his family and is over three, the IFSP is reviewed and revised each year, unless there is a specific reason to do so more often. If the person lives with his parents and is younger than three, a review occurs at least twice a year.

**Other ways to get a new plan.** The person or his family may ask the Counselor for a new plan or an addendum to the plan at any time. It is not necessary to wait for a scheduled review with the Counselor or for a team meeting. The person with a disability or family may want a new plan if, after some period of time, something is not working well for him, if he has achieved the outcomes written by the team, if there was an important change in his life and some part of the plan is no longer appropriate, or if he chose something to be in the plan but no longer wants it.

**IT'S ABOUT PEOPLE, NOT PAPER.**

## **RESOLVING DISAGREEMENTS.** People who receive services

from HRC or their families may sometimes disagree with some members of the team about one or more aspects of the IFSP. Staff of Harbor Regional Center try to resolve such issues informally, through discussions and attempts to collaborate on the development of solutions to problems.

Clients and families are always encouraged to talk to their Counselor if they have a problem with a plan or a decision made by the regional center. If they are not happy with the response of their Counselor, they may also choose to talk to the Counselor's supervisor.

If discussions with regional center staff or supervisors do not resolve the problem to the satisfaction of the person or his family, they may initiate the formal appeal process. The appeal process provides for three possible ways of resolving disagreements:

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1. an informal meeting with the regional center’s executive director or representative;
2. a process called “mediation” in which an independent third party works with the disagreeing parties to reach an agreement; and
3. a formal “fair hearing” conducted by a representative of the state Office of Administrative Hearings.

Any and all of these options are available for people with a disability or their families. Just ask your Counselor.

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# Conclusion

The Individual and Family Service Plan is both the symbol and the substance of the person-centered approach to service planning. Successful implementation of a person-centered plan requires a partnership that brings together the resources of the regional center and the resources of the client and the community in which he lives. The more effective the partnership, the greater the likelihood that the person will achieve his preferred future.

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## NOTES





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August 2016