STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
Division of Developmental Disabilities
6 Harrington Road
Cranston, RI 02920-3080
TEL: (401) 462-3421
FAX: (401) 462-2775

Interim ISP

in response to COVID-19 precautions

The Center for Disease Control (CDC) recommends community actions designed to limit exposure to COVID-19. In response to this recommendation and the State of Emergency declared by Rhode Island, the Division of Developmental Disabilities (DDD) encourages individuals and plan writers to modify, postpone, or cancel ISP meetings for the safety and well-being of themselves, family, friends, staff, and the community.

In order to comply with the Medicaid requirement for a signed plan every 365 days, DDD has developed the attached affirmation form for use by individuals who assert that their current plan continues to meet their needs.

If your current plan does not reflect your goals, interests, and needs, then a new plan will need to be submitted. DDD encourages individuals and plan writers to follow RI Department of Health and CDC recommendations for prevention actions. Consider alternative methods for team input into the plan rather than a meeting, such as conference calls, Skype or other video conferencing, or gathering written comments. New plans will have to be submitted before the expiration date of the prior plan.

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Interim ISP

COVID-19

This form is to be used only by those who have a current plan.

Interim plans needed for transition into services should use the regular IISP form.

NAME OF PERSON: _____

SOCIAL SECURITY NUMBER: _____

CASE MANAGEMENT AGENCY/DDO: _____

ASSIGNED TIER: _____

Please select ONE of the following. Sign the form and return to the DDD before the current plan's expiration date.

☐ **NO CHANGES:** I have reviewed my current plan and affirm that the current plan continues to reflect my goals, interests, and needs. I will continue to receive the same services and supports from my current providers, or I will continue to self-direct my services. I request that my current authorization be rolled over. I will submit a new plan within 90 days after the end of the RI State of Emergency due to COVID-19.

☐ **NO PLAN CHANGE/NEW PROVIDER:** I have reviewed my current plan and affirm that the current plan continues to reflect my goals, interests, and needs. However, I am changing my service provider(s). A new Purchase Order is attached reflecting the new provider(s). I will submit a new plan within 90 days after the end of the RI State of Emergency due to COVID-19.

☐ **NO PLAN CHANGE/PO CHANGE:** I have reviewed my current plan and affirm that the current plan continues to reflect my goals, interests, and needs. However, I am revising my Purchase Order due to a change in where I want to use my funding or because I have recently been assessed at a higher SIS tier. A new Purchase Order is attached. I will submit a new plan within 90 days after the end of the RI State of Emergency due to COVID-19.

Print Name of Individual	Print Guardian Name (if applicable)
Individual Signature	Guardian Signature
Date	Date

Print name of individual completing this form: _____