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|  | DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)RESIDENTIAL HABILITATION CENTER (RHC) • INDIVIDUAL HABILITATION PLAN (IHP) • INDIVIDUAL PLAN OF CARE (IPOC)**Meeting Notification** |
| To: **Name of Guardian / Representative**You are invited to attend the [ ]  IHP or [ ]  IPOC meeting at **RHC**, **Location** ,on **Date of Meeting** on **Day of Meeting** at **Time of Meeting (please indicate AM or PM)**. We welcome your written comments and suggestions. Feel free to add pages or write a letter. Your reply will be discussed at the meeting with the interdisciplinary team. These forms and your letter will become part of the record.Do you plan to attend the meeting? [ ]  Yes [ ]  NoIf yes: [ ]  In-person [ ]  Virtual: video, or telephoneWould you prefer to have the meeting time or date changed? [ ]  Yes [ ]  NoIf yes, please contact **HPA or SSS Name** at **Phone Number (with Area Code)**. |
| **Community Services** |
| Per our regulations through Center for Medicaid Services (CMS), we are required to discuss a plan for discharge at least annually and begin to plan for a less restrictive environment.Do you wish to consider community services? [ ]  Yes [ ]  NoWould you like to discuss this with the Transition Coordinator? [ ]  Yes [ ]  No |
| **Comments** |
| Are there any concerns, comments, or questions you want to discuss at the meeting? |
|                  |
| GUARDIAN / REPRESENTATIVE SIGNATURE DATE  |
| NAME: DSHS NUMBER: LIVING UNIT: BIRTHDATE:  | **Meeting Notification** |