

SKILL PLAN FORM #4

FULL NAME: \_\_\_\_\_

RESIDENCE: \_\_\_\_\_

DAY PROGRAM: \_\_\_\_\_

AREAS OF IMPLEMENTATION: \_\_\_\_\_

PLAN WRITTEN BY: \_\_\_\_\_

PERSON(S) RESPONSIBLE FOR (Data Collection & Review of Progress of the Plan): \_\_\_\_\_

The Objective is written by the team and is sequenced and prioritized to meet the individuals needs. This is a detailed description of what the person will do once the training goal is accomplished. For every 20 hours of HAH Service, at least one written objective is required on one specific training goal. The written objective answers the question Who, Will do What, When/Under What Conditions, With What Assistance/Support, To What Degree/How Well, and By When?

Objective (from ISP): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Criteria: \_\_\_\_\_

Start Date: \_\_\_\_\_

Target Date: \_\_\_\_\_

Review period (no less than monthly): \_\_\_\_\_

METHOD:

Materials/Equipment: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Location and Set Up: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



WHAT TO DO WHEN THE PERSON RESPONDS CORRECTLY:

Reinforcement: \_\_\_\_\_

Reinforcement schedule: \_\_\_\_\_

WHAT TO DO IF THE PERSON MAKES AN INCORRECT RESPONSE:

If he/she attempts but responds incorrectly:

If he/she fails to respond:

If there are repeated incorrect responses:

TRAINING SCHEDULE: \_\_\_\_\_

DATA COLLECTION (type and frequency): \_\_\_\_\_

Attach Therapy Recommendation/Instruction & a Sample Data Sheet to the Skill Plan