The ICSP documentation should include:

- The development of the ICSP consistent with Statutes, section 245.4711
- To the extent possible, the recipient, the recipient's family, advocates, service providers, and significant others must be involved in all phases of development and implementation of the individual community support plan.
- The client's individual community support plan must state:

  (1) the goals of each service;

  (2) the activities/tasks of the recipient, case managers, involved others for accomplishing each goal;

  (3) a schedule for each activity/task; and

  (4) the frequency of face-to-face contacts by the case manager, as appropriate to recipient need and the implementation of the individual community support plan.
- The ICSP should reflect the prioritization of recipient goals and needs identified in the assessment process.
- The ICSP should identify the natural supports, services, programs and resources that the recipient is gaining access to, who and how that access will be gained, and planned monitoring and coordination to assure recipient progress and value of supports, services, programs and resources.
- A written ICSP needs to be completed within 30 days of beginning adult MH-TCM services, and a new functional assessment completed at least every 180 days thereafter. More often, if the recipient requests. The ICSP needs to be written by a mental health professional, or signed by the clinical supervisor of the case manager.
- The recipient name, date of completion of the ICSP, signatures of the recipient, case manager, clinical supervisor (optional: signatures of others who participate in the development/implementation of the ICSP).