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| **Identifying Information**  |
| Individual Name:Click here to enter text. | DDD ID: Click here to enter text. | Date of Contact: Click here to enter a date. |
| Support Coordinator: Click here to enter text. | Support Coordination Agency:Click here to enter text. | Individual’s Contact #: Click here to enter text. |
| Name/Relationship of Person Providing Information to Support Coordinator:Click here to enter text. | Contact Period: Choose an item.Contact Method: Choose an item.Contact Location: Choose an item. If other, please specify: Click here to enter text.  | Date of Approved Plan: Click here to enter a date.Reporting Period: Click here to enter text. |
| ***Please complete all of the following sections based on your observations/conversations. Please include in your comments the type of service you are commenting about, including but not limited to employment, day, transportation, individuals supports, etc.*** |
| **Outstanding Issues/Outcomes of Corrective Actions** |
| * **Were there any outstanding issues from the last point of contact?** Choose an item.
* **Provide an update of the status of the issue and progression of corrective action:** Click here to enter text.
 |
| **Medicaid Eligibility Status**  |
| * **Is your Medicaid/waiver eligibility still maintained (Redetermination)?** Choose an item.
* **Describe corrective actions to be taken:** Click here to enter text.
 |
| **Budget & Assessment** |
| * **Are you continuing to operate within your budget?** Choose an item.
* **Describe corrective actions to be taken:** Click here to enter text.
* **Has there been any change that warrants a reassessment of need?** Choose an item.
* **Please describe:** Click here to enter text.
 |
| **Service Plan (Review all services indicated on the ISP)**  |
| ***Needs:**** **Are all of your assessed needs being met through the current service plan?** Choose an item.
* **Do the services in the plan continue to meet your needs?** Choose an item.
* **Describe any issues and the corrective action(s) including any modifications that need to be made to the service plan:** Click here to enter text.
 |
| ***Services:**** **Are the services being delivered in accordance with the service plan?** Choose an item.
* **Are there any issues or barriers to your service delivery?** Choose an item.
* **Describe any issues and the corrective action(s) including any modifications that need to be made to the service plan:** Click here to enter text.
 |
| ***Progress:**** **Is progress being made towards the planning goals/outcomes? Choose an item.**
* **Describe any issues and the corrective action(s) including any modifications that need to be made to the service plan: Click here to enter text.**
 |
| **Provider Satisfaction**  |
| * **Are you having any issues with providers or staff who work with you or other people around you? Choose an item.**
* **Explain and describe follow up needed:** Click here to enter text.
 |
| **Behavior** |
| * **Have there been any changes in type/frequency of behaviors? Choose an item.**
* **Are there any trends or concerns needing follow-up? Choose an item.**
* **Description of behaviors: Click here to enter text.**
* **Follow-up/corrective action to be taken: Click here to enter text.**
 |
| **Community Involvement** |
| * **Do you have the supports you need to access your community as frequently as you would like? Choose an item.**
* **Describe follow up needed:** Click here to enter text.
 |
| **Friendships and Social Interactions**  |
| * **Do you have the supports you need to make and maintain your friendships as much as you would like? Choose an item.**
* **Describe follow up needed:** Click here to enter text.
 |
| **Choice and Decision Making**  |
| * **Are you making your own choices and are your choices being respected? Choose an item.**
* **Do you have the supports you need to make your own decisions? Choose an item.**
* **Describe follow up needed: Click here to enter text.**
 |
| **Employment** |
| * **Do you have the supports you need to reach your employment goals? Choose an item.**
* **Was the ISP approved with employment follow up required? Choose an item.**
* **Describe follow up needed: Click here to enter text.**
 |
| **Communication**  |
| * **Contact with the Interdisciplinary Team: Choose an item.**
* **Date of contact: Click here to enter a date.**
* **Reason for contact:** Click here to enter text.
 |
| * **Contact with the Interdisciplinary Team: Choose an item.**
* **Date of contact: Click here to enter a date.**
* **Reason for contact:** Click here to enter text.
 |
| **Health & Safety** |
| * **Are you protected from abuse, neglect, exploitation, physical harm, emotional distress (as reported by the individual family and/or service providers/DSP or based on observations)? Choose an item.**
* **Description: Click here to enter text.**
* **Describe corrective actions to be taken: Click here to enter text.**
* **Date reported to DDD: Click here to enter a date.**
 |
| * **Indicate if there have been any changes in your health status (e.g. changes in seizure or aspiration frequency, sleep patterns, bowel/bladder function, activity level, mood, or other typical behavior/routines that may indicate a health concern, significant weight gain or loss, wounds, signs of pain- including dental pain, medication changes, hospital or ER since last visit, etc.): Choose an item.**
* **Description of change in health status: Click here to enter text.**
* **Date reported to medical professional (as applicable): Click here to enter a date.**
* **Follow-up/corrective action to be taken, including name of medical professional involved:**

**Click here to enter text.** |
| * **Indicate if there is any health, welfare or safety related needs or issues that need attention at this time: Choose an item.**
* **Description of issue/need: Click here to enter text.**
* **Follow-up/corrective action to be taken: Click here to enter text.**
* **Date reported to DDD: Click here to enter a date.**
 |
| * **Do any of the above health and safety issues require a change to the service plan? If so, describe and update plan:** Click here to enter text.
 |
| **Unusual Incident Reports (UIR)**  |
| * **Please indicate if any UIRs occurred since the last point of contact: Choose an item.**
 |
| ***New Incident Report:**** **Type/description of incident(s): Choose an item.**
* **Date of incident:** **Click here to enter a date.**
* **Description of incident: Click here to enter text.**
* **Follow-up actions taken: Click here to enter text.**
* **Resolution(s): Click here to enter text.**
 |
| ***New Incident Report:**** **Type/description of incident(s): Choose an item.**
* **Date of incident: Click here to enter a date.**
* **Description of incident: Click here to enter text.**
* **Follow-up actions taken: Click here to enter text.**
* **Resolution(s): Click here to enter text.**
 |
| ***Pending Incident Report:**** **Indicate if there are any UIRs still pending this month: Choose an item.**
* **Type/description of incident(s): Choose an item.**
* **Date of Incident: Click here to enter a date.**
* **Description of incident: Click here to enter text.**
* **Follow-up actions taken: Click here to enter text.**
* **New/additional information on this incident report: Click here to enter text.**
 |
| **Evidence of Health Discussion** |
| **The health and safety of the individual and any changes to service or support needs were discussed in the context of current local/state/national health conditions (such as COVID, influenza, etc.). Risks and responsibilities were addressed.** Local and state health departments and the Centers for Disease Control and Prevention can be used as resources.**Choose an item.**Click here to enter text. |
| **Summary of Contact (Required Narrative)** |
| Click here to enter text. |
| **Quarterly Face-to-Face Review (if applicable)**  |
| * **Summary of observations and impressions of individual: Click here to enter text.**
* **Please describe any concerns or issues that you identified during the course of the face to face visit related to the individual and/or program site visited: Click here to enter text.**
* **Have you noticed any ongoing issues or trends within the quarter that need to be addressed? Choose an item.**
* **Please describe: Click here to enter text.**
 |
| **Annual In-Home Review (if applicable)**  |
| * **Summary of observations and impressions of individual: Click here to enter text.**
* **Please describe any concerns or issues that you identified during the course of the in-home visit related to the individual and/or the home visited: Click here to enter text.**
* **Have you noticed any ongoing issues or trends within the year that need to be addressed? Choose an item.**
* **Please describe: Click here to enter text.**
 |
| ***Annual Reminder: Advise individual to attend medical and dental visits at least once a year.*** |
| **Acknowledgements** |
| **Completed by: Click here to enter text. Title: Click here to enter text. Date: Click here to enter a date.** |
| **Reviewed by (if applicable): Click here to enter text. Title: Click here to enter text. Date: Click here to enter a date.** |