Required ISP Documentation for Waiver/Electronic Checklist

Person's Name_____ Pre ISP Meeting Date_____

ISP Meeting Date_____

ISP Amendment Date:_____

Residential Documents	Yes	No	N/A	Selected Provider
1. 3rd or 4th Quarterly Report with progress documented				
2. Annual IPP with goals, objectives, and actions steps				
3. Person Centered Planning Tools				
4. Staffing Ratio				
5. Bank Account Balances				
Medical Documents	**Yes**	**No**	**N/A**	
1. Annual Physical *				
• Are the appropriate waiver services recommended by the doctor?				
2. Lab results*				
3. Health Care Management Plan (HCMP)*				
4. Health Passport*				
5. Nursing Assessment A or B*				
6. Annual Preventive Health Screening Report(Male)*				
7. Annual Preventive Health Screening Report (Female)*				
8. Self Administration Medication Form*				
9. Current Psychotropic Medication Review Form				
10. Abnormal Involuntary Movement Scale (AIMS)				
11. Most recent Dental Consult*				
12. Fall Risk Assessment				
13. Glascow Depression Scale (Self-Report)				
14. Glascow Depression Scale (Care Giver Supplement)				
15. Protocol For Refusal Form				
16. Physical Therapy				
• 3rd or 4th Quarterly with recommended hours				
• Annual assessment with recommended hours				
• Repositioning Protocol				
17. Occupational Therapy				
• 3rd or 4th Quarterly with recommended hours				
• Annual assessment with recommended hours				
18. Nutrition				
• 3rd or 4th Quarterly with recommended hours				
• Annual assessment with recommended hours				
19. Specialty Consult*				
• Urology				
• Podiatry				
• OB/GYN				
• Mammogram				

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• Colonoscopy				
• Neurology				
• Ophthalmology				
• ENT				
• Gastroenterology				
• Other:				
Day/Vocational/Supported Employment	Yes	No	N/A	
1. 3rd or 4th Quarterly Report with progress documented				
2. Annual IPP with goals, objectives, and action steps				
3. Weekly/ Monthly Schedule				
4. Positive Personal Profile (PPP)				
• Individual Job Search Plan and Community Integration Plan				
Individualized Day Service	Yes	No	N/A	
• 3rd or 4th Quarterly				
• Community Integration Plan				
Level of Need	Yes	No	N/A	
1. Risk Factors Reviewed at the meeting				
2. Goals Developed for the risk factors identified in the LON				
Other Waiver Services	Yes	No	N/A	
1. BSP				
• Diagnostic Assessment Report				
• Annual BSP				
• BSP 3rd or 4th Quarterly Report				
• BSP work sheet				
2. Speech and Language				
• 3rd or 4th quarterly report with goal(s), objective(s), action step(s), and recommended hours				
• Annual assessment with goal(s), objective(s), action steps (s) recommended hours				
• Mealtime Protocol				
• Feeding Guidelines				
3. In-home support				
• 3rd or 4th quarterly report with progress				
• Annual IPP with goals, objectives, and action steps				
4. Family Training				
• 3r or 4th quarterly report with recommended hours				
• Annual assessment with recommended hours				
5. Art Therapies (Art, Dance, Drama, Music)				
• 3rd or 4th quarterly report with goal(s), objective(s), action				

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step(s), and recommended hours				
• Annual assessment with recommended hours				
6. Bereavement				
• 3rd or 4th Quarterly with recommended hours				
• Annual assessment with recommended hours				
7. Fitness				
• 3rd or 4th Quarterly with goal(s), objective(s), action step(s), and recommended hours				
• Annual assessment with recommended hours				
8. Sexual Education				
• 3rd or 4th Quarterly with goal(s), objective(s), action step(s), and recommended hours				
• Annual assessment with recommended hours				
9. Massage Therapy				
• 3rd or 4th Quarterly with goal(s), objective(s), action step(s), and recommended hours				
• Annual assessment with recommended hours				
Other Documents	Yes	No		
1. Choice of Provider Form				
2. Bill of Rights Reviewed and Signed				
3. Abuse and Neglect Fact Sheet Reviewed				
4. Internal Resolution Fact Sheets Reviewed				
5. Silver Alert Form				
6. Voters Registration				
7. National Core Indicator				
Recommended HCBW Services (completed at ISP and ISP amendment meetings)	Yes	No	Unmet Need	
1. Supported Living				
2. Supported Living with transportation				
3. Residential Habilitation				
4. Host Home				
5. In-home Support				
6. Respite				
7. Shared Living				
8. Day Habilitation				
9. Day Habilitation 1:1				
10. Employment Readiness				
11. Supported Employment				
12. Small Group Supported Employment				
13. Individualized Day Habilitation				
14. Person Care(must exhaust state plan)				

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15. Skilled Nursing (must exhaust state plan)				
16. Art Therapies (Art, Dance, Drama, Music Therapy)				
17. Behavior Support				
18. Family Training				
19. Occupational Therapy				
20. Physical Therapy				
21. Speech/Hearing and Language				
22. Wellness Therapies (Bereavement, Fitness, Nutrition, Sexual Education, Massage Therapy				
23. Environmental Accessibility Adaptions				
24. Personal Emergency Response System				
25. One Time Only Transitional Services				
26. Vehicle Modifications				
Rejected Services by the person/IDT Team				
1.				
2.				
3.				

*required medical forms for people residing in a Supported Living, Residential Habilitation, and Host Home setting.

Service Coordinator's Signature_____ Date_____

QIDP/Program Manager's Signature_____ Date_____

Supervisory Service Coordinator_____ Date_____

Issues entered for missing documentation: Yes_____ No_____