ISP Sample

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FACILITY ANNUAL REVIEW

Consumer:

DOA: _____
(Date of Admission)

DOB: _____
(Date of Birth)

UCI#: _____

FACILITY: _____
(Name)

_____
(Address)

Regional Center: _____
(Name of Regional Center)

Service Coordinator: _____
(Name)

Period of Report: _____
(Time frame – example 1/1/16 – 3/31/16)

Date of Plan: _____
(Date)

P & I Balance: $ _____ as of _____
Amount Date

Quarterly: 1 (_____) 2 (_____) 3 (_____) 4 (_____)

Yes No	The consumer assisted in coordinating the meeting. (If not, please describe why.)
Yes No	The consumer was present and helped lead their meeting. (If not, please describe why.)

PROGRESS TOWARDS IPP OBJECTIVES

1. PLACEMENT: Describe placement and indicate that it is the least restrictive, most appropriate environment.

_____

_____

_____

CURRENTLY: (Include placement date, how does the client feel about the home, what supports the client receives in the home, the resources and community activities that make this an appropriate placement. – close to bus stop, shopping centers, etc.)

2. MEDICAL INFORMATION & MEDICATIONS (Include current diagnosis, health conditions, including physicians information, tests (TB, EKG, Chest x-rays, lab work, etc. – please include results), medications, additional health documentation such as seizures, diets, allergies,

Please list all physicians, name, address, and phone number. Use grid to list type of visit, date of last visit and up-coming visits, reason for visit, and outcome of visit.

Primary Physician ..... Dentist ..... Psychiatrist
Neurologist ..... Cardiologist..... Podiatrist
Physical Therapist ..... Occupational Therapist ..... Nutritionist
Psychologist ..... Other specialty physicians

APPOINTMENTS	DATES	REASON	OUTCOME	DOCTORS
				Name Address Phone Number
				Name Address Phone Number
				Name Address Phone Number
				Name Address Phone Number
				Name Address Phone Number

				Name Address Phone Number
				Name Address Phone Number

List of current medications:

MEDICATIONS	**DOSAGE**	**REASON**

MEDICATION CHANGE: ☐ YES ☐ NO

Height: _____ Weight: _____ Date: (Date last taken) _____

3. DAY PROGRAM

Currently: (Program name, address, days and times at program, contact person and phone number, program goals and current outcomes, transportation to and from the program.)

4. INDEPENDENT LIVING SKILLS

(Describe current independent living skills being addressed, for example, daily hygiene, health maintenance, cooking, social interactions with others, making a small purchases, and community skills training.)

Currently: (Describe current skill building goals, types of training tools and strategies)

5. COMMUNITY/SOCIAL ACTIVITIES

(Include community outings and social events)

Currently: (Describe community activities including supports needing for successful integration into everyday outings and events. Examples can include safety awareness, social interactions, communication, supervision, etc.)

6. BEHAVIOR MANAGEMENT

(Statement on type of behavior management supports provided in the home.)

Currently: (Describe behavior management supports including consultant contact information and dates of services. Also include revisions and updates to the behavior plan)

TARGET BEHAVIORS

(List and describe target behaviors and progress. Include Behavior Report as attachment.)

a. Tantrums/Outburst – Describe objective and progress

b. Property Destruction – Describe objective and progress

c. Elopement – Describe objective and progress

7. SAFETY AWARENESS

(Describe risk and safety awareness issues.)

Currently: (Describe any risk or safety awareness issues that may affect a person health and safety.)

8. FAMILY INVOLVEMENT

(Describe individual's family, their involvement and any legal considerations such as conservatorship, legal guardian, etc.)

_____

_____

_____

❑ This report was written and reviewed in conjunction with the client.

_____ _____

Administrator Date