

Provider Information Form For Yearly ISP Meeting

Consumer Name: _____

Provider: _____

Supervisor (if applicable): _____

***Supervision Level:
Services Rendered:
*Summary of Progress/Regression:
**Medical/Mental Health update/status:
Summary of behavior progress/regression:
Update of Social Security income, wages, benefits:
Goals for Next Year (include provider, frequency, duration):
Updated Ratio information (if recent changes):
Submit copy of assessment (review and update):

SSA will provide copies of applicable assessments, required LOC, copy of completed ISP

* - Address each skill development goal and other tracking areas.

** - Include current medications, attending physicians, doctor appointments, and needs

*** - (1) General Supervision – Individual may or may not display target behaviors or have medical needs

(2) Redirection is successful – When target behaviors are displayed and immediate redirection is necessary, the individual responds positively to the redirection

(3) Redirection is not successful – The individual is difficult to redirect when target behaviors are displayed, but constant and immediate supervision is not needed or required

(4) Requires in-view monitoring for behavioral or medical reasons during all scheduled programming

(5) Requires arms length monitoring, supervision and training from staff for behavioral or medical reasons during at least **50%** of scheduled programming

(6) Requires extensive arms length monitoring, supervision and training from staff for behavioral or medical reasons during **all** scheduled programming.