ISC Documentation Form: **PERIODIC REVIEW** COMPLETED EVERY THIRD MONTH

Person's Name: _____ Month & Year: _____

REVIEW DETAILS:

Location of Face-to-Face Visit:	Name of Provider:	Date of Face-to-Face Visit:

PERIODIC REVIEW CHECKLIST:

Note: These items are reviewed once every third calendar month during the regular monthly face-to-face visit with the person. Additional contacts with family members, or the legal representative, providers & others; and the review of any documentation available to the ISC, should be conducted if needed to determine these review items. Items marked "No", are reported to the Provider and/or DMRS, as appropriate. Items marked "No" that indicate abuse, neglect or mistreatment must be reported according to DMRS policy & immediate action taken or initiated by the ISC to protect the person from jeopardy, if abuse, neglect or mistreatment is observed or discovered.

	INDIVIDUAL PLANNING & IMPLEMENTATION	YES	NO	N/A
P-1	A current and complete ISP is available to staff providing direct supports to the person.	☐	☐	☐

	RIGHTS, RESPECT & DIGNITY	YES	NO	N/A
P-2	The person has time and space for privacy (i.e., phone calls, medical interventions, hygiene, personal care, etc.)	☐	☐	
P-3	The person is supported in making choices about how to spend his/her personal spending money.	☐	☐	
P-4	Any problems/concerns related to the person are addressed/ resolved in a timely and satisfactory manner.	☐	☐	
P-5	The person understands his/her right to appeal any reduction, denial, or delay in services.	☐	☐	☐
P-6	The person understands his/her options for resolving complaints (e.g., provider's resolution process; change of providers; change of supports & services; complain to DMRS/TennCare; etc.) (N/A, if the person has a legal representative)	☐	☐	☐

	CHOICE & DECISION-MAKING	YES	NO	
P-7	The person lives in the place/location that he/she prefers as identified in the ISP.	☐	☐	
P-8	The person lives with whom he/she prefers as identified in the ISP.	☐	☐	

	OPPORTUNITIES FOR WORK	YES	NO	
P-9	The person reports that he/she desires to remain in his/her current job or day service/activities.	☐	☐	

	ADMINISTRATIVE AUTHORITY & FINANCIAL ACCOUNTABILITY	YES	NO	N/A
P-10	The person's funds are being managed to keep his/her asset within the limits required for maintaining Medicaid Waiver eligibility, if applicable. (Mark N/A, if not Waiver. Mark "NO", if assets are approaching, or are over, the $2,000 mark.)	☐	☐	☐

Signature of ISC Conducting Review: _____ **Date:** _____