MONTHLY DOCUMENTATION FORM

☐ **FOR ISC SERVICES**

☐ **FOR CASE MANAGEMENT SERVICES**

(Person's Name) (Month & Year)

(ISC Agency or DMRS Office Name)

FACE-TO-FACE VISIT:

(Other information gathered during this visit may be recorded in the additional notes section. If additional face-to-face contact occurs during the month, record the details in the additional contacts section.)

(Date) (Time am/pm) Choose location (Location Type) (Name of Provider @ This Location)

(Names of the staff or other caregivers present during the face-to-face visit)

(Name & Job Title of Person Conducting Visit) X (Signature)

MONTHLY MONITORING INDICATORS:

(Apply these indicators during the face-to-face visit and other review activities. If an indicator is marked as "No", complete and send a "Plan Implementation Communication Tool" to the responsible DMRS service provider as applicable.)

ISP / Plan of Care Implementation:

1.	Staff is observed to be including, encouraging and supporting the person in actively participating in activities that are routine and natural to the location of the face-to-face visit. (N/A if no staff present)	☐ Yes	☐ No	☐ N/A
2.	Staff interactions and conversations with the person appear positive, affirming, respectful and inclusive toward the person. (N/A if no staff present)	☐ Yes	☐ No	☐ N/A
3.	There is documentation at the location of the face-to-face visit to evidence that the plan is being implemented and progress is being assessed, (N/A if such documentation is not required or necessary at the location of the visit.)	☐ Yes	☐ No	☐ N/A
4.	The person reports or indicates satisfaction with the current supports and services identified in the current plan. (N/A if unable to communicate or discern. Periodic contact with the legal representative or family may be necessary to ascertain satisfaction.)	☐ Yes	☐ No	☐ N/A
5.	There is a copy of the current ISP at the location of the face-to-face visit. (N/A if a copy of the ISP is not required or necessary at the location of the visit.)	☐ Yes	☐ No	☐ N/A

Health & Safety:

6.	The person reports / indicates that he/she feels safe and secure. (N/A if unable to communicate or discern. Periodic contact with the legal representative or family may be necessary to ascertain the person's safety and security.)	☐ Yes	☐ No	☐ N/A
7.	The person reports / appears to be healthy as observed during the face-to-face visit (not a medical opinion). (N/A if unable to communicate or discern. Periodic contact with the legal representative or family may be necessary to ascertain the person's health status.)	☐ Yes	☐ No	☐ N/A
8.	The person's grooming, hygiene and clothing indicate that support is being provided as appropriate to meet the person's needs and preferences (as observed during the face-to-face visit).	☐ Yes	☐ No	
9.	As applicable to the person's needs and the location of the visit, adaptive equipment and/or medical supplies are available and being used according to	☐ Yes	☐ No	☐ N/A

	the person's plan. (N/A if the person does not need or use special equipment or medical supplies.)			
10.	Staff appears knowledgeable about the healthcare issues and supports as identified in the person's plan. (N/A if the person's plan does not identified ongoing healthcare issues or supports.)	☐ Yes	☐ No	☐ N/A

MONTHLY REVIEW OF THE ISP / PLAN OF CARE:

(Based on the information gathered during the month, assess each of these indicators. If an indicator is marked as "No", complete and send a "Plan Implementation Communication Tool" to the responsible DMRS service provider as applicable.)

11.	Providers of waiver services as required have submitted to the ISC / CM a monthly review of their services to include the status of the implementation of their assigned actions and responsibilities in the plan and the results or recommendations from any recent medical consults or assessments. (N/A if there are no providers of waiver services in place at this time.)	☐ Yes	☐ No	☐ N/A
12.	The services currently authorized are being provided at the amount and frequency indicated in the person's plan.	☐ Yes	☐ No	
13.	The outcomes and actions in the person's plan are being implemented as written and the person is being supported in his/her preferences and needs around work, socialization, learning and community involvement as appropriate to the person's age and current health status.	☐ Yes	☐ No	
14.	Appropriate action has been or is being taken in response to any emerging health problems including obtaining needed evaluation, treatment or follow-up. (N/A if there are no emerging health problems at this time.)	☐ Yes	☐ No	☐ N/A
15.	The ongoing healthcare services identified in the person's plan are being provided as needed. (N/A if there are no healthcare issues identified in the plan.)	☐ Yes	☐ No	☐ N/A
16.	Any risks identified for this person are being addressed. (N/A if no risks are identified at this time.)	☐ Yes	☐ No	☐ N/A

▶ THE STATUS OF THE PERSON'S PLAN AT THIS TIME IS AS FOLLOWS: (check one)

☐ The person's plan is current and any changes or updates have been made this month as needed.

☐ The person's plan requires updating or amendment and the actions to be taken or needed are noted in the additional notes section.

▶ THE REVIEW OF THE PERSON'S PLAN WAS FINALIZED FOR THE MONTH ON THIS DATE: _____

_____ X _____

(Name & Job Title of Person Conducting Review) (Signature or Initials)

SELF-DETERMINATION WAIVER – QUARTERLY REVIEW OF BUDGET:

(If the person is enrolled in the Self-Determination Medicaid Waiver, every three months review the budget and ensure that it continues to meet the needs of the person.)

☐ A review is not due this month or applicable because the person is not enrolled in the SD waiver.

☐ A review was conducted and the results or actions taken are noted in the additional notes section.

The review, if due, was conducted on this date:

	X
(Name & Job Title of Person Conducting Review)	(Signature or Initials)

ADDITIONAL NOTES & CONTACTS:

(Use this section throughout the month to make notes about any of the contacts made or the actions taken.)
*Activity Codes: FF = face-to-face. HV = home visit. PV = provider site visit. OV = other visit. MR = monthly review activity.
MTG = meeting. TC = telephone contact. EM = e-mail correspondence. WC = written correspondence. FX = fax transmittal.
MC = monthly contact.

Date	Code*	Activity / Contact Notes	Sign or Initial
	(TAB TO HERE)	(TAB to here. Insert a separate row for each dated entry by pressing TAB key at the end of each row, or by using the TABLE, Insert commands.)	