Date Completed: ____________

Residential Comprehensive
Progress Summary

Annual ☐ Six month ☐ 30 Day ☐

Consumer name: ____________

Review period (start month /end month): ____________

Date of the IP: ____________

Legal Status

☐ Own Guardian

☐ Legally Appointed Guardian Who? / Type (full/limited): ____________

☐ Power of Attorney Who? / Type (medical, financial): ____________

☐ Medical Proxy Who? ____________

☐ Other Explain: ____________

Legal Matters (court orders/past criminal history/probation/pending):

____

____

Advance Directives currently in place:

____

____

Financial Status/Benefits (Please provide monthly amounts for all sources of income)

SSI: ____________ VA: ____________

SSDI (SSA): ____________ OAP: ____________

Wages: ____________ AND/AB: ____________

Other (type/amount): ____________

Checking Account Balance: ____________ Savings Account Balance: ____________

Trust: ____________ Burial Plot: ____________

☐ Medicaid # ____________

☐ Medicare Part A

☐ Medicare Part B

☐ Private Insurance (list company/policy number): ____________

☐ HUD

☐ Food Stamps

Representative payee: ______________________________

Who completes redetermination? ______________________________

Who reports wages? ______________________________

Risk of Exploitation:

- ☐ High
- ☐ Moderate
- ☐ Low

Level of money management assistance needed:

- ☐ Total
- ☐ Partial
- ☐ Independent

Comments: ______________________________

How much can they currently manage independently?

____

Medical and Health

Primary Care Physician: ______________________________ Address: ______________________________

Phone number: ______________________________

Present health status:

- ☐ Stable
- ☐ Declining
- ☐ Improving

Comments: ______________________________

Date of last annual physical: ______________________________

Recommendations/ Follow-Up:

____

____

Other appointments with PCP during review period:

Date:	Reason/Results:

Indicate which of the following have been completed:

- ☐ Pap/pelvic exam Date completed: ______________ Results: ____
- ☐ Prostate exam Date completed: ______________ Results: ____
- ☐ Mammogram Date completed: ______________ Results: ____
- ☐ TB Date completed: ______________ Results: ____
- ☐ Blood Work Date completed: ______________ Results: ____
- ☐ ______________ Date completed: ______________ Results: ____
- ☐ ______________ Date completed: ______________ Results: ____

Medications

List current routine medications (do not include PRN's, Psych. Meds, or dosages):

____

____

Changes in medications during review period:

____

____

Diagnosis (List all primary medical diagnosis):

____

Dental

Dentist/Clinic: ____

Appointments with dentist during review period:

Date: Reason/Results:

________________ ____

________________ ____

________________ ____

________________ ____

Special Considerations (Pre-med needed or under GA):

____

____

Vision

Date of last vision exam: ________________________________

Completed by: ____

Consumer wears glasses? ☐ Yes ☐ No

Recommendations/ Follow-Up:

____

____

Hearing

Date of last audiological exam: ______________________________

Completed by: ____

Consumer uses hearing aids? ☐ Yes ☐ No

Recommendations/ Follow-Up:

___

___

Therapy Appointments (i.e. PT, OT, Wheelchair, Vision, Speech, Hearing)

Type: ____

Therapist name: ____

Evaluation Date: ____________________________

Recommendations/ Frequency of Therapy/ Follow-Up:

___

___

Specialist Appointments (i.e. Cardiologist, Neurologist, Urologist, Podiatrist, Dietician)

Type: ____

Completed by: ____

Date(s): ______________________________________

Recommendations/ Follow-Up:

___

___

Seizure Activity

How are seizures currently being tracked? (i.e. incident reports, seizure logs)

___

Check if in place: ☐ VNS ☐ Seizure Protocol

Summarize seizure activity during review period (changes in frequency, intensity, etc.):

___

___

Equipment needed

☐ Electric Wheelchair ☐ Hospital Bed ☐ Hoyer Lift
☐ Manual Wheelchair ☐ Walker ☐ Ostomy Care
☐ Communication Devices ☐ Oxygen ☐ G-Tube Supplies
☐ Adaptive Utensils ☐ Attends ☐ Hand Rails
☐ Shower Chair ☐ Cane ☐ Gait Belt
☐ Other ____

Psychiatric

Diagnosis (mental health): ______________________________

Prescribing physician: ______________________________

Psychiatrist: ______________________________

List target symptoms necessitating psychotropic medications:

____

____

List all psychotropic medications:

1. ______________________ Date of informed consent: ____________
2. ______________________ Date of informed consent: ____________
3. ______________________ Date of informed consent: ____________
4. ______________________ Date of informed consent: ____________

Dates reviewed by psychiatrist: ________ ________ ________ ________ ________

Dates reviewed by HRC: ________ ________ ________ ________ ________

Side effects observed during review period:

____

____

ISSP (state ISSP objective to support for symptoms and monitoring of side effects):

____

____

Therapist/counselor: ______________________________

Frequency of visits: ______________________________

Group or Individual: ______________________________

Health and Safety Skills/Plan

Assessment completed (date and by whom): ______________________________

Plan Date (required for IRSS programs): ______________

Services and Supports

Day Program Setting

Location of day program (i.e. FGI, REM, Community Job): ______________________________

Transportation (i.e. FGI, HHP, Transfort, DAR): ______________________________

Residential Setting

Type of residential setting (GRSS/IRSS/Host Home): ______________________________

Number of Housemates: ________

Community Access (frequency and places visited):

Consumer highlights for review period (i.e. accomplishments, new experiences/places visited):

Assessments

Indicate when the following assessments were completed/updated:

Money Management — Date: ____________

Residential (personal care, household skills, meal prep) — Date: ____________

Medication administration — Date: ____________

Other: ____________ — Date: ____________

Comprehensive Life Review — Date: ____________

Functional Analysis — Date: ____________

List identified target behaviors:

How are behaviors currently being tracked? (ie. ABC'S, Charting for ISSP)

Significant changes in behaviors during review period:

ISSP'S (for review period)

#1 Goal/ISSP**:** ____________

Support or Service Plan?

☐ Support (staff supports to individual)

☐ Service (training to increase skill)

Criteria:

Objective/Criteria met? (explain in details or %):

Includes restrictive procedure? ☐ Yes ☐ No

Describe restrictive procedure (what is it?):

____

____

Date restrictive procedure was reviewed by HRC: ____________________

#2 Goal/ISSP**:** ____

____

Support or Service Plan?

☐ Support (staff supports to individual)

☐ Service (training to increase skill)

Criteria:

____

____

____

Objective/Criteria met? (explain in details or %):

____

____

____

Safety Control Procedure

Safety Control Procedure in place? ☐ Yes ☐ No

If yes, explain why needed?

____

____

Number of times SCP implemented during review period: ____________________

Date HRC reviewed SCP: ____________________

Suspension of Rights

Suspension: ____

Notice Sent/Date implemented: ____________________________________

Current Fading Plan/Progress Toward Restoring Right:

____

____

Recommendations

Follow up on residential recommendations from previous IP:

Recommendation	Follow-up

Recommendations for ISSP's for the upcoming year:

Other Recommendations:

Completed by/ Title

Medical and Health Continued

Therapy Appointments (i.e. PT, OT, Wheelchair, Vision, Speech, Hearing)

Type: ____

Therapist name: ______________________________

Evaluation Date: _______________

Recommendations/ Frequency of Therapy/ Follow-Up:

___

___

Therapy Appointments (i.e. PT, OT, Wheelchair, Vision, Speech, Hearing)

Type: ____

Therapist name: ______________________________

Evaluation Date: _______________

Recommendations/ Frequency of Therapy/ Follow-Up:

___

___

Specialist Appointments (i.e. Cardiologist, Neurologist, Urologist, Podiatrist, Dietician)

Type: ____

Completed by: ________________________________

Date(s): __________________________________

Recommendations/ Follow-Up:

___

___

Specialist Appointments (i.e. Cardiologist, Neurologist, Urologist, Podiatrist, Dietician)

Type: ____

Completed by: ________________________________

Date(s): __________________________________

Recommendations/ Follow-Up:

___

___

Services and Supports Continued

ISSP'S (for review period)

\# Goal/ISSP**:** ______________________________

Support or Service Plan?

☐ Support (staff supports to individual)

☐ Service (training to increase skill)

Criteria:

____

____

Objective/Criteria met? (explain in details or %):

____

____

ISSP'S (for review period)

\# Goal/ISSP**:** ______________________________

Support or Service Plan?

☐ Support (staff supports to individual)

☐ Service (training to increase skill)

Criteria:

____

____

Objective/Criteria met? (explain in details or %):

____

____

ISSP'S (for review period)

\# Goal/ISSP**:** ______________________________

Support or Service Plan?

☐ Support (staff supports to individual)

☐ Service (training to increase skill)

Criteria:

____

____

Objective/Criteria met? (explain in details or %):

____

____

Suspension of Rights

Suspension: ____

Notice Sent/Date implemented: ________________________________

Current Fading Plan/Progress Toward Restoring Right:

____

____

Suspension of Rights

Suspension: ____

Notice Sent/Date implemented: ________________________________

Current Fading Plan/Progress Toward Restoring Right:

____

____