

Community Living Assistance and Support Services  
**IPP Service Review**

Name of Individual		Medicaid No.	Review Date	Next Review Date
Case Management Agency (CMA)		Direct Service Agency (DSA)		Financial Management Services Agency (FMSA)
CMA Vendor Number		DSA Vendor Number		FMSA Vendor Number

**5A – Dental Services** Is this service authorized on the Individual Plan of Care (IPC)?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with the Individual Program Plan (IPP)/IPC? .....  Yes  No

2. Is this service meeting the individual's needs? .....  Yes  No

3. Status of services provided: \_\_\_\_\_  
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Follow-up: \_\_\_\_\_

**5B – Dental Sedation** Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No 2. Is this service meeting the individual's needs?  Yes  No

3. Status of services provided: \_\_\_\_\_  
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Follow-up: \_\_\_\_\_

**7 – Occupational Therapy** Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No 2. Is this service meeting the individual's needs?  Yes  No

3. Status of services provided: \_\_\_\_\_  
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Follow-up: \_\_\_\_\_

**8 – Physical Therapy** Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No 2. Is this service meeting the individual's needs?  Yes  No

3. Status of services provided: \_\_\_\_\_  
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Follow-up: \_\_\_\_\_

Name of Individual	Medicaid No.	Review Date
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**9 – Speech and Language Pathology** Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No 2. Is this service meeting the individual's needs?  Yes  No

3. Status of services provided: \_\_\_\_\_  
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Follow-up: \_\_\_\_\_

**10 – Habilitation** Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No 2. Is this service meeting the individual's needs?  Yes  No

3. Did Service Planning Team (SPT) identify a need for a backup plan? .....  Yes  No

4. Did SPT create a backup plan for this service? .....  Yes  No

5. Was backup plan implemented? .....  Yes  No

6. Did backup plan meet the individual's needs? .....  Yes  No

7. Status of services provided: \_\_\_\_\_  
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Follow-up: \_\_\_\_\_

Is habilitation training provided? .....  Yes  No

Document the progress of each service, goal or objective as indicated on the IPP:

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Follow-up: \_\_\_\_\_

Name of Individual	Medicaid No.	Review Date
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**10 – Community First Choice (CFC) – Personal Assistance Services (PAS) Habilitation**

Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No 2. Is this service meeting the individual's needs?  Yes  No

3. Did (SPT) identify a need for a backup plan? .....  Yes  No

4. Did SPT create a backup plan for this service? .....  Yes  No

5. Was backup plan implemented? .....  Yes  No

6. Did backup plan meet the individual's needs? .....  Yes  No

7. Status of services provided: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

Is habilitation training provided? .....  Yes  No

Document the progress of each service, goal or objective as indicated on the IPP:

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Follow-up: \_\_\_\_\_

**10A – Delegated Habilitation** Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No 2. Is this service meeting the individual's needs?  Yes  No

3. Did SPT identify a need for a backup plan? .....  Yes  No

4. Did SPT create a backup plan for this service? .....  Yes  No

5. Was backup plan implemented? .....  Yes  No

6. Did backup plan meet the individual's needs? .....  Yes  No

7. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

Name of Individual	Medicaid No.	Review Date
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**10B – Prevocational Services**      Is this service authorized on the IPC?  Yes  No      If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No      2. Is this service meeting the individual's needs?  Yes  No

3. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

**11 – Respite (In-Home)**      Is this service authorized on the IPC?  Yes  No      If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No      2. Is this service meeting the individual's needs?  Yes  No

3. Status of services provided: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

**11A – Respite (Out-of-Home)**      Is this service authorized on the IPC?  Yes  No      If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No      2. Is this service meeting the individual's needs?  Yes  No

3. Status of services provided: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

**12 – Case Management**      Is this service authorized on the IPC?  Yes  No      If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No      2. Is this service meeting the individual's needs?  Yes  No

3. Status of services provided: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

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**13A – LVN Nursing Services**      Is this service authorized on the IPC?  Yes  No      If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. Is this service meeting the individual's needs? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Did SPT identify a need for a backup plan?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Did SPT create a backup plan for this service? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Was backup plan implemented?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Did backup plan meet the individual's needs?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Document the progress on each service, goal or objective as indicated on the IPP: _____	
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Follow-up: _____	

**13B – RN Nursing Services**      Is this service authorized on the IPC?  Yes  No      If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. Is this service meeting the individual's needs? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Did SPT identify a need for a backup plan?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Did SPT create a backup plan for this service? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Was backup plan implemented?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Did backup plan meet the individual's needs?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Document the progress on each service, goal or objective as indicated on the IPP: _____	
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Follow-up: _____	

**13C – RN Specialized Nursing**      Is this service authorized on the IPC?  Yes  No      If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. Is this service meeting the individual's needs? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Did SPT identify a need for a backup plan?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Did SPT create a backup plan for this service? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Was backup plan implemented?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Did backup plan meet the individual's needs?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Document the progress on each service, goal or objective as indicated on the IPP: _____	
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Follow-up: _____	

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**13D – LVN Specialized Nursing** Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No 2. Is this service meeting the individual's needs?  Yes  No

3. Did SPT identify a need for a backup plan?.....  Yes  No

4. Did SPT create a backup plan for this service?.....  Yes  No

5. Was backup plan implemented?.....  Yes  No

6. Did backup plan meet the individual's needs?.....  Yes  No

7. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

**15 – Adaptive Aids** Is this service authorized on the IPC?  Yes  No If yes, amount authorized:

1. Specifications obtained:  Yes  No If no, explain: \_\_\_\_\_

\_\_\_\_\_

2. Was this service category delivered in accordance with IPP/IPC?  Yes  No 3. Is this service meeting the individual's needs?  Yes  No

4. List each adaptive aid authorized on the IPC and the status of each: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

**16 – Minor Home Modifications** Is this service authorized on the IPC?  Yes  No If yes, amount authorized:

1. Specifications obtained:  Yes  No If no, explain: \_\_\_\_\_

\_\_\_\_\_

2. Was this service category delivered in accordance with IPP/IPC?  Yes  No 3. Is this service meeting the individual's needs?  Yes  No

4. List each minor home modification authorized on the IPC and the status of each: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

**20 – CFC - Emergency Response Services (ERS)**

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No 2. Is this service meeting the individual's needs?  Yes  No

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**34 – Dietary Services**      Is this service authorized on the IPC?  Yes  No      If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No      2. Is this service meeting the individual's needs?  Yes  No

3. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

**35B – Auditory Integration/  
Auditory Enhancement Training**      Is this service authorized on the IPC?  Yes  No      If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No      2. Is this service meeting the individual's needs?  Yes  No

3. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

**37 – Supported Employment**      Is this service authorized on the IPC?  Yes  No      If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No      2. Is this service meeting the individual's needs?  Yes  No

3. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

**42A – Massage Therapy**      Is this service authorized on the IPC?  Yes  No      If yes, amount authorized:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No      2. Is this service meeting the individual's needs?  Yes  No

3. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

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**42B – Recreation Therapy**      Is this service authorized on the IPC?  Yes  No      If yes, amount authorized:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No    2. Is this service meeting the individual's needs?  Yes  No

3. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

**42C – Music Therapy**      Is this service authorized on the IPC?  Yes  No      If yes, amount authorized:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No    2. Is this service meeting the individual's needs?  Yes  No

3. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

**42D – Aquatic Therapy**      Is this service authorized on the IPC?  Yes  No      If yes, amount authorized:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No    2. Is this service meeting the individual's needs?  Yes  No

3. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

**42E – Hippotherapy**      Is this service authorized on the IPC?  Yes  No      If yes, amount authorized:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No    2. Is this service meeting the individual's needs?  Yes  No

3. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

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**42F – Therapeutic Horseback Riding**

Is this service authorized on the IPC?  Yes  No If yes, amount authorized:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No 2. Is this service meeting the individual's needs?  Yes  No

3. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

**43A – Behavioral Supports**

Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No 2. Is this service meeting the individual's needs?  Yes  No

3. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

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4. Is a Behavior Support Plan in place?  Yes  No 5. Was a service summary provided by the DSA?  Yes  No

6. Did service summary include required behavioral data?  Yes  No

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Follow-up: \_\_\_\_\_

**48 – Transportation-Habilitation**

Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No 2. Is this service meeting the individual's needs?  Yes  No

3. Does the Transportation Plan require revision? .....  Yes  No

4. Have non-waiver resources, including Medicaid transportation for medical appointments, been accessed prior to using this service? .....  Yes  No

5. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

**54 – Employment Assistance**

Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No 2. Is this service meeting the individual's needs?  Yes  No

3. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

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Follow-up: \_\_\_\_\_

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**61 – Cognitive Rehabilitation Therapy**

Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No 2. Is this service meeting the individual's needs?  Yes  No  
3. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

Follow-up: \_\_\_\_\_

**Required only for individuals participating in Consumer Directed Services (CDS)**  
(Skip this section if the individual is not participating in Consumer Directed Services.)

**7V – Occupational Therapy**

Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC? .....  Yes  No  
2. Is this service meeting the individual's needs? .....  Yes  No  
3. Did the individual receive a quarterly report from the FMSA?.....  Yes  No  
4. Is individual satisfied with the services/providers?.....  Yes  No  
5. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

Follow-up: \_\_\_\_\_

**8V – Physical Therapy**

Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC? .....  Yes  No  
2. Is this service meeting the individual's needs? .....  Yes  No  
3. Did the individual receive a quarterly report from the FMSA?.....  Yes  No  
4. Is individual satisfied with the services/providers?.....  Yes  No  
5. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

Follow-up: \_\_\_\_\_

**9V – Speech and Language Pathology**

Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC? .....  Yes  No  
2. Is this service meeting the individual's needs? .....  Yes  No  
3. Did the individual receive a quarterly report from the FMSA?.....  Yes  No  
4. Is individual satisfied with the services/providers?.....  Yes  No  
5. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

Follow-up: \_\_\_\_\_

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**10V – Consumer Directed Habilitation**

Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is this service meeting the individual's needs? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Did SPT identify a need for a backup plan? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Did SPT create a backup plan for this service? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Was backup plan implemented? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Did backup plan meet the individual's needs? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Did the individual receive a quarterly report from the FMSA? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is individual satisfied with the services/providers? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Document the progress on each service, goal or objective as indicated on the IPP: _____	
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_____	
Follow-up: _____	

**10CFV – CFC Consumer Directed PAS/Habilitation**

Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is this service meeting the individual's needs? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Did SPT identify a need for a backup plan? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Did SPT create a backup plan for this service? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Was backup plan implemented? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Did backup plan meet the individual's needs? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Did the individual receive a quarterly report from the FMSA? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Is individual satisfied with the services/providers? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Document the progress on each service, goal or objective as indicated on the IPP: _____	
_____	
_____	
Follow-up: _____	

**11PV – Consumer Directed In-Home Respite**

Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is this service meeting the individual's needs? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Did the individual receive a quarterly report from the FMSA? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is individual satisfied with the services/providers? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Status of services provided: _____	
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Follow-up: _____	

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**11AV – Consumer Directed  
Out-of-Home Respite**

Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Is this service meeting the individual's needs? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Did the individual receive a quarterly report from the FMSA?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Is individual satisfied with the services/providers? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Status of services provided: _____		
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Follow-up: _____		

**13AV – LVN Nursing Services**

Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Is this service meeting the individual's needs? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Did the individual receive a quarterly report from the FMSA?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Is individual satisfied with the services/providers? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Did SPT identify a need for a backup plan for this service? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Did SPT create a backup plan for this service? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Was backup plan implemented?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Did backup plan meet the individual's needs?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Document the progress on each service, goal or objective as indicated on the IPP: _____		
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_____		
Follow-up: _____		

**13BV – RN Nursing Services**

Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Is this service meeting the individual's needs? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Did the individual receive a quarterly report from the FMSA?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Is individual satisfied with the services/providers? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Did SPT identify a need for a backup plan for this service? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Did SPT create a backup plan for this service? .....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Was backup plan implemented?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Did backup plan meet the individual's needs?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Document the progress on each service, goal or objective as indicated on the IPP: _____		
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Follow-up: _____		

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**13CV – RN Specialized Nursing**    Is this service authorized on the IPC?     Yes     No    If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC? .....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
2. Is this service meeting the individual's needs? .....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
3. Did the individual receive a quarterly report from the FMSA?.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
4. Is individual satisfied with the services/providers?.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
5. Did SPT identify a need for a backup plan for this service? .....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
6. Did SPT create a backup plan for this service? .....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
7. Was backup plan implemented?.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
8. Did backup plan meet the individual's needs?.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
9. Document the progress on each service, goal or objective as indicated on the IPP: _____				
_____				
_____				
Follow-up: _____				

**13DV – LVN Specialized Nursing**    Is this service authorized on the IPC?     Yes     No    If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC? .....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
2. Is this service meeting the individual's needs? .....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
3. Did the individual receive a quarterly report from the FMSA?.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
4. Is individual satisfied with the services/providers?.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
5. Did SPT identify a need for a backup plan for this service? .....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
6. Did SPT create a backup plan for this service? .....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
7. Was backup plan implemented?.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
8. Did backup plan meet the individual's needs?.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
9. Document the progress on each service, goal or objective as indicated on the IPP: _____				
_____				
_____				
Follow-up: _____				

**37V – Supported Employment**    Is this service authorized on the IPC?     Yes     No    If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC? .....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
2. Is this service meeting the individual's needs? .....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
3. Did the individual receive a quarterly report from the FMSA?.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
4. Is individual satisfied with the services/providers?.....	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
5. Document the progress on each service, goal or objective as indicated on the IPP: _____				
_____				
_____				
Follow-up: _____				

Name of Individual	Medicaid No.	Review Date
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**48V – Transportation-Habilitation** Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC?  Yes  No 2. Is this service meeting the individual's needs?  Yes  No

3. Does the Transportation Plan require revision? .....  Yes  No

4. Have non-waiver resources, including Medicaid transportation for medical appointments, been accessed prior to using this service? .....  Yes  No

5. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Follow-up: \_\_\_\_\_

**54V – Employment Assistance** Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC? .....  Yes  No

2. Is this service meeting the individual's needs? .....  Yes  No

3. Did the individual receive a quarterly report from the FMSA?.....  Yes  No

4. Is individual satisfied with the services/providers?.....  Yes  No

5. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Follow-up: \_\_\_\_\_

**61V – Cognitive Rehabilitation Therapy** Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Was this service category delivered in accordance with IPP/IPC? .....  Yes  No

2. Is this service meeting the individual's needs? .....  Yes  No

3. Did the individual receive a quarterly report from the FMSA?.....  Yes  No

4. Is individual satisfied with the services/providers?.....  Yes  No

5. Document the progress on each service, goal or objective as indicated on the IPP: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Follow-up: \_\_\_\_\_

**Support Management**

1. Did the individual request this service on the IPC.....  Yes  No

2. Did the individual receive the training requested? .....  Yes  No

Follow-up: \_\_\_\_\_

**57V – Support Consultation** Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Did the support advisor deliver services based on needs and request of the individual?.....  Yes  No

2. Is the support advisor meeting the individual's needs? .....  Yes  No

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Follow-up: \_\_\_\_\_

Name of Individual	Medicaid No.	Review Date
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**57CFV – CFC Support Consultation** Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Did the support advisor deliver services based on needs and request of the individual?.....  Yes  No

2. Is the support advisor meeting the individual's needs? .....  Yes  No

\_\_\_\_\_

\_\_\_\_\_

Follow-up: \_\_\_\_\_

**63V – Financial Management Services**

Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Did the FMSA provide financial management services in accordance with the IPP/IPC?.....  Yes  No

2. Is FMSA meeting the individual's needs? .....  Yes  No

For Item 3 and 4: If yes, what changes/problems have occurred? If no, explain what measure were taken to acquire the information.

3. Did the FMSA provide a report to the employer at least quarterly for each CLASS CDS service? .....  Yes  No

4. Did the FMSA provide a report to the CLASS case manager at least quarterly? .....  Yes  No

5. Has the FMSA reported any concerns or problems this quarter? .....  Yes  No

If yes, provide explanation.

\_\_\_\_\_

\_\_\_\_\_

6. Is the individual satisfied with the financial management services provided by the FMSA? .....  Yes  No

If no, provide explanation.

\_\_\_\_\_

\_\_\_\_\_

Follow-up: \_\_\_\_\_

**63CFV – CFC Financial Management Services**

Is this service authorized on the IPC?  Yes  No If yes, number of authorized units:

1. Did the FMSA provide financial management services in accordance with the IPP/IPC?.....  Yes  No

2. Is FMSA meeting the individual's needs? .....  Yes  No

For Item 3 and 4: If yes, what changes/problems have occurred? If no, explain what measures were taken to acquire the information.

3. Did the FMSA provide a report to the employer at least quarterly for each CLASS CDS service? .....  Yes  No

4. Did the FMSA provide a report to the CLASS case manager at least quarterly? .....  Yes  No

5. Has the FMSA reported any concerns or problems this quarter? .....  Yes  No

If yes, provide explanation.

\_\_\_\_\_

\_\_\_\_\_

6. Is the individual satisfied with the financial management services provided by the FMSA? .....  Yes  No

If no, provide explanation.

\_\_\_\_\_

\_\_\_\_\_

Follow-up: \_\_\_\_\_

Name of Individual	Medicaid No.	Review Date
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**53 – Transition Assistance Services**

Is this service authorized on the IPC?  Yes  No

Dollar Amount: \$

1. Was this service category delivered in accordance with IPP/IPC? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is this service meeting the individual's needs? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is the individual satisfied with the services delivered? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, provide explanation. _____ _____	
4. Status of services provided: _____ _____	
Follow-up/Other: _____	

**55 – Support Family Services**

Is this service authorized on the IPC?  Yes  No

Dollar Amount: \$

1. Was this service category delivered in accordance with IPP/IPC? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is this service meeting the individual's needs? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is the individual satisfied with the services delivered? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, provide explanation. _____ _____	
4. Status of services provided: _____ _____	
Follow-up/Other: _____	

**55A – Continued Family Services**

Is this service authorized on the IPC?  Yes  No

Dollar Amount: \$

1. Was this service category delivered in accordance with IPP/IPC? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is this service meeting the individual's needs? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is the individual satisfied with the services delivered? .....	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, provide explanation. _____ _____	
4. Status of services provided: _____ _____	
Follow-up/Other: _____	

Name of Individual	Medicaid No.	Review Date
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**Community Living Assistance and Support Services**  
IPP Review (Continuation Sheet)

List any non-CLASS Resources accessed:


General Comments:


Location of the IPP Service Review:

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**Signatures**

Individual/LAR	Date
Case Manager	Date
Other	Date
DSA Acknowledgement of Receipt	Date
FMSA Acknowledgement of Receipt	Date
Support Family Services/Client Financial Services Acknowledgement of Receipt	Date