State of New Hampshire
Department of Health and Human Services

Bureau of Developmental Services
Prior Authorization Documentation Training

January 6, 2022

Prior Authorization Packet Quality Assurance Checklists

Functional Screen QA Checklist

This checklist provides a walkthrough of the review process for the current NH Bureau of Developmental Service Functional Screen for Waiver Services (05/22/13 – v1).

The Functional Screen is the tool utilized for determining institutional level of care for eligibility of waiver services.

Individual Service Agreement QA Checklist

This checklist provides a walkthrough of the review process elements for the Individual Service Agreement in conjunction with the prior authorization request for services.

Functional Screen QA Checklist

Applicant demographic information

- Applicant Name should be full legal name (no nicknames, etc.)
- Check Medicaid number
  - ❖ Should be 11 places; AO, OH or BO is old numbering system – NO hyphens
- Check the date of birth for accuracy
- Enter provider number and name in area agency box
- Review address to make sure it is the current address

NH Bureau of Developmental Services Functional Screen for Waiver Services

APPLICANT'S DEMOGRAPHIC INFORMATION

Applicant Name (first)	Middle Initial	Last	Suffix

Gender ☐ Female ☐ Male	Applicant's Medicaid I.D.	Date of Birth (mm/dd/yyyy)	Area Agency (number and name)

Applicant's Street Address:		
City	State	Zip Code

Telephone - Home	Telephone - Work	Telephone - Cell
( ) -	( ) -	( ) -

Functional Screen QA Checklist Continued

Guardianship

If guardian is yes, enter name and address (should be consistent with information on file with DHHS – Bureau of Family Assistance in New Heights)

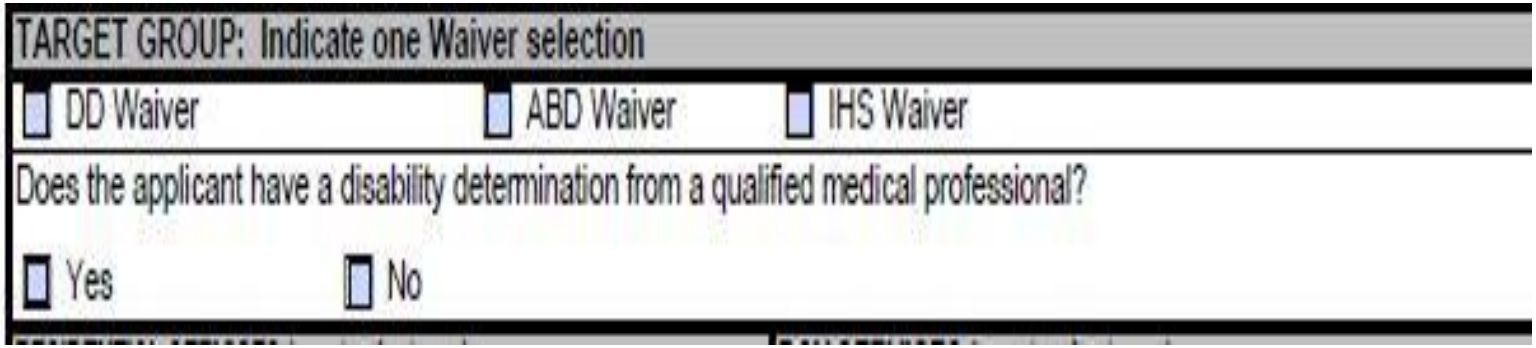
- *Note – Space is limited to enter two separate guardians with different addresses, agencies can be creative utilizing slashes etc. to get all information into this limited space.*

GUARDIANSHIP			
Individual has court appointed guardian	☐ Yes ☐ No	If "Yes" provide guardian information	
Name (First)	(Middle)	(Last)	
Address			
City	State		Zip Code

Functional Screen QA Checklist Continued

Target Group

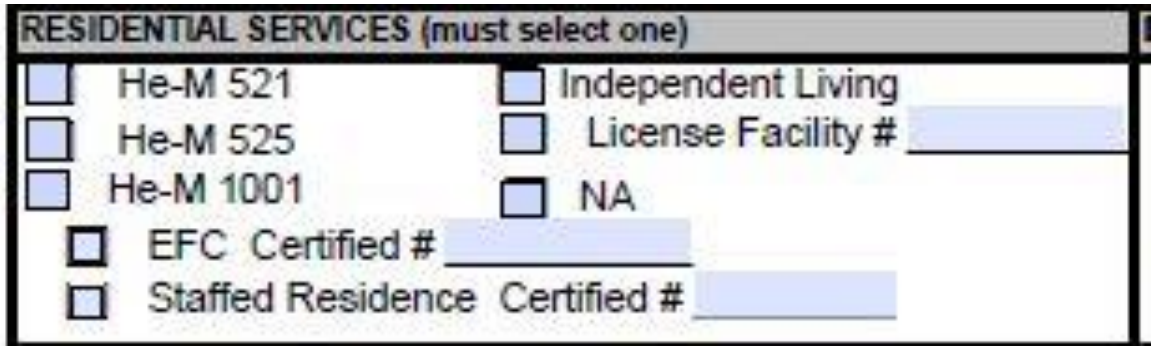
- Select correct waiver: DD, ABD or IHS
- Disability determination should be **yes (documentation from qualified medical professional supporting this needs to be on file with area agency)**
  - ❖ IEP (educational coding) is not diagnosis made by a medical professional



Functional Screen QA Checklist Continued

Residential Services (Must select one)

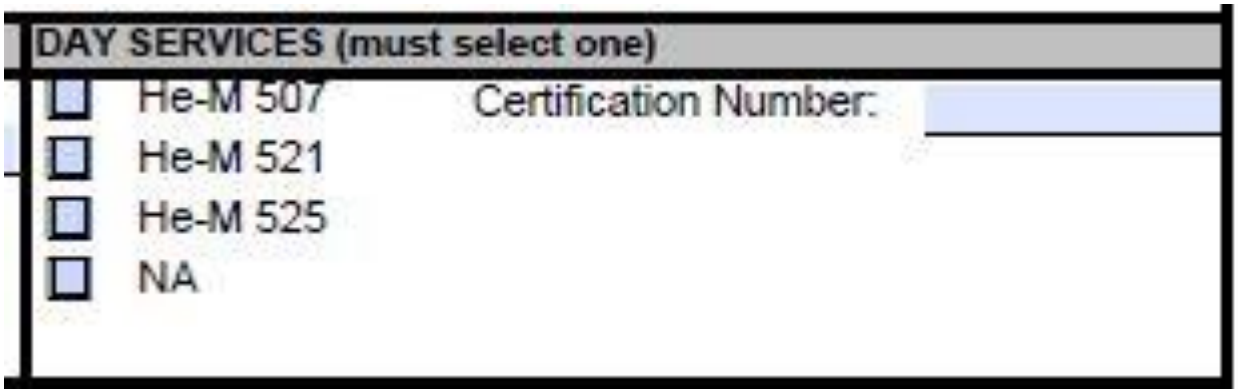
- He-M 521 No cert. #.
- He-M 525 (residential only or combined res & day) No cert. #.
- He-M 1001: Enhanced Family Care Cert # needed, Staff Residence Cert # needed, Licensed Facility – Need License #,
  - If Cert# has yet to be issued TBD is accepted.
- Independent Living: Check if CSS
  - **If CSS is being provided in the family home check N/A as individual does not live independently**.
- Select N/A if not receiving a Residential Service.



Functional Screen QA Checklist Continued

Day / Community Participation Services (must select one)

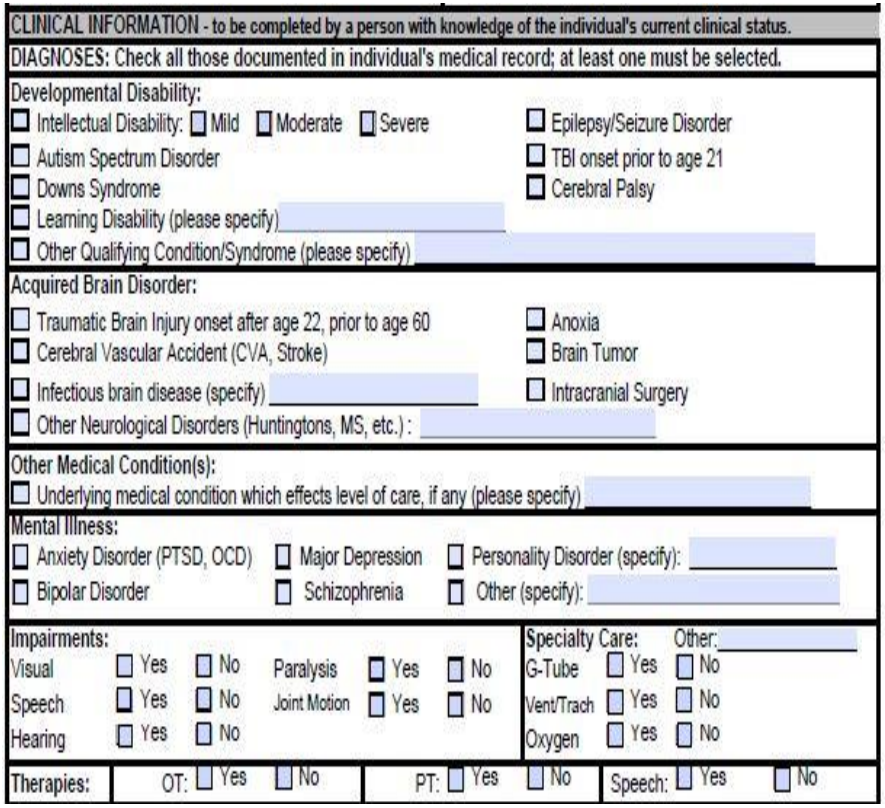
- He-M 507 – Cert. # needed,
  - ❖ If Cert # has yet to be issued TBD is accepted.
- He-M 521 – No cert. # must have 521 residential services (no He-M 521 day only).
- He-M 525 – No cert. #.
- Select N/A if not receiving a Day/CPS Service.



Functional Screen QA Checklist Continued

Diagnosis: (relates to eligibility for DD, IHS or ABD waiver)

- **Developmental Disability (DD and IHS Waivers)**
  - Intellectual disability (ID) level of Mild, Moderate or Severe must be selected if the individual's diagnosis has a specified level; if the individual has a diagnosis of ID with no specified level or ID, Unspecified then only the ID should be selected. (Borderline ID/Intellectual Functioning or Profound ID should be listed under Other Qualifying Diagnosis section).
  - Learning disability (means math, reading, language, processing speed, etc.), the specific type section must be completed (this section cannot be left blank).
  - Other qualifying diagnosis: Might be a syndrome i.e. Rett Syndrome or chromosome abnormality. List only qualifying DD conditions in this section.
  - Any other condition should be under "Other Medical Conditions" as other medical issues affect level of care.
- **Acquired Brain Disorder (ABD Waiver)**
  - Under Infectious brain disease and Other Neurological Disorder if these boxes are checked than the specific type section must be completed (this section cannot be left blank).



CLINICAL INFORMATION - to be completed by a person with knowledge of the individual's current clinical status.

DIAGNOSES: Check all those documented in individual's medical record; at least one must be selected.

Developmental Disability:
- ☐ Intellectual Disability: ☐ Mild ☐ Moderate ☐ Severe
- ☐ Epilepsy/Seizure Disorder
- ☐ Autism Spectrum Disorder
- ☐ TBI onset prior to age 21
- ☐ Downs Syndrome
- ☐ Cerebral Palsy
- ☐ Learning Disability (please specify)
- ☐ Other Qualifying Condition/Syndrome (please specify)

Acquired Brain Disorder:
- ☐ Traumatic Brain Injury onset after age 22, prior to age 60
- ☐ Anoxia
- ☐ Cerebral Vascular Accident (CVA, Stroke)
- ☐ Brain Tumor
- ☐ Infectious brain disease (specify)
- ☐ Intracranial Surgery
- ☐ Other Neurological Disorders (Huntingtons, MS, etc.):

Other Medical Condition(s):
- ☐ Underlying medical condition which effects level of care, if any (please specify)

Mental Illness:
- ☐ Anxiety Disorder (PTSD, OCD)
- ☐ Major Depression
- ☐ Personality Disorder (specify):
- ☐ Bipolar Disorder
- ☐ Schizophrenia
- ☐ Other (specify):

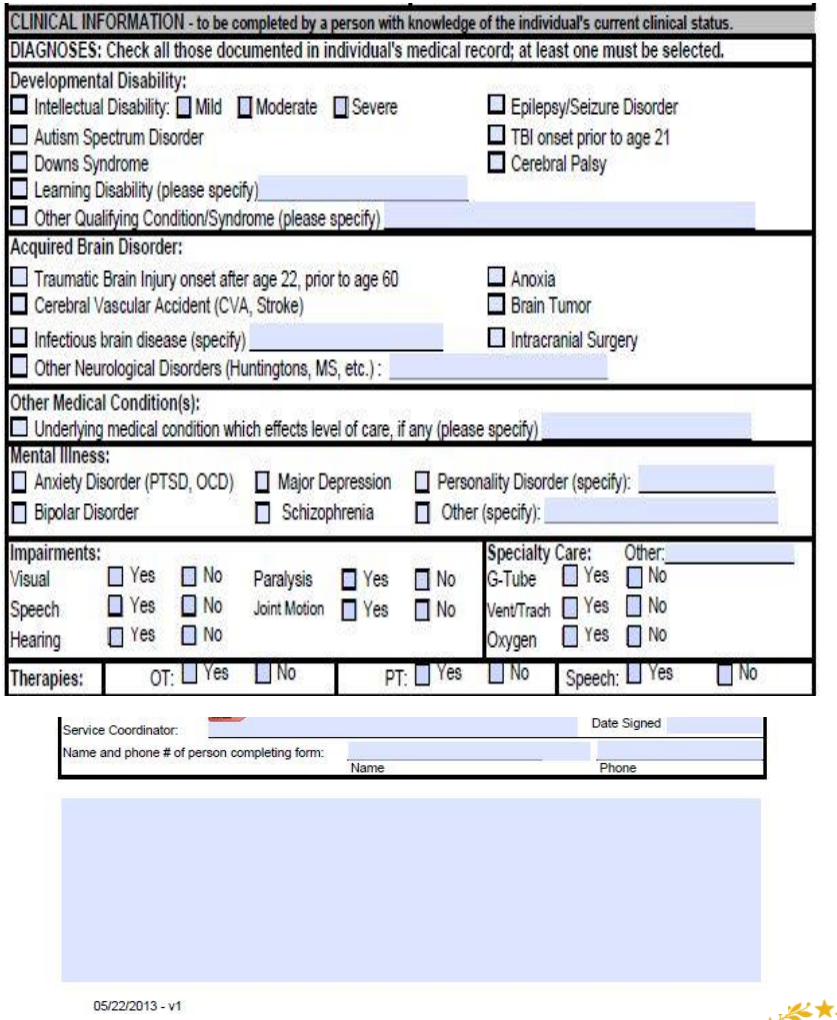
Impairments:						Specialty Care:	Other:	
Visual	☐ Yes	☐ No	Paralysis	☐ Yes	☐ No	G-Tube	☐ Yes	☐ No
Speech	☐ Yes	☐ No	Joint Motion	☐ Yes	☐ No	Vent/Trach	☐ Yes	☐ No
Hearing	☐ Yes	☐ No				Oxygen	☐ Yes	☐ No

Therapies:	OT: ☐ Yes ☐ No	PT: ☐ Yes ☐ No	Speech: ☐ Yes ☐ No

Functional Screen QA Checklist Continued

Diagnosis: (relates to eligibility for DD, IHS or ABD waiver) Continued

- Other Medical Conditions: This portion of the form has limited space; type in what space allows, an additional page can be attached if needed or …
- Mental Illness: All applicable boxes should be selected. If Other box is selected than the specific diagnosis must be listed (this section cannot be left blank).
- Impairments – Must check yes or no
- Specialty Care – Must check yes or no
- Therapies – Must check yes or no (even if not provided under waiver completion of this section is required as it is for level of care).
  - Diagnosis in DD section should only be selected for DD and IHS waiver services and Diagnosis in ABD section should only be selected for ABD waiver services. For example, if individual on DD Waiver has Anoxia as a Diagnosis this should be listed under Other Medical Condition(s) not under Acquired Brain Disorder section of form.
  - For the following sections: Other Qualifying Condition/Syndrome; Other Neurological Disorders; Underlying Medical condition which effects level of care; and Mental Illness – Other, these sections can no longer indicate "See attached ISA for information". The space in these sections is limited, to ensure all information can be captured a blank text box is at the bottom of page four to list the additional Diagnosis information from these sections. For example, the textbox would include Other Medical Condition(s): Diabetes Type 1, Chronic Kidney Disease, COPD, and Glaucoma.



CLINICAL INFORMATION - to be completed by a person with knowledge of the individual's current clinical status.

DIAGNOSES: Check all those documented in individual's medical record; at least one must be selected.

Developmental Disability:
- ☐ Intellectual Disability: ☐ Mild ☐ Moderate ☐ Severe
- ☐ Autism Spectrum Disorder
- ☐ Downs Syndrome
- ☐ Learning Disability (please specify)
- ☐ Other Qualifying Condition/Syndrome (please specify)
- ☐ Epilepsy/Seizure Disorder
- ☐ TBI onset prior to age 21
- ☐ Cerebral Palsy

Acquired Brain Disorder:
- ☐ Traumatic Brain Injury onset after age 22, prior to age 60
- ☐ Cerebral Vascular Accident (CVA, Stroke)
- ☐ Infectious brain disease (specify)
- ☐ Other Neurological Disorders (Huntingtons, MS, etc.):
- ☐ Anoxia
- ☐ Brain Tumor
- ☐ Intracranial Surgery

Other Medical Condition(s):
- ☐ Underlying medical condition which effects level of care, if any (please specify)

Mental Illness:
- ☐ Anxiety Disorder (PTSD, OCD)
- ☐ Bipolar Disorder
- ☐ Major Depression
- ☐ Schizophrenia
- ☐ Personality Disorder (specify):
- ☐ Other (specify):

Impairments:
- Visual ☐ Yes ☐ No
- Speech ☐ Yes ☐ No
- Hearing ☐ Yes ☐ No
- Paralysis ☐ Yes ☐ No
- Joint Motion ☐ Yes ☐ No

Specialty Care: Other:
- G-Tube ☐ Yes ☐ No
- Vent/Trach ☐ Yes ☐ No
- Oxygen ☐ Yes ☐ No

Therapies: OT: ☐ Yes ☐ No PT: ☐ Yes ☐ No Speech: ☐ Yes ☐ No

Service Coordinator: Date Signed

Name and phone # of person completing form: Name Phone

05/22/2013 - v1

Functional Screen QA Checklist Continued

ADLS (ACTIVITIES of Daily Living)

- Review Level of Assistance code carefully and match levels with the level of assistance an individual needs to complete the task. Complete all boxes required.
  - ❖ Make sure to review toileting section, as Incontinence section must also have a box selected. Make sure to select any adaptive equipment utilized.

ADLs (ACTIVITIES OF DAILY LIVING)

Level of Assistance Scale

0 - Person is **completely** independent in his/her ability to safely accomplish task.

1 - Assistance, including supervision, cueing, or hands-on, is necessary for the individual to complete the task safely, but **helper DOES NOT have to be physically present throughout.**

2 - Assistance, including supervision, cueing, and/or hands-on assist, is necessary to safely complete the task with **helper present throughout** or task is not age appropriate.

IADLs (Instrumental Activities of Daily Living)		Select only one box
BATHING	The ability to shower and/or bathe to maintain adequate hygiene, including the ability to: get in and out of the shower and/or tub; turn faucets on and off; regulate water temperature; wash; and dry fully.	☐ 0 ☐ 1 ☐ 2
	Select all adaptive equipment used, if any: ☐ Grab Bar(s) ☐ Shower Chair ☐ Tub Bench ☐ Mechanical Lift	
DRESSING	The ability to dress/undress including selection of weather appropriate clothing, completed with or without assistive devices; this includes fine motor coordination for buttons and zippers on the front of clothing (do not include difficulties with zippers and/or buttons at the back of an article of clothing).	☐ 0 ☐ 1 ☐ 2
EATING	The ability to eat and drink using routine or adaptive utensils, this includes the ability to cut, chew, and swallow food. Note: If individual is fed via tube or intravenous, check "0" if they can accomplish task themselves, or "1" or "2" if assistance is required.	☐ 0 ☐ 1 ☐ 2
MOBILITY IN HOME	The ability to move between locations in the individual's living environment-defined as kitchen, living room, bathroom, and sleeping area (excluding basements, attics, yards, and any equipment used outside the home).	☐ 0 ☐ 1 ☐ 2
	Indicate all adaptive equipment used, if any: ☐ Cane in Home ☐ Quad-Cane in Home ☐ Wheelchair/Scooter in Home ☐ Crutches in Home ☐ Prosthesis ☐ Walker in Home ☐ Person assist/other physical support	
TOILETING	The ability to use the toilet, commode, bedpan, or urinal, including ability to transfer on/off the toilet, cleansing of self, managing an ostomy or catheter, and adjusting clothes.	☐ 0 ☐ 1 ☐ 2
	Indicate all adaptive equipment/strategies used, if any: ☐ Grab Bar(s) ☐ Ostomy ☐ Commode or adaptive equipment ☐ Training Protocol ☐ Urinary Catheter	
	INCONTINENCE: *not including stress incontinence* ☐ Does not have incontinence ☐ Has incontinence daily ☐ Has occasional incontinence ☐ Regular training protocol	
TRANSFERRING	The ability to get in and out of bed and to move between surfaces: bed/chair to wheelchair, walker or standing position (include the ability to use assistive devices for transfer).	☐ 0 ☐ 1 ☐ 2
	Select all adaptive equipment used, if any: ☐ Grab Bar(s) ☐ Shower Chair ☐ Tub Bench ☐ Mechanical Lift	

Functional Screen QA Checklist Continued

IADLS (INSTRUMENTAL Activities of daily living)

- Bottom of page 2 and page 3 – Complete all boxes
  - Medication Administration and Management Section. Self-Administration should only be selected if the individual has been deemed able to Self-Administer by the Area Agency Nurse.

IADLs (Instrumental Activities of Daily Living)		Select only one box
MEAL PREPARATION	Independent	☐ 0
	Needs assistance weekly (e.g., meal planning, grocery shopping)	☐ 1
	Needs help with every meal	☐ 2
MEDICATION ADMINISTRATION AND MANAGEMENT	Has no medication	☐ 0
	Self-Administering/Independent (with or without assistive devices)	☐ 1
	CANNOT direct the task; is required to have medications administered	☐ 2
MONEY MANAGEMENT	Independent	☐ 0
	Needs monitoring	☐ 1
	Needs help from another person with all transactions	☐ 2
LAUNDRY and/or CHORES	Independent	☐ 0
	Needs help from another person weekly or less often	☐ 1
	Needs help more than once a week	☐ 2
TRANSPORTATION	Individual drives regular vehicle	☐ 0
	Individual is able to take public transportation	☐ 1
	Individual cannot drive due to impairment(s), including no driver's license.	☐ 2

Functional Screen QA Checklist Continued

Employment/Volunteer

- Current Employment Status – This section indicates to select one (this will be corrected when the form is redone), however the volunteer box should be selected if applicable. For example, if the box is selected for Not Working and the individual volunteers both boxes should be selected.

EMPLOYMENT/VOLUNTEER

Section concerns the need for assistance to perform employment specific activities. The need for help with ADLS and IADLs (e.g., transportation, personal care) is captured in other sections, this section concerns only those supports necessary for successful performance of job duties.

A. Current Employment Status (select one):

- ☐ Working full time (paid work avg 30 or more hours per week)
- ☐ Working part-time (paid work avg less than 30 hours per week)
- ☐ Not Working (engages in no paid work)
- ☐ Retired (age 65+ only)
- ☐ Volunteer

B. Need for Assistance to Work/Volunteer (select one):

- ☐ Independent (includes use of assistive devices if needed)
- ☐ Needs help weekly or less (e.g., if a problem arises)
- ☐ Needs help daily, but does not need the continuous presence of another
- ☐ Needs the continuous presence of another person

Functional Screen QA Checklist Continued

Communication And Cognition

- Review and complete all boxes.
  - ❖ Under Executive Dysfunction please note that this section is **Check All That Apply**.

COMMUNICATION AND COGNITION

Communication (select one) Ability to express oneself, including non-English languages, American Sign Language, or other generally recognized communication strategy with or without assistive technology.

- ☐ Able to fully communicate without impairment or with minor impairment (e.g., slow speech)
- ☐ Able to fully communicate with the use of assistive device
- ☐ Able to communicate basic needs to others and/or comprehend basic language
- ☐ No effective communication

Memory Loss (select one):

- ☐ No memory impairments evident
- ☐ Short-term memory loss (seems unable to recall things a few minutes up to 24 hours later)
- ☐ Unable to remember things over several days or weeks
- ☐ Long-term memory loss (seems unable to recall distant past)
- ☐ Memory impairments are unknown or unable to determine

Cognition for Daily Decision Making (select one)

- ☐ Independent - Individual makes decisions that are generally consistent with his/her own lifestyle, values and goals (not necessarily in alignment with professionals' values and goals).
- ☐ Individual makes safe decisions in familiar situations, but needs help with new tasks or challenging situations.
- ☐ Person needs help from another person most or all of the time to ensure safe decision-making

Executive Dysfunction (check all that apply)

- ☐ Lack of awareness
- ☐ Lack of initiation
- ☐ Diminished organization and planning
- ☐ Impulsivity and disinhibition
- ☐ Diminished problem solving

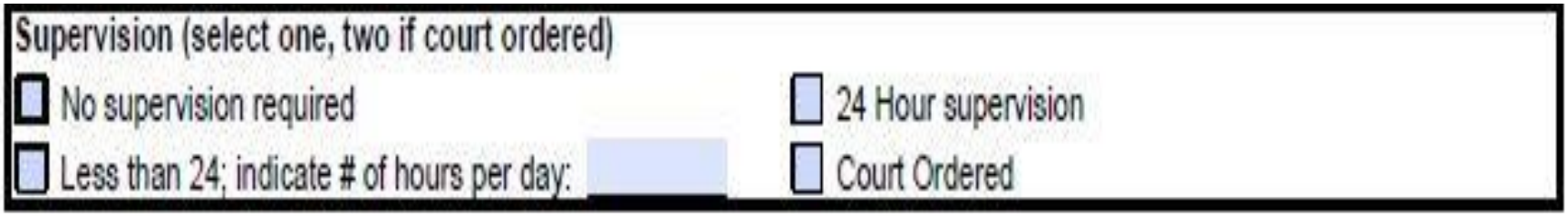
Resistant to Care (select one)

- ☐ Yes, individual is resistive to care due to a cognitive impairment
- ☐ No

Functional Screen QA Checklist Continued

Supervision

- This section is for level of care purposes. The selection should be consistent with the individual's supervision needs across all settings, regardless of if a service is provided by an agency/vendor in this setting.



Functional Screen QA Checklist Continued

Behavior(s)/Mental Health

- Review and complete all boxes.
  - Please ensure that under Self-Injurious and Offensive or Violent behavior section the “Indicate behavior(s) exhibited” section is completed. Completion of this section would not be necessary if the selection of “demonstrates no...” boxes are selected.

BEHAVIOR(S)/MENTAL HEALTH

Wandering (select one) Individual has cognitive impairments and leaves residence/immediate area without informing

- ☐ Does not wander
- ☐ Wanders during the day, but sleeps nights
- ☐ Wanders at night, or wanders day and night

Self-Injurious Behaviors (select one) Behaviors that cause or could cause injury to one's own body, including: physical self-abuse (hitting, biting, head banging, etc.), pica (eating inedible objects), and etc.

- ☐ Demonstrates no self-injurious behavior
- ☐ Some self-injurious behaviors requiring intervention weekly or less frequently
- ☐ Self-injurious behaviors requiring interventions 2-6 times per week OR 1-2 times per day
- ☐ Self-injurious behaviors require intensive one-on-one interventions more than twice each day
- ☐ Indicate behavior(s) exhibited: _____

Offensive or Violent Behavior toward others (select one): Behaviors that causes others significant pain, substantial distress, or law enforcement typically called to intervene.

- ☐ Demonstrates no offensive or violent behaviors
- ☐ Some offensive or violent behaviors require occasional interventions weekly or less
- ☐ Offensive or violent behaviors require interventions 2-6 times per week OR 1-2 times per day
- ☐ Offensive or violent behaviors require intensive one-on-one interventions more than twice each day
- ☐ Indicate behavior(s): _____

Substance Use (check all that apply)

- ☐ No active substance use issues evident at this time
- ☐ Individual or others report substance use issue, evidence suggests possibility of a current issue, or a high likelihood of
- ☐ In the past year, the person has had significant problems due to substance use issues, examples include: *police intervention, detox, inpatient treatment, job loss, and/or major life changes.*

Functional Screen QA Checklist Continued

Risk To Community Safety

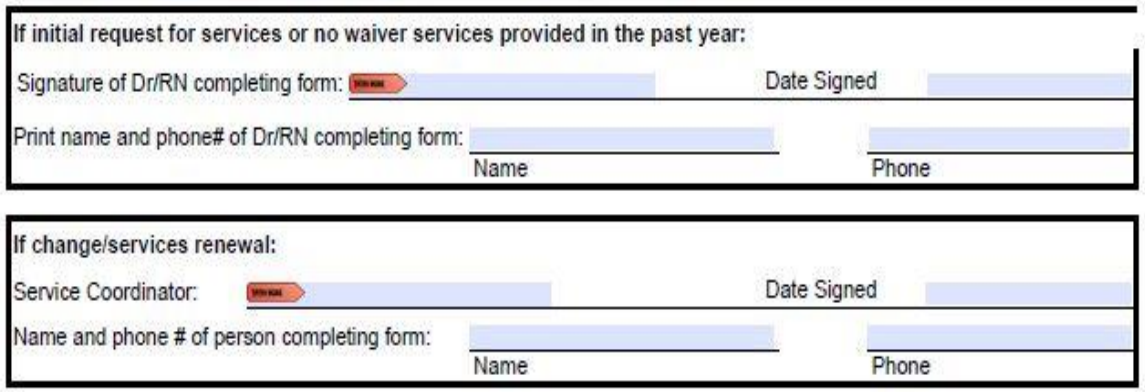
- This section is **Check All That Apply**, please note if “No known history…” is selected, no other boxes should be selected.

RISK TO COMMUNITY SAFETY (check all that apply):
☐ No known history of problematic sexual behavior, arson and/or violence
☐ History of problematic sexual behaviors, arson and/or violence WITHOUT legal involvement
☐ History of legal involvement related to problematic sexual behaviors, arson and/or violence
☐ Individual reports deviant thinking related to thoughts of sexual offending, fire setting, or violence

Functional Screen QA Checklist Continued

SIGNATURES

- If initial request for services or no waiver services provided in the past year a signature from a Dr. or Nurse completing the form is required. Please ensure that the “date”, “print name” and “phone portion” is completed as well.
- If a change or renewal request a signature of Service Coordinator is required, please complete entire section (print name phone and date signed). For a change (UCR, EMod) the Functional Screen must be updated. Even if there are no changes to previous Functional Screen submitted, it must be reviewed and signed with a current date.
  - The service coordinator name and phone # of person completing the form **must be the same person** signing the form.
  - Digital signatures (with a Date/Time stamp attestation) are accepted.



Individual Service Agreement (ISA) QA Checklist

ISA Date Span

- **Check service agreement date range**. ISA date range needs to fall within the date range of the PA. If an approved Amendment to extend the ISA has been completed it needs to be submitted as part of the PA Documentation Packet. For example - a PA with a 4/1/21 start date, the ISA submitted cannot end on or before 3/31/21.

NH Bureau of Developmental Services

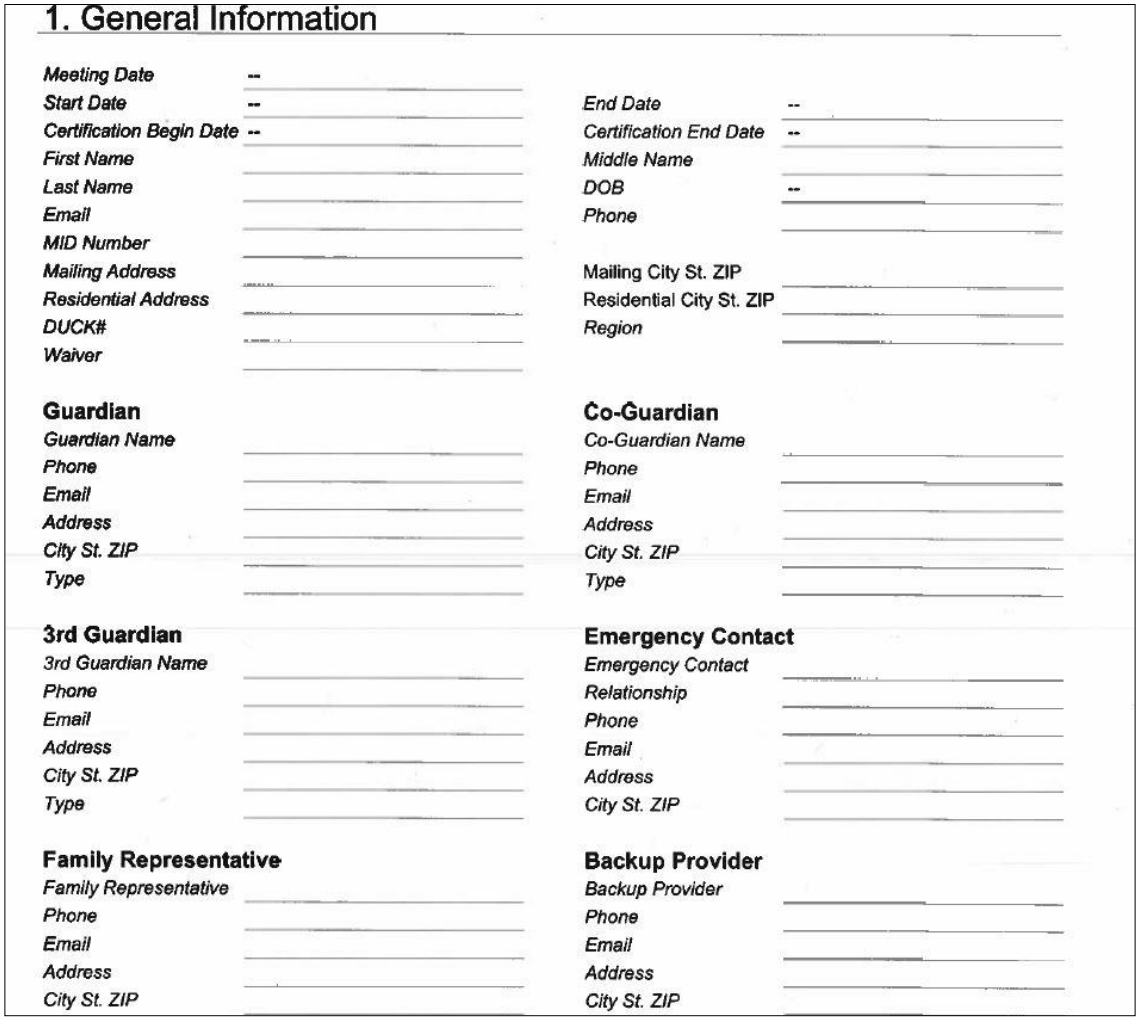
Service Agreement

Individual			
Start Date	--	End Date	--

Individual Service Agreement (ISA) QA Checklist Continued

General Information

- All information is completed and verified.
- Certification Begin Date and End Date section is completed if certification type is He-M 521 or He-M 525.
- Waiver section corresponds with appropriate waiver that individual is accessing services.



1. General Information

Meeting Date	--		
Start Date	--	*End Date*	--
Certification Begin Date	--	*Certification End Date*	--
First Name		*Middle Name*	
Last Name		*DOB*	--
Email		*Phone*	
MID Number			
Mailing Address		Mailing City St. ZIP	
Residential Address		Residential City St. ZIP	
DUCK#		*Region*	
Waiver			

Guardian		**Co-Guardian**	
Guardian Name		*Co-Guardian Name*	
Phone		*Phone*	
Email		*Email*	
Address		*Address*	
City St. ZIP		*City St. ZIP*	
Type		*Type*	

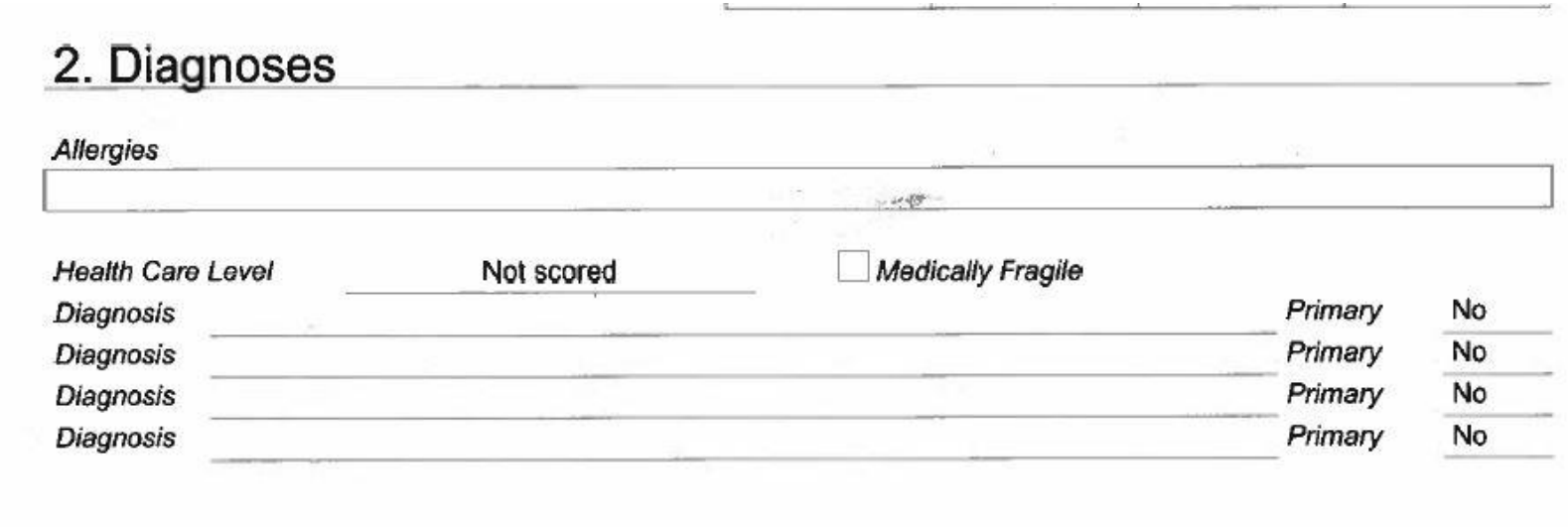
3rd Guardian		**Emergency Contact**	
3rd Guardian Name		*Emergency Contact*	
Phone		*Relationship*	
Email		*Phone*	
Address		*Email*	
City St. ZIP		*Address*	
Type		*City St. ZIP*	

Family Representative		**Backup Provider**	
Family Representative		*Backup Provider*	
Phone		*Phone*	
Email		*Email*	
Address		*Address*	
City St. ZIP		*City St. ZIP*	

Individual Service Agreement (ISA) QA Checklist

DIAGNOSES

- All diagnoses information is completed and verified.
- The primary diagnosis(es) must be listed that makes the individual eligible for waiver services.



2. Diagnoses

Allergies

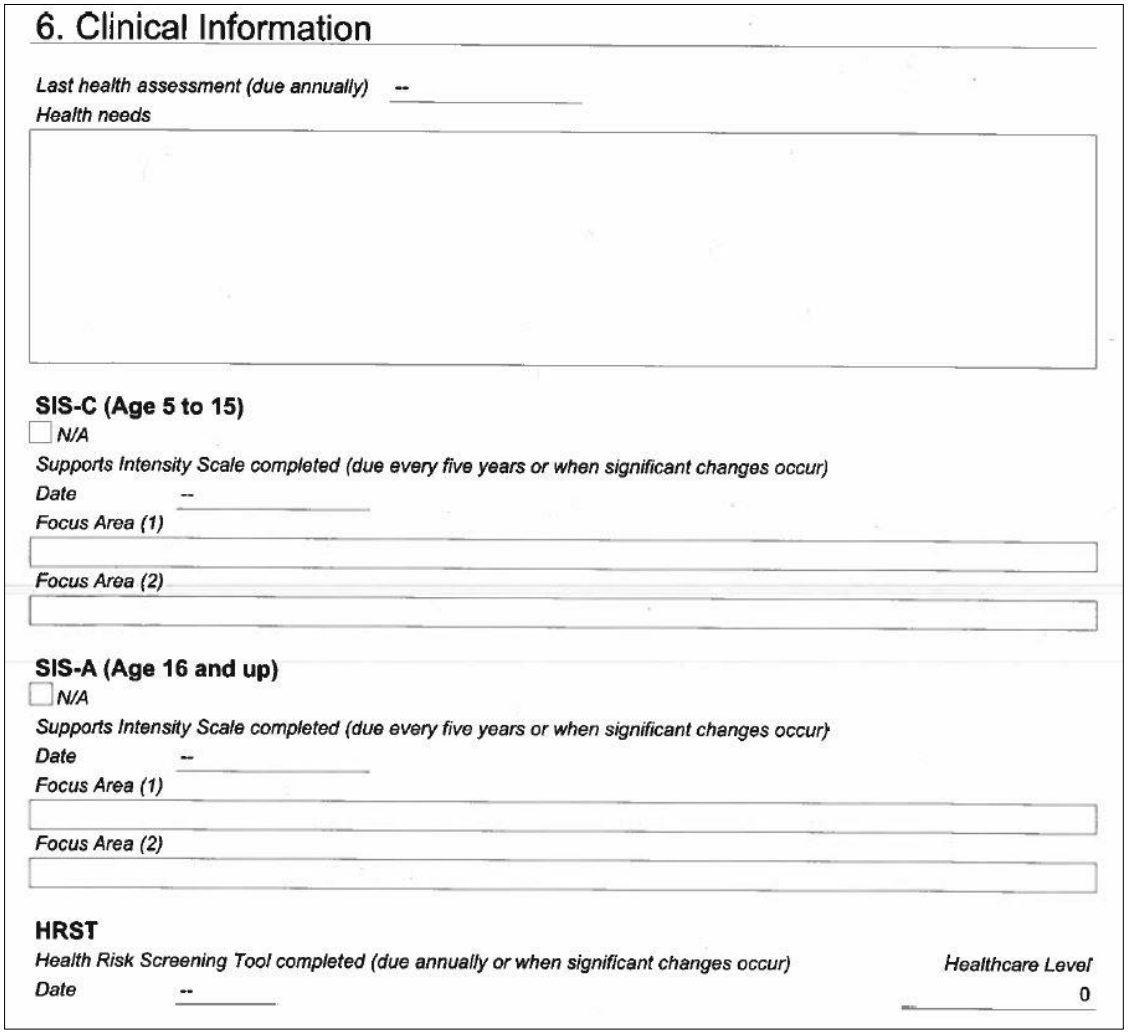
Health Care Level Not scored ☐ Medically Fragile

Diagnosis	Primary	No
Diagnosis	Primary	No
Diagnosis	Primary	No
Diagnosis	Primary	No

Individual Service Agreement (ISA) QA Checklist Continued

CLINICAL INFORMATION

- All sections are current and completed.



6. Clinical Information

Last health assessment (due annually) --

Health needs

SIS-C (Age 5 to 15)

☐ *N/A*

Supports Intensity Scale completed (due every five years or when significant changes occur)

Date --

Focus Area (1)

Focus Area (2)

SIS-A (Age 16 and up)

☐ *N/A*

Supports Intensity Scale completed (due every five years or when significant changes occur)

Date --

Focus Area (1)

Focus Area (2)

HRST

Health Risk Screening Tool completed (due annually or when significant changes occur)

Date --

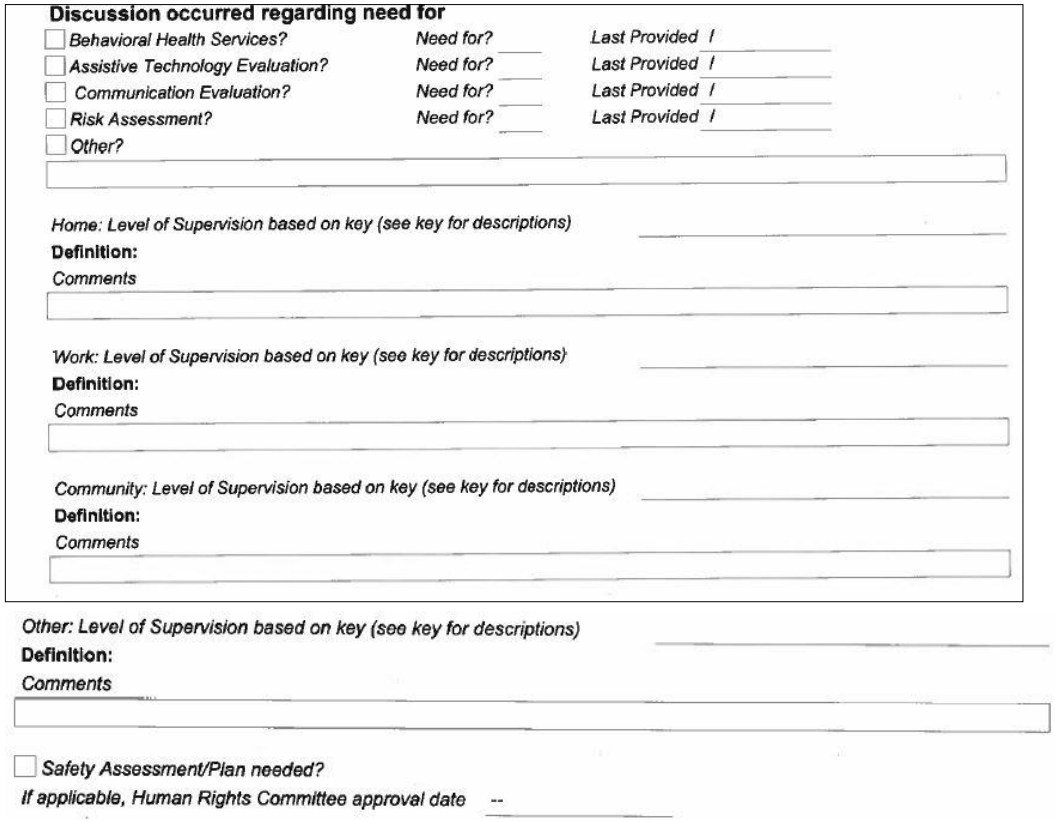
Healthcare Level

0

Individual Service Agreement (ISA) QA Checklist Continued

CLINICAL INFORMATION - CONTINUED

- Supervision levels for settings are completed at a minimum for all services being requested.



Discussion occurred regarding need for

☐ *Behavioral Health Services?*	*Need for?*	*Last Provided* /
☐ *Assistive Technology Evaluation?*	*Need for?*	*Last Provided* /
☐ *Communication Evaluation?*	*Need for?*	*Last Provided* /
☐ *Risk Assessment?*	*Need for?*	*Last Provided* /
☐ *Other?*		

Home: Level of Supervision based on key (see key for descriptions)

Definition:

Comments

Work: Level of Supervision based on key (see key for descriptions)

Definition:

Comments

Community: Level of Supervision based on key (see key for descriptions)

Definition:

Comments

Other: Level of Supervision based on key (see key for descriptions)

Definition:

Comments

☐ *Safety Assessment/Plan needed?*

If applicable, Human Rights Committee approval date --

Individual Service Agreement (ISA) QA Checklist Continued

SERVICES TO BE PROVIDED

- All services being requested on the Prior Authorization must be listed/selected in this section.
- Medication Administration boxes need to have a selection made (this was a new addition to the ISA template last year in November and needs to be utilized).
- For all services requiring goals (i.e. residential, day, etc.) these must be listed.

7. Services to be provided

☑ Service Coordination # of home visits during the year 12 # of home visits required by regulation 12
☑ Family Support Service Coordination
☑ Family Support
☑ Respite # of units 36 Annual amount 35 ☑ Med/Behavioral (waiver) ☑ State Plan
☑ Participant Directed and Managed Services Service Level Employment/Day & Family Support/Respite
☑ Environmental Modifications
☑ In Home Supports # of hours per week 24
☑ Community Support Services # of hours per week 24.00
☑ Community Participation Services # of hours per week 24.00
☑ Supported Employment Services # of hours per week 24.00
☑ Residential he-M 1001 Type of setting Independent Home or Apartment

Describe Services
Monthly QA checks for compliance

☑ Nursing Support Recieved
Oversight and resource as needed.
☑ Specialty Services Describe Services
Monthly QA checks for compliance

☑ START Describe Services
Monthly QA checks for compliance

☑ Choices For Independence Describe Services
Monthly QA checks for compliance

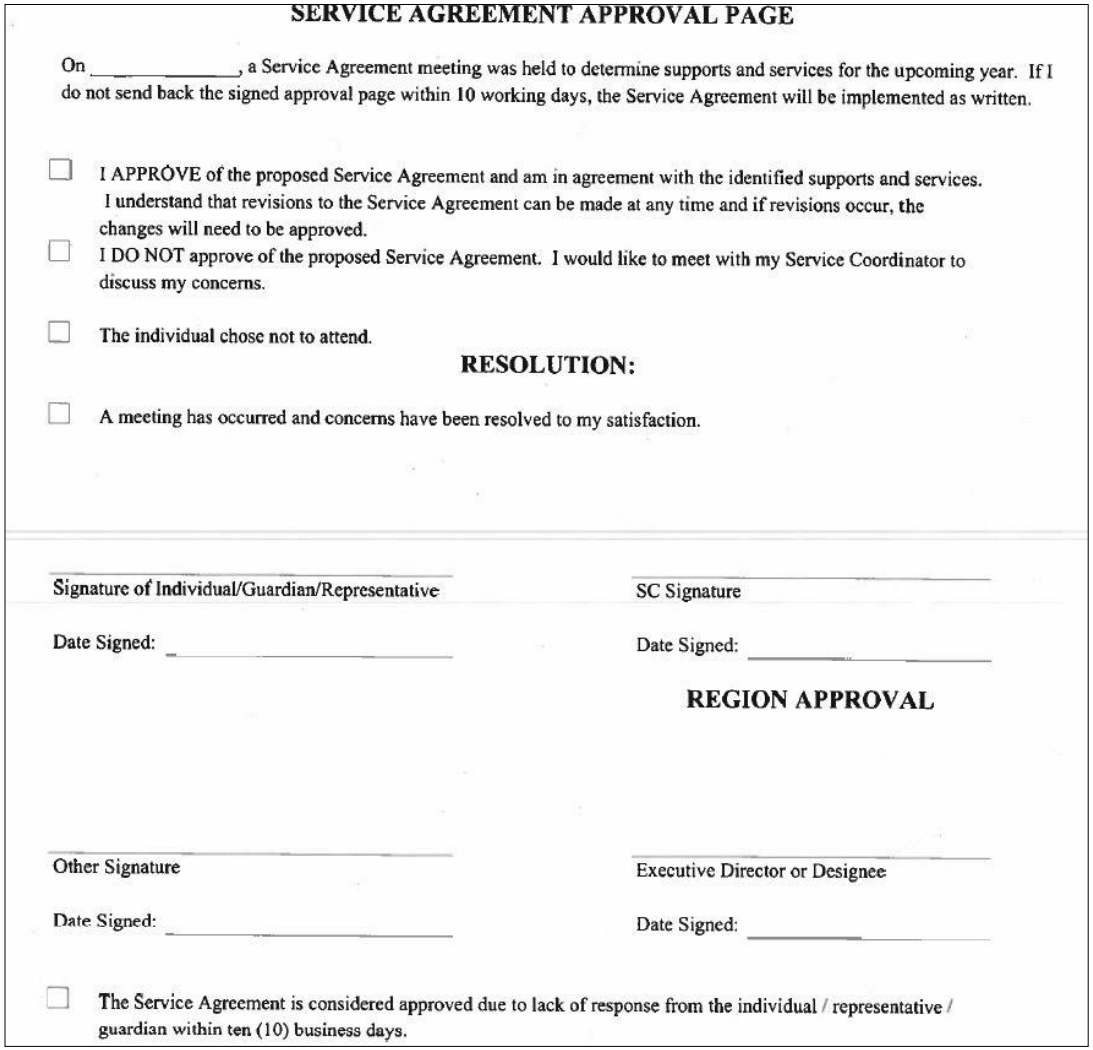
☑ Med/Behavioral (waiver)
☑ State Plan

Medication Administration
☐ HEM 1201 ☐ NUR 404 ☐ Self-Administering ☐ N/A

Individual Service Agreement (ISA) QA Checklist Continued

Service Agreement Approval Page

- **A signed signature page must be** included. This requires the Executive Director/Designee and Service Coordinator signatures, as well as the Individual/Guardian signature or a tacit approval if not signed by individual/guardian.



SERVICE AGREEMENT APPROVAL PAGE

On _____, a Service Agreement meeting was held to determine supports and services for the upcoming year. If I do not send back the signed approval page within 10 working days, the Service Agreement will be implemented as written.

☐ I APPROVE of the proposed Service Agreement and am in agreement with the identified supports and services. I understand that revisions to the Service Agreement can be made at any time and if revisions occur, the changes will need to be approved.

☐ I DO NOT approve of the proposed Service Agreement. I would like to meet with my Service Coordinator to discuss my concerns.

☐ The individual chose not to attend.

RESOLUTION:

☐ A meeting has occurred and concerns have been resolved to my satisfaction.

Signature of Individual/Guardian/Representative

Date Signed: _____

SC Signature

Date Signed: _____

REGION APPROVAL

Other Signature

Date Signed: _____

Executive Director or Designee

Date Signed: _____

☐ The Service Agreement is considered approved due to lack of response from the individual / representative / guardian within ten (10) business days.