|  |  |
| --- | --- |
| **Client Name:** | **Month/Year** |
| **Agency Name:** | |
| **Waiver Service**  ❑ Transitional CM ❑ ACT ❑ CSP ❑ Supported Employment ❑ Peer Support | |
|  | |

|  |  |
| --- | --- |
| **Goal Number:** | **Objective Number:** |
| **(**Describe progress or continued stabilization, evidence of progress or stabilization from perspective of both provider and client.) | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
| **Average Level of Assistance Provided**  ❑ Maximum ❑ Moderate ❑ Minimum ❑ Standby ❑ Independent | |

|  |  |
| --- | --- |
| **Goal Number:** | **Objective Number:** |
| **(**Describe progress or continued stabilization, evidence of progress or stabilization from perspective of both provider and client.) | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
| **Average Level of Assistance Provided**  ❑ Maximum ❑ Moderate ❑ Minimum ❑ Standby ❑ Independent | |

|  |  |
| --- | --- |
| **Goal Number:** | **Objective Number:** |
| **(**Describe progress or continued stabilization, evidence of progress or stabilization from perspective of both provider and client.) | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
|  | |
| **Average Level of Assistance Provided**  ❑ Maximum ❑ Moderate ❑ Minimum ❑ Standby ❑ Independent | |
| **Client Name:** | |
| **Agency Name:** | |

**Summary of Client Progress**

|  |
| --- |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

|  |  |  |
| --- | --- | --- |
| **Stressors/Extraordinary Events During Past Month:** ❑None Reported❑Required Modification of Plan see below | | |
|  | | |
|  | | |
| **Hospital Notification**  **N/A** | | |
| Facility Name: | | Date: |
| ❑Emergency Dept ❑Inpatient | ❑Medical ❑Psychiatric | ❑ Planned ❑ Unplanned |

|  |
| --- |
| **Suggestions for changes or modification of Recovery Plan:** |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

|  |  |
| --- | --- |
| **Signature of Primary WISE Service Staff/Credential:** | **Date:** |
| **Signature of Licensed Clinician/Date (if required)** | **Date:** |
| **Signature and Date of Client (Optional):** | **Date:** |

***Level of Assistance (LOA) Definitions:***

**MAXIMUM ASSISTANCE – Unable to meet minimal standards of behavior or functioning in order to participate in daily living activities or performance of basic tasks approximately 75% of time.**

**MODERATE ASSISTANCE – Needs constant cognitive assistance such as 1:1 cueing, prompting/coaching or demonstrations to sustain or complete simple, repetitive activities or tasks safely and accurately approximately 50% of time. MINIMUM ASSISTANCE – Needs periodic cognitive assistance (cueing and/or prompting/coaching) to correct mistakes, check for safety and/or solve problems approximately 25% of time.**

**STANDBY ASSISTANCE – Supervision by one person is needed to enable the individual to perform new procedures for safe and effective performance.**

**INDEPENDENT – No physical or cognitive assistance needed to perform activities or tasks.**