Print Form

NEW YORK STATE DEPARTMENT OF HEALTH
Office of Medicaid Management
Bureau of Long Term Care

INDIVIDUAL SERVICE REPORT (ISR)

HOME AND COMMUNITY BASED SERVICES MEDICAID WAIVERS

☐ Nursing Home Transition and Diversion (NHTD) **NOT YET AVAILABLE**

☐ Traumatic Brain Injury (TBI)

Participant Medicaid #

Waiver Service Provider Agency Telephone

Date of Current Approved Service Plan From _____ To _____.

Date of Addendum (if applicable) _____

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1. Identify each of the participant's goal(s) for this service which have been addressed based on the current approved Service Plan.

2. Identify the interventions used to address each goal as described in your Detailed Plan.

3. Identify any progress made for each goal as described in your Detailed Plan.

4. Identify any barriers to progress for each goal as described in your Detailed Plan.

5. Identify the participant's goal(s), expected interventions and outcomes for this service in the next Service Plan.

6. Provide recommendations for frequency and duration of this service in the next Service Plan.

7. Explain why this service is necessary in the next Service Plan.

Provider Signature Date

Service Coordinator Signature Date ISR Received