Traumatic Brain Injury Waiver

TEAM MEETING SUMMARY

Participant’s Name: ____________________________________________

Date/Time of Meeting: ___/___/___ at _____ am/pm

Location: ______________________________________________________

Facilitator: _________________________________________________

Participant’s Comments: _______________________________________

Recommendations for changes in the Service Plan: ________________

Issues Addressed: _____________________________________________
TEAM MEETING SUMMARY
continued

Participant's Name: ___________________________ Date: ________

Outstanding Issues/Health and Welfare Concerns: __________________________

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Next Steps: __________________________

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Anticipated Time Frame for Next Team Meeting: __________________________

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### TEAM MEETING SUMMARY

**continued**

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<th>Service</th>
<th>Attendee Signature</th>
<th>Agency Name</th>
<th>ISR Submitted?</th>
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<td>Assistive Technology</td>
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<td>Community Transitional Services</td>
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<td>Environmental Modifications Services</td>
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<td>Home and Community Support Services</td>
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<td>Structured Day Program Services</td>
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**Participant (and/or Guardian, if applicable) Signature**  
Date: __________________________

**Signature of Service Coordinator / Agency**  
Date: __________________________