Participant's Name:_____ Date: _____

TEAM MEETING SUMMARY

☐ **NHTD Waiver**
☐ **TBI Waiver**

Date and Time of Meeting: _____ at _____ am ☐ pm ☐

Date and Time of last Meeting: _____ at _____ am ☐ pm ☐

Location: _____

Facilitator: _____

Provide a brief summary of the current goals included in the participant's plan:

Participant's Comments:

1. Does the participant feel as though he/she has met these goals? If not, why?

2. Does the participant want to change and/or add to his/her goals? Describe.

3. Does the participant feel the supports and services he/she receive support the Service Plan goals? ☐ Yes ☐ No

Participant's Name:_____ Date: _____

Provider Comments:

1. What goals have been attained? What goals should be continued and what goals, if any, should be discontinued?

2. How were issues from the last team meeting addressed since the team meeting was held?

3. Have these issues been resolved? ☐ Yes ☐ No

3a. Which issues, if any, are still unresolved?

3b. How were these issues addressed during the team meeting?

Participant's Name:_____ Date: _____

4. Outstanding Health and Welfare Concerns:

4a. Actions required:

5. Roadblocks to goal attainment:

5a. Actions required:

Participant's Name:_____ Date: _____

6. New Issues not previously presented in the Plan and action required:

7. Participant's and provider's recommendations for changes in the Service Plan:

8. Any other important comments addressed in the meeting that were not covered by the questions above:

Date for next Team Meeting: _____

Participant's Name:_____ Date: _____

TEAM MEETING SUMMARY

ATTENDANCE: List all services on the approved service grid, only include those services where attendance would be appropriate.

Service **The participant utilizes the following services:**	**Attendee Signature**	**Agency Name**	**ISR Submitted? (Y) (N) (N/A)**

Participant (and/or Guardian, if applicable) Signature Date

Signature of Service Coordinator / Agency Date