State of Illinois
Department of Human Services

CASE CONFERENCE SUMMARY

See information bulletins for instructions and required attachments.
This form is required for all long-term additional staff support requests.
This form is required for any request for a 1 or 2 Person CILA with 24 hour shift staff supports.
This form must be filled out on-line or typed. Handwritten forms will not be accepted.

1. Individual & Agency Descriptive Information:

Individual's Name	Individual's SSN	Individual's RIN
60D CILA Agency Name	CILA Agency FEIN	CILA Agency ID
31U Developmental Training Agency Name	DT Agency FEIN	DT Agency ID

2. THIS CASE CONFERENCE SUMMARY RELATES TO A REQUEST FOR: (Check all that apply)

- ☐ 60D CILA Residential - authorization for a 1 or 2 person CILA with 24 hour shift staff.
  - ☐ A pre-award letter for a 1 or 2 person CILA was granted. Date of PAL: _____
- ☐ 60D CILA Residential - long-term additional staff supports.
- ☐ 31U Developmental Training - long-term additional staff supports.
- ☐ Renewal to continue additional staff supports, or a 1 or 2 person CILA
  - ☐ Date current supports expire: _____

3. Date of case conference: _____

4. List all individuals who participated in this case conference:

Individual _____
Individual's Guardian (If Applicable) _____
Family Member (Authorized by Individual or Guardian) _____
QIDP _____
Provider Agency Management _____
ISC Agency _____
CART or SST _____
Other: _____ _____
Other: _____ _____
Other: _____ _____
Other: _____ _____

CASE CONFERENCE SUMMARY

5. Statement of need: Provide a brief explanation of the individual's critical medical, physical and/or behavioral needs. Please include the frequency, duration, and intensity of medical, physical and/or behavioral needs:

6. Summary of current status:

a. Provide a statement(s) of strategies currently in use:

b. Describe the individual's response to strategies listed above:

c. Describe projected challenges:

CASE CONFERENCE SUMMARY

7. Summary of team discussion & recommendations:

a. Statement of whether to continue and/or modify strategies currently in use to resolve individual's issue(s).

b. Statement of the development and/or modification of a positive behavior support plan.

c. Statement as to need for referral and/or follow up with other professionals (e.g.: medical, psychiatric, tests or evaluations)

d. Statement as to need for referral to CART and/or SST. (Attach copy of CART or SST Referral/Request if applicable.)

8. Follow up steps: List any follow up action(s) recommended by the team; the name of the person responsible, time frame for completion AND if completion is required before submitting a request.

Signature of Agency Qualified Intellectual Disability Professional

Date of Distribution