State of Illinois
Department of Human Services - Division of Developmental Disabilities

INDEPENDENT SERVICE COORDINATION (ISC) SPECIALIZED ADDITIONAL MONITORING REPORT

Provider: ______________________ Date of Visit: ______________________

Site Address: ______________________ Time of Visit: ______________________

____

Individuals: ______________________ Provider Staff Names: ______________________

______________________ ______________________

______________________ ______________________

I. Identified Concerns:

II. Visit Observations/Concerns/General Comments: (Detail what was observed noting positive actions as well as areas needing follow-up.)

INDEPENDENT SERVICE COORDINATION (ISC) SPECIALIZED ADDITIONAL MONITORING REPORT

III. Discussion/Contact: (Detail any discussions or contact with individuals or staff. Please, list the names of the individuals/ staff below.)

Individual(s): ______________________________

____

Provider Staff/Support Person(s): ______________________________

____

Discussion details:

IV. Follow-up Actions: (Detail what action steps will be taken by the provider. Identify what provider staff will be responsible and the time frame for the follow-up to be completed.)

Report completed by:

Printed Name/Title	Signature	Date

cc: Division of Developmental Disability
Provider Agency