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

OUTREACH VISIT FORM

Name of Person: _____

Date: _____

Guardian (as applicable): _____ Present: Yes ☐ No ☐

☐ In person Location: _____ ☐ Virtual ☐ Telephonic

Provider Agency Name: _____

Agency Contact: _____ ☐ SODC ☐ ICF/DD

Phone Number: _____ Ext.: _____ Fax: _____ Email: _____

Agency Address: _____ City: _____ State: _____

ISC Agency Name: _____ Region: _____

Agency Contact: _____

Phone Number: _____ Ext.: _____ Email: _____

Summary (attendees, topics covered, etc.):

Information about the range of developmental disability services was shared with the Individual and/or Guardian. Yes ☐ No ☐

Comments:

The Individual and/or Guardian is currently interested in exploring other services outside of their current ICF/DD or SODC?

Yes ☐ No ☐

Follow up needed:

The Individual and/or Guardian requested registration on the PUNS List (ICF/DD only) Yes ☐ No ☐

Comments:

_____ _____

Signature of ISC Service Coordinator Date

_____

Printed Name of ISC Service Coordinator