NEW YORK STATE DEPARTMENT OF HEATLH
Division of Home and Community Based Services
Participant: _____ **Waiver Service**: _____

TBI Waiver Program

Individual Service Report

(To Be Completed by the Provider of the Service)

Please check one: ☐ **CIC** ☐ **HCSS** ☐ **ILST** ☐ **PBIS** ☐ **Respite**
☐ **SAP** ☐ **SDP** ☐ **SC**

Participant: _____

Waiver Provider: _____

Provider Agency: _____ **Phone:** _____

Date waiver service was first provided: _____

Current frequency and hours of services: _____

Proposed frequency and hours for the next reporting period: _____

Justification for waiver service

1. **List specific goals, as listed in the individual's Detailed Plan, for this service for the past six months.**
   -

2. **List progress made on each of the above outlined goals, using measurable outcomes. Describe any functional skills gains made by the individual during the past reporting period.**
   -

3. **Describe compensatory strategies and/or specific interventions utilized to assist the participant in obtaining the above outlined goals.**
   -

4. **List barriers, as related to the above outlined goals, and actions taken to address these barriers.**
   -

5. **List changes in goals, as will be noted in the Detailed Plan for the next six months, for this service.**
   -

NEW YORK STATE DEPARTMENT OF HEATLH
Division of Home and Community Based Services
Participant: _____ **Waiver Service**: _____

Participant Signature: _____ Date: _____

Provider Signature: _____ Date: _____

Service Coordinator Signature: _____ Date: _____