The Arc Of East Central Iowa

Intermittent Medical Monitoring Treatment (IMMT)
Service Documentation

Consumer's Legal Name: _____ **Medicaid #:** _ _ _ _ _ _ _ _ _
(include nicknames used in summary)

Date of Service: _ _ / _ _ / _ _ **Start Time*:** _ _ : _ _ **End Time*:** _ _ : _ _ **Date of Birth:** _ _ / _ _ / _ _
* Use military time to document

Location of Service (check all that apply – if visiting more than one location, document when and where in summary):

☐ Consumer's Home ☐ Daycare (circle one): BASICS OASIS SDP Other: _____

Objectives worked on:

1. _____

2. _____

3. _____

4. _____

5. _____

#	IMMT Service Notes	DSP Initials

Continue on back if more room is needed. ***DSP & Primary Caregiver/Consumer must complete & sign back.***

Consumer's Legal Name:_____ **Medicaid #:** _ _ _ _ _ _ _ _ **Date of Birth:** _ _ / _ _ / _ _
(include nicknames used in summary)

#	IMMT Service Notes	DSP Initials

Were there any injury, illness, or safety issues during the service that required an incident/seizure report:
☐ Yes *(complete & submit incident report)* ☐ No

Are there any additional notes, concerns or issues to communicate: ☐ Yes (document below) ☐ No

_____

_____

Direct Service Provider (DSP) Verification: *Did the DSP have access to Care & SCL Plan* (i.e. ELP): ☐ **Yes** ☐ **No***

***If no, explain**: _____

Full Legal Name (*Print*): _____ DSP ID # _____

Full Legal Name (*Signature*): _____ Date _____

Primary Caregiver/Person Responsible for Consumer:

Did the DSP complete documentation and provide a summary of the service? (check one) ☐ **Yes** ☐ **No**

Is the DSP responsible for dispensing/observing medications/procedures? (check one) ☐ **Yes**** ☐ **No**

** if yes, complete a medication log

Signature of Person Responsible for Consumer_____ **Date** _____

Completed service notes must be turned in on the 1st & 16th each month to the Arc at:
680 2nd Street SE, Suite 200 • Cedar Rapids, IA 52401
Phone: 319-365-0487 • Fax: 319-365-9938

Office Use Only

Lead/Dir QA by: _____ **Date:**_____

Office QA by: _____ **Date:** _____

See Discussion Log: ❑ Consumer ❑ DSP