SUPPORTS INTENSITY SCALE (SIS) AND INVENTORY FOR CLIENT AND AGENCY (ICAP) ASSESSMENT PROVIDER CHECKLIST

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
SFN 1802 (2-2023)

Clear Fields

Form to be completed by the Provider

Date of Interview

Name of Client Receiving Services	
Name of Provider	
Responsible Provider Personnel	
Type of Assessment ☐ ICAP ☐ SIS	Assessment ☐ Initial ☐ Re-assessment ☐ Out-of-Sequence for Life-Changing Event

Instructions: Providers will complete this checklist for the following items they are responsible to complete prior to the assessment interview. This checklist will be brought to the assessment interview and given to the assessor.

Prior to Interview

Provider notified and invited the client and legal decision maker (if applicable) of the assessment interview.	☐ Yes ☐ No
Provide documentation below of the date of contacts, type of contact, and with whom as recorded in the client's record:	

** Proof of this contact may be requested at any time.*

Provider arranged the interview at a time and location convenient for the client and legal decision maker? Interview location shall be private and accessible and/or necessary accommodations provided for the interview.	☐ Yes ☐ No
Interview Location and Time	
Provider notified the DDPM of the interview. (DDPM is not required to attend and should not be a respondent.)	☐ Yes ☐ No
Provide documentation below of the date of contacts, type of contact, and with whom as recorded in the client's record:	
Provider arranged for qualified respondents to be in attendance for the entire assessment. (Refer to policy for qualified respondent requirements)	☐ Yes ☐ No
The provider sent the ICAP or SIS assessment fact sheet to the client and legal decision maker?	☐ Yes ☐ No