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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
SFN 1802 (11-2023)

Clear Fields

Date of Interview

Form to be completed by the Provider

Name of Individual 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 individual using the required letter template. ☐ Yes ☐ No	Date of Contact
Provider notified and invited the legal decision maker using the required letter template. ☐ Yes ☐ No	Date of Contact

For each service the individual receives, provide the documentation below:

Service	Other Involved DD Provider	Date of Contact	Type of Contact	Contacted by Who
ICF/IID				
Residential Habilitation				
Independent Habilitation				
Day Habilitation				
Prevocational Services				
Small Group Employment				
Individual Employment				

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

Provider arranged the interview at a time and location convenient for the individual and legal decision maker? Interview location shall be private and accessible and/or necessary accommodations provided for the interview.	☐ Yes ☐ No
Provider notified the DDPM of the interview. (DDPM is not required to attend and should not be a respondent.) Date of Contact: _____	☐ Yes ☐ No
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 individual and legal decision maker?	☐ Yes ☐ No