ASSESSMENT RESULTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEVELOPMENTAL DISABILITIES
SFN 1815 (12-2024)

Clear Fields

The purpose of this form is to notify the individual and/or legal decision maker that a Support Intensity Scale (SIS-A®) or Inventory for Individuals and Agency Planning (ICAP) assessment has been completed. A SIS-A or ICAP assessment is necessary to determine service payment for individuals who are eligible for specific developmental disability services.

INDIVIDUAL INFORMATION

Individual Name (First, Last)			
Address	City	State	ZIP Code
Date Assessment Results Form Completed	Effective Start Date of Assessment Score		

SIS-A ASSESSMENT RESULTS

Date of Assessment	Name of Assessor
Section 2A Score - Home Living (Score used for both Residential and Day Services)	
Section 2B Score - Community Living (Score used for both Residential and Day Services)	
Section 2C Score - Health and Safety (Score used for both Residential and Day Services)	
Section 2E Score - Work Activities (Score used for Day Services)	
Exceptional Medical Support Needs Total Score	
Exceptional Behavioral Support Needs Total Score	

*** This information listed above is a summary of the assessment. You may contact your DDPM to request and expanded version explaining the results in detail.**

ICAP ASSESSMENT RESULTS

Date of Assessment	Name of Assessor
Service Score	

INDIVIDUAL CHOSEN SERVICES

(The services listed below identify the assessment score hours for the current service(s) chosen by the individual. The assessment score monthly hours may change based on any service delivery changes by the individual to the amount and frequency.)

Service Category	Check current services receiving	Services	Assessment Scores Monthly Hours (complete only for the "checked" services)
Residential Service	☐	ICF/IID	
	☐	Residential Habilitation	
	☐	Independent Habilitation	
Day Service	☐	Day Habilitation	
	☐	Prevocational Services	
	☐	Small Group Employment Support	
	☐	Individual Employment Support	

SERVICE OPTIONS (The services listed below identify the assessment score hours for all available services).

Service Category	Services	Assessment Scores Monthly Hours
Residential Services	ICF/IID	
	Residential Habilitation	
	Independent Habilitation	
Day Service Hours listed are based on 40 hours per week, which is the maximum cumulative amount allowable.	Day Habilitation, Prevocational Services, and Small Group Employment Support	
	Individual Employment Supports	

The assessment score hours listed above are an average number of hours that may fluctuate on a daily, weekly, or monthly basis. Other supports and recommendations may be utilized in addition to the assessment score hours, which may be discussed at a person centered planning meeting. A person centered planning meeting may be requested at any time.

If you disagree with the manner in which the assessment was completed, you have the right to have it reviewed informally by Developmental Disabilities (DD). A written request for reconsideration can be submitted to:

Quality Assurance Manager
Developmental Disabilities
Department of Health and Human Services
1237 W Divide Ave, Ste 1A
Bismarck, ND 58501-1208
Phone: (701) 328-8930
dhsddreq@nd.gov

The request for reconsideration must be postmarked or received within ten (10) calendar days of the date of this notice.

The use of the Request for Reconsideration will not preclude or delay your right to a fair hearing by filing an appeal. You or your authorized representative has the right to request an appeal. A request for an appeal my be through telephone, internet website, mail, in person, or other common available electronic means. A request for hearing must be postmarked or received by the Appeals Supervisor within thirty (30) calendar days of the date of this notice. You may represent yourself in an appeal hearing or may use legal counsel, a friend, or other spokesperson. Send appeal requests to:

Appeals Supervisor
Department of Health and Human Services
600 East Boulevard Avenue Dept. 325
Bismarck, ND 58505-0250
Phone: (701) 328-2311
Toll Free: (800) 472-2622
TTY: (711)
dhslau@nd.gov

Your request for a hearing will be acknowledged and will contain information regarding the date, time, and place that the hearing will be held. If the request for a hearing is postmarked or received within 10 calendar days of the date of the notice, you may continue to receive the service you are currently authorized for until a hearing decision is made on your appeal, or you withdraw the request for a hearing, fail to appear at a hearing, or it is decided that the only issue in the appeal is one of federal or state law/policy. You are advised, however, that if the hearing decision is not in your favor, the total additional amount paid with Medicaid funds on your behalf may be considered an overpayment subject to recovery.

If you have any questions regarding the assessment results, would like to request a meeting, or need assistance with the appeals process, please contact:

DDPM Name	DDPM Telephone Number