Traumatic Brain Injury Waiver

TEAM MEETING SUMMARY

Participant's Name: _____

Date/Time of Meeting: ___/___/___ at _____ am/pm

Location: _____

Facilitator: _____

Participant's Comments: _____

Recommendations for changes in the Service Plan: _____

Issues Addressed: _____

TEAM MEETING SUMMARY
continued

Participant's Name: _____ Date: _____

Outstanding Issues/Health and Welfare Concerns: _____

Next Steps: _____

Anticipated Time Frame for Next Team Meeting: _____

TEAM MEETING SUMMARY
continued

Participant's Name: _____ Date: _____

ATTENDANCE:

Service	Attendee Signature	Agency Name	ISR Submitted? (Y) (N) (N/A)
Service Coordinator			
Assistive Technology			
Community Integration Counseling			
Community Transitional Services			
Environmental Modifications Services			
Home and Community Support Services			
Independent Living Skills Training			
Positive Behavioral Interventions and Supports			
Respite Services			
Structured Day Program Services			

_____

Participant (and/or Guardian, if applicable) Signature Date

_____

Signature of Service Coordinator / Agency Date