**Outcome Status**

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| **DESIRED OUTCOMES** | **Status of outcome**  *Achieved = accomplished, removing from plan*  *On track = progressing as expected, no gaps/barriers*  *Limited or no progress = experiencing gaps/barriers or regress* | **Plan updates** |
| Start date:  End date:  [Enter Outcome Statement] | Achieved  On track  Limited or no progress  Status description: **Comment based on status selected.** | Plan change needed?  Yes  No  If yes, describe: |
| Start date:  End date:  [Enter Outcome Statement] | Achieved  On track  Limited or no progress  Status description: **Comment based on status selected.** | Plan change needed?  Yes  No  If yes, describe: |
| Start date:  End date:  [Enter Outcome Statement] | Achieved  On track  Limited or no progress  Status description: **Comment based on status selected.** | Plan change needed?  Yes  No  If yes, describe: |

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| 1. | For the reporting period have there been any **safety risks (health or behavioral)** identified? | Yes  No | If yes, describe risks and how they were/will be addressed and documented in the plan: |
| 2. | Does the person or substitute decision-maker desire and/or need any **changes** to the plan or services and supports? | Yes  No | If yes, describe plans to address: |
| 3. | Is the person and substitute decision-maker **satisfied** with all services and supports? | Yes  No | Describe how you know the response indicated and any plans to address dissatisfaction: |
| 4. | Were **all Medicaid services** in the plan **implemented**? | Yes  No | If no, describe plans to address: |
| 5. | Were there any **significant events** (health or otherwise) not reported above? | Yes  No | If yes, describe: |

Completed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (signature) Date: \_\_\_\_\_\_\_\_