DEPARTMENT OF HEALTH AND WELFARE
QUALIFIED INTELLECTUAL DISABILITIES PROFESSIONAL (QIDP) VISIT

Participant Name _____ Medicaid # _____

Address _____ Phone _____

QIDP Name (please print)_____

I. Progress toward identified goals:

_____
_____
_____
_____

II. Change in developmental plan:

_____
_____
_____
_____

III. Summary:

_____
_____
_____
_____

Plan has been discussed with provider? ☐ Yes ☐ No

Provider Name _____

Provider Name _____

QIDP's next visit in _____days.

_____ _____
QIDP Signature Date

_____ _____
Participant Signature Date