DUE BY THE 15TH OF EACH MONTH

Risk Mitigation Monthly Report

Client's Name: _____Medicaid#: _____

SSN# : _____Current Date: _____Transition Date:_____

Date	Risk	Status Plan
	Nutrition	
	Risk of Institutionalization	
	Health	
	Transportation	
	Fall Risk	
	Social Needs	
	Direct Service Worker	
	Behavior Mental Health	
	Repairs/Replacement of Medical & Other Equipment	
	Fragility of the Informal Caregiver System	

	Other (Specify)	

Was Back-up Plan Implemented and if not why?

Comments:

Client's Signature Date

ITM Signature Date