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| Client Name:  Agency Providing Service(s) Reviewed: |  | Date of review:  Review Completed By | Kristy Warner CDDO of SEK  Quality Assurance Coordinator |

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| Services Reviewed | Day |  | Residential |  | PCS |  | TCM |  |

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| **Item**  **T = Therap F = Site files** | | **Present** | **Not Present** | **In Process** | **N/A** | **Comments** | **Date of Corrections** | **Date of CDDO Follow Up & Outcome** |
| 1 | Application for IDD Services |  |  |  |  |  |  |  |
| 2 | Documents used to determine eligibility (psych. Evals, medical reports etc.) MR 9 |  |  |  |  |  |  |  |
| 3 | Guardianship Papers |  |  |  |  |  |  |  |
| 4 | Financial and/or Service Agreement |  |  |  |  |  |  |  |
| 5 | Release for emergency medical & publications |  |  |  |  |  |  |  |
| 6 | BASIS, within 365 days |  |  |  |  |  |  |  |
| 7 | Annual Choice Form |  |  |  |  |  |  |  |
| 8 | Current ISP, MCO Funding Documents |  |  |  |  |  |  |  |
| 9 | Physical Exam within past 2 years |  |  |  |  |  |  |  |
| 10 | Medically Fragile Exemption |  |  |  |  |  |  |  |
| 11 | External TCM Checklist |  |  |  |  |  |  |  |
| 12 | Status Change Reports updated as needed |  |  |  |  |  |  |  |
| 13 | Behavior plan, if take psychotropic medication or restrictive interventions within 365 days |  |  |  |  |  |  |  |
| 14 | Informed consent for psychotropic medication within 365 days |  |  |  |  |  |  |  |
| 15 | Current PCSP |  |  |  |  |  |  |  |
| 16 | Documentation that training on rights & ANE offered within 365 days |  |  |  |  |  |  |  |
| 17 | Rental agreement |  |  |  |  |  |  |  |
| 18 | **Final Rule Certificate** |  |  |  |  |  |  |  |

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| **T = Therap F = Site files** |

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| **Date of PCSP** | |  |
| **Standard** | | | **Present** | | **Not Present** | | **In Process** | **N/A** | | | **Comments** | **Date of Correction** | | **Date of CDDO Follow Up & Outcome** | |
| 1 | Names of all individuals involved in the development of plan to include the person, guardian, and provider(s). Lead coordinator is listed. | |  | |  | |  |  | | |  |  | |  | |
| 2 | Signed and dated by person, guardian, and provider. | |  | |  | |  |  | | |  |  | |  | |
| 3 | Updated within 365 days. | |  | |  | |  |  | | |  |  | |  | |
| 4 | Describes the type of setting the person wants to live. Can include next best options. | |  | |  | |  |  | | |  |  | |  | |
| 5 | Describes who the person wants to live with. Can include next best options. | |  | |  | |  |  | | |  |  | |  | |
| 6 | Describes what work or valued activity the person wants to do. Can include next best options | |  | |  | |  |  | | |  |  | |  | |
| 7 | Describes who the person wants to socialize with. Can include next best options. | |  | |  | |  |  | | |  |  | |  | |
| 8 | Describes the social, leisure, religious or other activities the person wants to participate in. Can include next best options. | |  | |  | |  |  | | |  |  | |  | |
| 9 | Describes what is needed to assist person accomplish preferred lifestyle, meet needs | |  | |  | |  |  | | |  |  | |  | |
| 10 | Describes any medical concerns or medical support needed. List any special diet needs. List Lead Coordinator for addressing health care needs. | |  | |  | |  |  | | |  |  | |  | |
| 11 | Describes any behavioral support needs & detailed description of how those needs will be met or plan confirms there is no need for support in this area. All restrictive plans m must be approved by behavior management committee. | |  | |  | |  |  | | |  |  | |  | |
| **Standard** | | | **Present** | | **Not Present** | | **In Process** | **N/A** | | | **Comments** | **Date of Correction** | | **Date of CDDO Follow Up & Outcome** | |
| 12 | Describes any assistance needed with financial issues, whom to contact for bills etc. Plan considers the financial limitations of the person and the provider. | |  | |  | |  |  | | |  |  | |  | |
| 13 | Describe any assistance the person needs regarding self-advocacy, rights & responsibilities. | |  | |  | |  |  | | |  |  | |  | |
| 14 | Describes any assistance needed with emergency preparedness. | |  | |  | |  |  | | |  |  | |  | |
| 15 | Describes in detail how opportunities of choice are offered & supported. | |  | |  | |  |  | | |  |  | |  | |
| 16 | There is documented indication of review & revision of plan in response to the changes in lifestyle preference, needs or when plan is ineffective. | |  | |  | |  |  | | |  |  | |  | |
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Summary

Please make the necessary corrections and return the revised documents to me no later than the date listed below.

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| Date Sent |  | Date CAP Due |  | Date Received |  | Date of CDDO Follow Up |  |