

EXTERNAL CASE MANAGEMENT CHECKLIST

New 11/21, Revised 6/25

Person Name:

Date:

TCM Name:

TCM Agency:

Day Provider Agency:

Residential Provider Agency:

PCS/SHC Provider Agency:

General Contact Information

TCM Contact Phone:

TCM Phone/email:

Day Provider Contact Name:

Day Provider Contact Phone/Email:

Residential Provider Contact Name:

Residential Provider Contact Phone/Email:

PCS/SHC Provider Contact Name:

PCS/SHC Provider Contact Phone/Email:

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List Responsible Staff Name and Contact Information for each of the following:

Medical Concerns:

Service Concerns:

Mental Health Concerns:

MFEI Scheduling:

AIR and GER Reports:

Who will complete these reports:	TCM	Day Provider	Residential Provider
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Who notifies guardian of incident(s):	TCM	Day Provider	Residential Provider
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THESE REPORTS MUST BE MADE WITHIN 24 HRS OF BECOMING INFORMED OF INCIDENT(S)

Behavior Support Plans:

What form will be used:	TCM	Day Provider	Residential Provider
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Whose Human Rights Committee will review BSP:	TCM	Day Provider	Residential Provider
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Other important information to document:

The TCM and provider(s) should review the form at least annually to ensure all information is correct. This form should be updated as changes occur during the year.

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Names of Persons Involved in the Completion of this Checklist:

How was this Form Completed?

In Person On Phone Via Email

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