

EXTERNAL CASE MANAGEMENT CHECKLIST

New 11/21, Revised 10/22

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:

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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Lead Person and contact information for each of the following:

Medical Concerns:

Service Concerns:

Mental Health Concerns:

BASIS Information:

Behavior logs, MAR,
Medical conditions, Seizure logs

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 misc. forms

Service Agreements:	TCM	Day Provider	Residential Provider
Annual Release Forms: Emergency medical Authorization for publications transportation	TCM	Day Provider	Residential Provider

Other Information important to document:

Name of Persons Involved in the Completion of this Checklist

Signature

Agency

Form Completed Via

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