

2012 County Record Review

Participant and Reviewer Identification Data

Please be as thorough as possible in your answers.

1. PARTICIPANT INFORMATION

Fill in the name of the participant whose file is being reviewed. Include middle initial if available.

Last Name

First Name

Middle Initial

ID Number (No spaces or dashes)

2. COUNTY SUPPORT & SERVICE COORDINATOR CONTACT INFORMATION

Enter the name or if there are split roles, i.e. contract case management, enter the names of all the persons doing case management and their roles and functions.

Name 1 (Last, First, MI)

Role 1

Name 2 (Last, First, MI)

Role 2

Name 3 (Last, First, MI)

Role 3

3. COUNTY OF RESPONSIBILITY

Choose the name of the county of financial responsibility from the dropdown list. If one county has contracted with another to do the case management function, enter the name of the county that is taking financial responsibility for the participant.

4. DATE RECORD REVIEW COMPLETED

Enter the date the CIS completed the review.

mm/dd/yyyy

5. REVIEWER INFORMATION

Enter CIS name and PROACT assigned number

Last Name	<input type="text"/>
First Name	<input type="text"/>
PROACT Number	<input type="text"/>

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File Materials for Eligibility

Answer Key: Yes = This is an affirmative answer to the question. No = This is a negative answer to the question. N/A = This means the question is not applicable.

6. Financial Eligibility: Is documentation present?

	YES	NO	N/A
DDES 919 (Cost Share Worksheet)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CARES Screen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. Date of most recent completed form:

mm/dd/yyyy



8. Is the participant required to pay a cost share to maintain eligibility?

- Yes
- No

9. Is the participant financially eligible to continue to receive waiver services?

- Yes
- No

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Level of Care Determination:

10. Is there evidence that the Support and Service Coordinator meets the minimum standard requirements to be a QMRP (Bachelor degree plus one year experience working with target group)?*

Yes

No

11. LOC Determination:

	YES	NO	N/A
A) Is there evidence that the Support Service Coordinator is registered and trained to use the LTCFS?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B) For CIP, has the Long Term Care Functional Screen been completed within the past 12 months?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C) After reviewing case notes and the current assessment, is the information on the Long Term Care Functional Screen accurate?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D) For BIW, has the DDE 2256 & 2256a been completed in the past 12 months?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E) Is the participant functionally eligible for the waiver program?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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Individual Service Plan; Process and Content

12. Individual Service Plan (DDE 445); Process and Content

	YES	NO	N/A
A) Was the Individual Service Plan (DDE 445) updated within the past twelve months?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B) Is there evidence that the Individual Service Plan (DDE 445) was reviewed at six months or when changes occurred?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C) Is there evidence that the Individual Service Plan (DDE 445) was reviewed by the designated county staff with the participant and guardian?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D) Do all services and costs listed on the DDE 445 match the services on the L-300?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E) Is there evidence that room and board is paid from a source other than the waiver?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F) Is there documentation on the DDE 445 that indicates how much the participant pays for room and board in a substitute care facility?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G) Is the personal allowance or monthly spending allocated listed on the DDE 445?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
H) Is the cost share, if any, documented on the DDE 445?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. Is there documentation in the participant's file that indicates that the county has assessed the provider qualifications?

- Yes
- No

14. Do the qualified providers match the participant's needs?

- Yes
- No

15. Identify the entity managing the participant's funds

- Participant
- County Waiver Agency
- Financial Management Services (HSRS 619) Provider
- Other Waiver Service Provider
- Guardian or Family Member

Other, please specify

16. Does the DDE 445 list any conflicts of interest?
(If "No" go to question 18)

Yes
 No

17. If Yes to the previous question, is the strategy to remediate the conflict acceptable?

Yes
 No (Explain below)

18. Were any conflicts of interest identified during the review of the ISP and the rest of the file that were not identified on the DDE 445?

Yes
 No

19. Is the Individual Outcomes page of the DDE 445 complete and up to date?

Yes
 No

20. Is there evidence in the file notes that shows the outcomes were developed with the consumer and/or others who may have some information to provide?

Yes
 No

21. Is the ISP DDE445 complete and approved as part of the on-going service packet?

Yes
 No

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County Monthly Recertification & Related Info

22. Is there evidence that indicates the most recent county Monthly Recertification Assurance Report was completed?
- Yes
- No
23. Is the recertification approval letter from DD Services Section in the participant's file?
- Yes
- No
24. Is there documentation that HFS 94 Rights and Grievances Procedure information has been shared with the participant and/or guardian, if any, both in writing and verbally on an annual basis?
- Yes
- No

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Support and Service Coordination

25. Is there sufficient evidence that the number of required contacts have been met?
- Yes
- No
26. Is the narrative and assessment updated to reflect changes?
- Yes
- No
27. Do the case notes describe what is happening in the participant's life?
- Yes
- No
28. Is there evidence that the case notes are reflective of the service the participant is receiving?
- Yes
- No
29. Is there evidence that the Support and Service Coordinator uses an acceptable method to keep the assessment up to date?
- Yes
- No
30. Did the CM/SSC use an acceptable method to assess the person's capacity to safely and effectively manage their medications?
- Yes
- No
- N/A
31. Did the CM/SSC use an acceptable method to assess the person's capacity to safely and effectively administer their medications?
- Yes
- No
- N/A
32. Is there documentation from the SSC/CM that they assessed the individual for any indicators of real or potential risks associated with medication management and/or administration?
- Yes
- No
- N/A

33. Is there sufficient assessment information in the participant's file to determine that the service plan continues to assure the participant's health, safety and welfare?

- Yes
- No

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Critical Incidents

34. In the last 12 months was there evidence of a Critical Incident?

If "No," skip the rest of this section and begin again at the Restrictive Measures section.

Yes

No

35. If a report is in the file, is there documentation that the report was sent to BLTS?

N/A

Yes

No

36. Did the reports contain sufficient information to indicate the situation was successfully resolved?

Yes

No (Explain below)

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37. Were follow-up responses to the incident documented in the case notes?

Yes

No

38. Was the response to each Critical Incident resolved in a manner that assured health and safety needs were met?

If "No," a Corrective Action Plan is needed

Yes

No

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Restrictive Measures

39. Are there any indications in the participant's record that Restrictive Measures are needed or being used?
If "No" skip the rest of this section.

- Yes
- No

40. Is there a current Restrictive Measures Approval in place for each restrictive measure?

- Yes
- No (Explain below)

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Survey Completion

41. Sign off to complete the review.
Choose one of the following:

Record met all requirements

Deficiencies found requiring corrective action (Enter date Corrective Action Plan due to CIS below:

42. Additional comments.

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