

Clearwater Council of Governments

Name: _____

Phone #: (____) _____ Resident #: _____

Address: _____

City: _____ State: ____ Zip: _____

General

1. Individual's Name:

2. Address:

3. Phone:

4. County:

5. Guardian:

6. Guardian Address:

7. Guardian Phone:

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8. Type of Service:

9. Service & Support Administrator:

10. Service Span:

11. Homemaker/Personal Care Provider:

12. Other Service Providers:

13. Date(s) of Review:

14. Date of Last QA Review:

15. Information for this review was obtained from the following sources:

16. The QA process was explained to the following individual:

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17. This occurred on the following date:

Comments:

18. He/she gave consent to the Clearwater COG to complete a QA review of the services and consent to send a copy of the report to the parties listed. Signature on file.

Individual Choices and Options

1. What services and supports does the individual receive regarding choices and options?

2. Have the services been provided according to the ISP?

Choose One: Yes - Y, No - N

Comments:

3. Does the individual have a choice in what direct care staff works with them?

Choose One: Yes - Y, No - N

Comments:

Community Membership

1. What services and supports does the individual receive regarding community membership?

2. Have the services been provided according to the ISP?

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Choose One: Yes - Y, No - N

Comments:

3. What are some of the community activities in which the individual participates?

4. Does the individual feel part of their community?

Choose One: Yes - Y, No - N

Comments:

Health

1. What services and supports does the individual receive regarding their personal health?

2. Have the services been provided according to the ISP?

Choose One: Yes - Y, No - N

Comments:

3. Is the individual's health maintained or improved as a result of services/supports?

Choose One: Yes - Y, No - N

Comments:

Housing

1. What services and supports does the individual receive regarding housing?

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2. Have the services been provided according to the ISP?

Choose One: Yes - Y, No - N

Comments:

3. Does the individual have a choice in where they live and who they live with?

Choose One: Yes - Y, No - N

Comments:

Personal Income

1. What services and supports does the individual receive regarding their personal income?

2. Have the services been provided according to the ISP?

Choose One: Yes - Y, No - N

Comments:

3. Is the individual's personal income maintained and protected to ensure basic needs are met and so the individual is not financially taken advantage of?

Choose One: Yes - Y, No - N

Comments:

Personal Satisfaction

1. What are the outcomes trying to be achieved and have they been achieved?

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2. Has the individual gained skills or independence as a result of having a provider?

Choose One: Yes - Y, No - N

Comments:

3. Are you/guardian satisfied with these services/supports?

Choose One: Yes - Y, No - N

Comments:

4. Are you/guardian satisfied with the support staff providing services?

Choose One: Yes - Y, No - N

Comments:

5. Does the individual feel in control of his choices, ISP, services/supports?

Choose One: Yes - Y, No - N

Comments:

6. Does the individual know who to contact regarding any complaints or requests for changes?

Choose One: Yes - Y, No - N

Comments:

7. Are there any services that are no longer needed or wanted that are identified in the ISP?

Choose One: Yes - Y, No - N

Comments:

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8. Are there any changes requested regarding the services/supports?

Choose One: Yes - Y, No - N

Comments:

9. Are there any suggestions regarding how services/supports could be improved?

Safety

1. What services and supports does the individual receive to ensure their safety?

2. Have the services been provided according to the ISP?

Choose One: Yes - Y, No - N

Comments:

3. Is there an increase in safety as a result of the services/supports?

Choose One: Yes - Y, No - N

Comments:

Service and Support Administrator

1. Were services implemented as directed in the ISP?

Choose One: Yes - Y, No - N

Comments:

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2. If no, what are the barriers that are preventing the services from being delivered and are those barriers being addressed by the individual's support team?

[Empty text box for barriers]

3. If the individual is not receiving services and supports and the individual and/or family are satisfied, have they been asked if they still are interested in being on a waiver?

[Empty text box for interest]

4. If services are not received monthly, is the SSA providing monthly monitoring?

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

[Empty text box for comments]

Residential Provider

1. Residential provider documentation included the following for the month of:

[Empty text box for documentation]

2. Name of individual and their Medicaid number.

Choose One: Yes - Y, No - N

Comments:

[Empty text box for comments]

3. Name of provider and their 7 digit provider number.

Choose One: Yes - Y, No - N

Comments:

[Empty text box for comments]

4. Type of service

Choose One: Yes - Y, No - N

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Comments:

5. Date of service

Choose One: Yes - Y, No - N

Comments:

6. Place of service

Choose One: Yes - Y, No - N

Comments:

7. Signature or initials of person delivering the service

Choose One: Yes - Y, No - N

Comments:

8. Number of units delivered or continuous amount of uninterrupted time during which the service was provided.

Choose One: Yes - Y, No - N

Comments:

9. Includes arrival and departure times

Choose One: Yes - Y, No - N

Comments:

10. Description and details of the services provided that relate to the ISP.

Choose One: Yes - Y, No - N

Comments:

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11. Includes monthly statement regarding the individual's response to their services

Choose One: Yes - Y, No - N

Comments:

12. ISP and BSP (if appropriate) was in the home

Choose One: Yes - Y, No - N

Comments:

13. A billing history was reviewed for the month of:

14. The provider had documentation to support the billing.

Choose One: Yes - Y, No - N

Comments:

Positive Outcomes

1. Have there been any positive outcomes as a result of receiving the services/supports?

Service Areas to Improve

For the Provider:

1. Recommendations for quality improvement:

2. Recommendations for the Provider that warrant SSA Follow-up.

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For the Service and Support Administrator:

3. Recommendations for quality improvement:

4. Quality Improvement Plan (QIP) Indicated for the SSA:

Choose One: Yes - Y, No - N

Comments:

5. Quality Improvement Plan due to Clearwater COG by:

Comments:

For the ISP Team

6. Additional recommendations for the ISP Team to Consider:

Choose One: Yes - Y, No - N, Not Applicable - NA

Comments:

Signatures

1. Quality Assurance Report prepared by:

Quality Assurance Coordinator

2. Date:

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Quality Assurance Manager

3. Date:

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4. Cc:

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