Bureau of Supports for Autism and Special Populations (BSASP) Expectations of Supports Coordination (SC) Individual Monitoring:

This document provides guidance on how to obtain and document the information needed to thoroughly answer each SC monitoring question.

Per the Adult Autism Waiver (AAW), the SC responsibilities are to:

- Assess the extent to which the participant has access to and is receiving services according to his or her Individual Support Plan (ISP). This includes monitoring that providers have delivered services at the frequency and duration identified in the ISP, and that the participant is accessing the non-waiver supports and health-related services as indicated in the ISP
- Evaluate whether the services furnished meet the participant's needs, and empower the participant to become more independent
- Assess the effectiveness of back-up plans and determine if changes are necessary
- Remind participants that they have free choice in choosing qualified providers
- Remind the participant, providers, and informal caregivers that they should contact the SC if they believe services are not being delivered as agreed upon at the most recent ISP meeting
- Review the participant's progress toward goals stated in the ISP
- Observe whether the participant appears healthy and not in any pain or is injured
- Interview the participant and others involved in the participant's services to identify any concerns regarding the participant's health and welfare
- Inform BSASP immediately when participant's health and welfare is in jeopardy.

BSASP requires that SCs have quarterly face to face visits with participants. During the quarterly visits the SC reviews a series of questions that help to ensure that the participant's health and welfare needs are being met. The SC reviews the participant's progress towards their goals, ensures that the plan is being implemented as written, and assesses the need for any plan revisions. The results of this visit are captured in the *SC Individual Monitoring Form* in HCSIS.

The intent of this *SC Individual Monitoring Form Guidance* is to provide information about what is expected to be included within the *SC Individual Monitoring Form* in HCSIS. It is important that the information contained within the SC Individual Monitoring Form is thorough and includes details to support the findings.

SC Supervisors are highly encouraged to review the SC Individual Monitoring findings with SCs prior to submission to ensure that each section is completed thoroughly and includes relevant information that provides a snapshot of how the participant is currently doing. Supervisors should provide guidance regarding the quality of the SC monitoring to their staff.

What SCs should do to prepare for SC Monitoring

- Print and review the prior completed *SC Individual Monitoring Form* from HCSIS and bring it to the monitoring visit. This is important so the SC can review any concerns from the previous monitoring visit and ensure any issue(s) that required follow-up or changes were addressed.
- Take a copy of this *AAW Supports Coordinator Monitoring Form Guidance and template*.
- Prior to the monitoring visit, review progress notes, incident reports, and any other correspondence with participant, caregiver, providers, or other parties to determine if there are any identified risks that may impact the participant's health and welfare.
- Review approved ISP and authorized services as well as goals and objectives.
- Review current health, health evaluations and health promotion information in the ISP.
- Review if the participant has any special dietary needs.
- Check the Service Details section of the participant's ISP to confirm contingency plan information is entered.
- Check EIM to determine if any incidents were reported for the participant since the previous monitoring visit.

Overall information to be mindful of when monitoring:
- Imminent risk needs to be brought to the attention of the SC Supervisor **immediately!**
- For all questions, interview the participant, as well as the caregiver and/or support staff, if applicable.
- Assure follow-up is completed from previous monitoring visits.

Instructions for completing SC Individual Monitoring Form:

All questions with an asterisk (*) are mandatory questions in the SC Individual Monitoring Form in HCSIS and will require a response.

Each question in the monitoring form includes two additional areas: Comments and Follow-up/Action Needed

For example:

1. Are there any barriers to accessing medical/mental health supports?

   Comments :

   Follow-up/Action Needed :

Comments and Follow-up/Actions Needed are **mandatory** if a **bold** answer is selected on the *SC Individual Monitoring Form* (note: these responses and the Comments and Follow-up/Actions Needed are also highlighted and underlined). However, Comments and Follow-up/Actions Needed may be provided for any answer and should be entered if the SC has relevant information to include.

Instructions for using the SC Individual Monitoring Form Guidance:

The left column on the *SC Individual Monitoring Form* includes prompts in italics for each question. The prompts include things to consider when determining the response to the question, whom to ask, and additional details regarding the question. For each question, you will see prompts that are relevant for all settings. Some questions will also have separate prompts for licensed settings. These prompts should be used *in addition to* the prompts for all settings. A licensed setting refers to both Residential Habilitation and Day Habilitation settings.

The right column includes the type of information that should be recorded in the **Comments** and **Follow-up/Action Needed** sections. These are suggestions only; comments do not need to be limited to what is listed in this guidance. Any information the SC feels is relevant should be included in the Comments and/or Follow-up/Action Needed sections.

For each question, if follow-up actions were needed from the last monitoring, note the follow-up that was taken and what resolution was reached.

If follow-up actions were needed from the last monitoring and were not yet completed, include the follow-up that is still needed.

Participant's Name: *		
Date of Contact: *	Announced?: * ☐ Yes ☐ No	
Time of Contact: *	Provider: *	Service: *
Supports Coordinator Performing Monitoring: *		

Type of Contact: *

☐ Community ☐ Home ☐ Day Support

☐ Community (ACAP) ☐ Home (ACAP) ☐ Day Support (ACAP)

Contact Type Definitions:

- **Community**: A face-to-face monitoring that takes place in a social, recreational, or other community setting. This could include a restaurant, sporting event, store, library or any other location of the participant's choice other than their home or day supports location.

- **Home:** A face-to-face monitoring that takes place at the participant's home. This could include a licensed residential habilitation home, participant's own apartment or home, etc.

- **Day Support:** A face-to-face monitoring that takes place wherever funded day supports are provided. This could include an adult training facility.

- **Community (ACAP), Home (ACAP) and Day Support (ACAP):** should only be selected for individuals served in the Adult Community Autism Program (ACAP).

Medical

Question	Answer
1. Are there any barriers to accessing medical/behavioral supports? * ***All Settings:*** *Interview the participant, as well as the caregiver and/or support staff, if applicable, to see if there have been any barriers in accessing medical/behavioral health supports.* *Possible barriers may include, but are not limited to:* • *Refusal of medical or mental health treatment* • *Trouble scheduling appointments* • *Transportation issues* ***Licensed Settings:*** *Things to consider:* • *Is there a desensitization plan? Is it documented within the participant's ISP?* • *What support has staff provided?*	☐ **Yes** ☐ No **Comments:** If Yes: Document the response specific to the barriers described. **Follow-up/Action Needed:** Describe the actions that will be taken to address identified barriers.

2a. Is a diagnosis or symptom present for each medication? *

    b. If yes, are symptoms still present? If so, what is the follow-up?

Note that question 2b remains hidden unless the response to question 2a is "**Yes**".

All Settings:

Discuss with the participant, as well as the caregiver and/or support staff, if applicable, the participant's medications and discuss why each medication is prescribed. Observe and document any physical or behavioral concerns.

Licensed Settings:
Review medical reports, medication logs, and prescriptions. Review any other written documentation by the prescribing physician.

2a. ☐ Yes ☐ **No** ☐ N/A

2b. ☐ **Yes** ☐ No

Comments:
==2a. If No: Document what medications do not have a diagnosis or symptom.==

==2b. If Yes: Document what symptoms are still present.==

Follow-up/Action Needed:
==Describe the actions that will be taken to address symptoms that are still present.==

| 3. Are blood levels completed and results shared for each medication requiring blood levels?

All Settings:
If the participant takes medications that require blood levels to be completed, discuss with the participant, as well as the caregiver and/or support staff, if applicable, the participant's last blood test result.

Licensed Settings:
Review medical reports, medication logs, and prescriptions to see if the participant takes medications that require blood level, if available. | ☐ Yes ☐ **<mark>No</mark>** ☐ N/A

Comments:
If Yes: Document the medication requiring blood levels and how often the blood levels are required, if known.
Document the most recent results of the last blood result, if available.

<mark>If No: Document which medications requiring blood levels are incomplete.</mark>

Follow-up/Action Needed:
<mark>Describe the actions that will be taken to have blood levels drawn as the per the physician's order.</mark> |

4a. Do support staff/caregiver know where to find information related to side effects of medication? b. Do support staff/caregivers know how to report observed side effects? Note that question 4b remains hidden unless the response to question 4a is "Yes" ***All Settings:*** *Discuss with the participant, as well as the caregiver and/or support staff, if applicable, the participant's medications and side effects of each medication* ***Licensed Settings:*** *Review medical reports, medication logs, and prescriptions. Request to see medication side effects documentation. Side effects are typically included as part of the medication log. Ask staff what their procedure is to report an observed side effect.*	4a. ☐ Yes ☐ No ☐ N/A 4b. ☐ Yes ☐ **No** **Comments:** 4a. If No: Document that the caregiver/support staff did not know where information is located. 4b. If Yes: Document what the support staff/caregiver indicated they would do to report an observed side effect. 4b. If No: Document that the caregiver/support staff did not know how to report side effects. **Follow-up/Action Needed:** Describe the actions that will be taken to Inform the participant as well as the caregiver and/or staff how or where to find information related to the side effects of the medication.

5a. Does the participant receive services from a medical specialist? * (i.e., psychiatrist, neurologist) b. If yes, is there appropriate and timely communication between the team and specialist(s)? c. If the participant receives services from a specialist, are specialist's recommendations being followed? Note that question 5b and 5c remain hidden unless the response to 5a. is "Yes" ***All Settings:*** *Discuss with the participant, as well as the caregiver and/or support staff, if applicable, the services the participant receives from a specialist and the communication they have, if any, with the rest of the team.* ***Licensed Settings:*** *Review documentation of each specialist's recommendations to determine if the recommendations are being followed. Documentation should be maintained in the participant's file. Discuss with staff how information is shared between specialists.*	5a. ☐ Yes ☐ No 5b. ☐ Yes ☐ No 5c. ☐ Yes ☐ **No** **Comments:** 5b. If No: Document the barriers of communication. 5c. If Yes: Document the recommendations of the specialist. 5c. If No: Document the reason recommendations are not being followed. **Follow-up/Action Needed:** Describe the actions that will be taken to address barriers, communication issues, and/or recommendations not being followed.

6a. Is the participant receiving Residential Habilitation or Day Habilitation Services? *	6a. ☐ Yes ☐ No
b. If yes, is an annual physical record available on site?	6b. ☐ Yes ☐ **No**
Note that question 6b remains hidden unless the response to question 6a is "**Yes**".	
c. Annual Physical Review Date (date of last known physical mm/dd/yyyy):	6c. Date:_____
Note that question 6c remains hidden unless the response to question 6a is "**Yes**".	**Comments:** 6a. If Yes: Document which service they are receiving; day habilitation or residential habilitation.
Licensed Settings:	6b. If Yes: Document if the next physical has been scheduled or not, if known.
Review the physical on file. Make sure it is current. If the annual physical is coming due, ask the staff if the appointment has been scheduled.	6b. If No: Document why the last physical is not on site.
	6c. Enter date of last known physical mm/dd/yyyy.
	Follow-up/Action Needed: Describe the actions that will be taken to ensure a physical record is available at the Licensed site.

7. Are there any additional medical concerns? * ***All Settings:*** *Discuss with the participant, as well as the caregiver and/or support staff, if applicable, any concerns for the participant's physical/mental health they may have at present.*	☐ **<mark>Yes</mark>** ☐ No **Comments:** <mark>If Yes: Document the medical concerns.</mark> **Follow-up/Action Needed:** <mark>Describe the immediate actions that were taken to address the medical concerns.</mark>

Health/Safety/Well Being

Question	Answer
1. Are all the participant's identified health care needs being addressed? * **All Settings:** *Ask the participant, as well as the caregiver and/or support staff, if applicable, if there are any health care needs. Discuss if those needs have been addressed and if not, why.*	☐ Yes ☐ <mark>**No**</mark> **Comments:** <mark>If No: Document details regarding what health care needs are not being addressed.</mark> **Follow-up/Action Needed:** <mark>Describe the immediate actions that will be taken to address the identified health issue(s).</mark>

2. Have there been observed changes in the participant's overall health functioning and health status since the last monitoring? * ***All Settings:*** *Discuss any changes such as sleep habits, appetite, or behavior with the participant, as well as the caregiver and/or support staff, if applicable.* *Observe and discuss if there have been any changes in weight, appetite, or behavior.* ***Licensed Settings:*** *Review participant's file.*	☐ **==Yes==** ☐ No **Comments:** ==If Yes: Document the changes observed.== **Follow-up/Action Needed:** ==Describe the actions that will be taken if the change(s) have a negative impact on the participant's overall functioning and health.==
3a. Were there appointments to be scheduled or completed since the last monitoring interval? * b. If yes, were the necessary appointments scheduled and kept? Note that question 3b remains hidden unless the response to question 3a is "**Yes**". ***All Settings***: *Discuss with the participant, as well as the caregiver and/or support staff, if applicable, any recent and/or upcoming appointments. Ask if any appointments were missed and if they were, were the appointments re-scheduled.* ***Licensed Settings:*** *Review participant file*	3a. ☐ Yes ☐ No 3b. ☐ Yes ☐ **==No==** **Comments:** 3a. If Yes: Document the medical appointments as well as the physician's name and contact information. 3b. If Yes: Document the results of the appointments. ==3b. If No: Document the appointments that should have been scheduled or need to be rescheduled.== **Follow-up/Action Needed:** ==Describe the actions that will be taken to support the participant in scheduling and attending needed appointments.==

4. Have there been any medication changes? *	☐ **==Yes==** ☐ No
All Settings: *Ask the participant, as well as the caregiver and/or support staff, if applicable, if the participant has had any medication changes since your last monitoring visit. If yes, discuss the reason for the change in medication.* ***Licensed Settings:*** *Review medical reports, medication logs, and prescriptions to see if there has been a change in medication. If there has been a medication change, discuss with staff the reason for the change and ensure the reason is documented.*	**Comments:** ==If Yes: Document the medication changes and the reason for the change.== **Follow-up/Action Needed:** ==Describe any follow up that may be needed including updating the ISP to ensure that medications are current.== ==Note: If the participant has been prescribed a new medication, please update the Medications Screen in the SC monitoring module. Also update the Medications/Supplements screen in the ISP==
5. If there are, has the participant experienced any side effects and/or adverse drug reactions to any medications since the last monitoring? *	☐ **==Yes==** ☐ No
All Settings: *Ask the participant, as well as the caregiver and/or support staff, if applicable, if the participant has experienced any side effects or has had any reactions from his/her medications. Observe the participant's appearance and mood/affect. If there has been a side effect or reaction, discuss what actions have already been taken to address the reaction.* ***Licensed Settings:*** *Review participant file.*	**Comments:** ==If Yes: Document the reaction or side effect and whether it has been resolved.== **Follow-up/Action Needed:** ==Describe the immediate actions that will be taken to address any ongoing side effects and/or adverse drug reactions.==

6. Is the monitored setting/environment clean, hygienic and odor free? * ***All Settings***: *Does the participant's home/environment during monitoring look to be clean and odor free? If no, are there any health/safety risks?*	☐ Yes ☐ **No** **Comments:** <mark>If No: Document what was observed and what the concerns were in detail. Include whether there were any health/safety risks and what immediate actions were taken to assure the safety of the participant prior to leaving the monitoring visit.</mark> **Follow-up/Action Needed:** • <mark>Describe follow up actions that will occur to address the observed concerns.</mark> • <mark>Describe the actions taken, while at the licensed setting, to address the issue(s).</mark>

7. If monitoring is being conducted in the home environment, are the home's furnishings and appliances in good condition and is this participant's room appropriately individualized and appointed?
 	
All Settings*:*
Observe the home. Ask the participant, as well as the caregiver and/or support staff, if applicable, if there are any concerns with the conditions of their home. Ask the participant to see where they sleep.
 	
Licensed Settings:
Ask the staff if there are any concerns with the furniture, appliances, etc.
 	
Things to consider:
   • *Is the refrigerator functioning properly?*
   • *Is the participant's bedroom decorated to their preference?*
	☐ Yes ☐ **No**
	
	Comments:
	If No:
	Document the concerns observed in the home.
	
	OR
	
	Document that the monitoring was not conducted in the home.
	
	Follow-up/Action Needed:
	   • Describe the follow-up that will be taken in order to repair or replace furnishings or appliances.
	   • Describe the follow up that will occur in order for the participant's room to be individualized.

8a. Does the participant need/use adaptive equipment? *	8a. ☐ Yes ☐ No
b. If yes, is necessary adaptive equipment available, in good condition, and being used?	8b. ☐ Yes ☐ <mark>**No**</mark>
Note that question 8b remains hidden unless the response to question 3a is "**Yes**".	**Comments:** 8a. If Yes: List the adaptive equipment used or needed.
All Settings: *Observe and ask the participant, as well as the caregiver and/or support staff, if applicable, if needed equipment is available, being used and in good repair. Ask if there are there any additional concerns about the equipment.*	<mark>8b. If No: Explain the issue with the equipment.</mark> **Follow-up/Action Needed:** <mark>Describe the actions that will be taken to request, obtain and/or repair adaptive equipment.</mark>
9. Is the home/day/community setting conducive to the participant's physical, behavioral, sensory, and communication needs? *	<mark></mark> ☐ Yes ☐ <mark>**No**</mark>
All Settings: *Discuss with the participant, as well as the caregiver and/or support staff, if applicable, if the setting meets the participant's needs. Ask if there are any changes to the participant's physical, behavioral, sensory or communication needs.*	**Comments:** <mark>If No: Document the needs present that are not being met including physical, behavioral, sensory and/or communication needs.</mark> **Follow-up/Action Needed:** <mark>Describe the actions that will be taken to address the participant's needs across environments.</mark>

10a. Is food handled and stored in the monitored setting? * b. If yes, is it handled in a safe and sanitary manner? Note that question 10b remains hidden unless the response to question 10a is "**Yes**". ***All Settings:*** *Observe the kitchen area during the monitoring visit for sanitation and odors.* ***Licensed Settings***: *If staff is cooking, observe them to ensure food is being handled and stored properly.*	10a. ☐ Yes ☐ No 10b. ☐ Yes ☐ **<u>No</u>** **Comments:** <mark><u>10b. If No: Document the concerns which were observed.</u></mark> **Follow-up/Action Needed:** <mark><u>Describe the immediate action that will be taken to ensure that food is handled and stored in a sanitary manner.</u></mark>
11a. Is a special diet recommended for the participant? * b. If yes, is the special diet being followed? Note that question 11b remains hidden unless the response to question 11a is "**Yes**". ***All Settings***: *Ask the participant, as well as the caregiver and/or support staff, if applicable, if the participant's physician recommended the participant follow a special diet.* ***Licensed Settings:*** *Review documentation of any orders or recommendations from physician/nutritionist. Ask the participant and staff if the diet is being followed. Look for availability of appropriate foods (low fat, etc.) and appropriate consistency of food. Is food available to prepare meals for the participant consistent with what is recommended by the physician/nutritionist?*	11a. ☐ Yes ☐ No 11b. ☐ Yes ☐ **<u>No</u>** **Comments:** 11a. If Yes: Document the specific special diet recommended. <mark><u>11b. If No: Document the reason that the diet is not being followed and any concerns.</u></mark> **Follow-up/Action Needed:** <mark><u>Describe the actions that will be taken to ensure the physician/nutritionist recommendations are followed across environments.</u></mark>

12. Are there adequate amounts of food in the home or available to the participant if in other settings (i.e. appropriate lunch packed, money available to purchase lunch)? * *All Settings: Ask the participant, as well as the caregiver and/or support staff, if applicable, what meals the participant has had lately to get a general idea of what food is available. If you have concerns based on the response, ask further questions.* *Licensed Settings: Ask the staff what the schedule is for shopping or food delivery. Observe the kitchen area. Ask day program staff if the lunches packed contain adequate amounts of food.*	☐ Yes ☐ **No** **Comments:** If No: Document the concern regarding inadequate food supply. OR Document that the meeting was held in the community. **Follow-up/Action Needed:** Describe the immediate actions that will be taken to ensure that the participant has an adequate amount of food or money to purchase food across environments.

13. Are there any additional health and safety issues or barriers affecting the participant's well-being? * *All Settings*: *Ask the participant, as well as the caregiver and/or support staff, if applicable, if they have any concerns regarding the participant's well-being. Ask the participant if he/she feels safe.* *Other things to consider:* • *Transportation to and from doctor appointments* • *Communication issues between the team*	☐ **Yes** ☐ No **Comments:** If Yes: Document the concerns or barriers regarding the participant's health and safety. **Follow-up/Action Needed:** Describe the immediate actions that will be taken to resolve any issues or barriers for the participant's well-being.
14. Is the participant dressed appropriately and well groomed? * *All Settings*: *Observe if clothing is in good repair, appropriate for the occasion/ situation, chosen by the participant, coordinated and fits properly. Participant appearance to include overall cleanliness, evidence of brushing teeth, nail and hair care, body odor, clothes washed, etc.*	☐ Yes ☐ **No** **Comments:** If No: Document what the participant was wearing that appeared to be problematic and/or the observed personal hygiene needs that are not being met. **Follow-up/Action Needed:** Describe the actions that will be taken to ensure the participant's personal hygiene improves and/or the participant will obtain appropriate clothing.

15. Is clothing available that is appropriate to weather conditions? * ***All Settings:*** *Observe if the participant is dressed appropriate to the weather conditions.*	☐ Yes ☐ **No** **Comments:** <mark>If No: Document what the participant was wearing and why it was not seasonally appropriate.</mark> **Follow-up/Action Needed:** <mark>Describe the actions that will be taken to ensure the participant has access to seasonally appropriate clothing.</mark>
16. Are there any risks affecting the participant's well-being (e.g., unstable housing; risk of abuse, neglect, or exploitation; stress that impedes informal caregiver supports; challenging behavior which may lead to hospitalization or incarceration; physical and mental health risks)? ***All Settings:*** *Based on observation and interview during the monitoring visit, were any risks noted? If risks were reported or observed that are imminent in nature (e.g., abuse, neglect, exploitation, or abandonment) a report should be made to APS and immediate action taken to protect the participant's health and safety.* ***Imminent risk needs to reported in accordance with the Adult Protective Services Act and brought to attention of the SC supervisor immediately.***	☐ **Yes** ☐ No **Comments:** <mark>If Yes: Document the risks and document what action the SC took to address those risks.</mark> **Follow-up/Action Needed:** <mark>Describe what immediate actions will be taken to ensure the safety and well-being of the participant. (consider APS requirements)</mark>

| 17. Was the individual/surrogate advised of the right to be free from abuse, neglect, and exploitation in a location where she or he feels comfortable disclosing concerns AND information was provided as to whom and how to report abuse, neglect and exploitation?

All Settings:
Interview individual, family/caregiver and/or staff (if appropriate), to determine if the individual knows:
   • *Basic definitions and ways to recognize abuse, neglect, exploitation and other incident types*
   • *how to report abuse, neglect, exploitation or other incident types.*

Interview individual, family/caregiver and/or staff (if appropriate) to determine if they have access to printed and other resource materials provided about the right to be free from abuse.

Interview the individual to determine if they have a contact(s) they trust and could report abuse, neglect, exploitation or other abuse. Support the individual to identify a variety of contacts (i.e. paid and unpaid persons, entities, protective service agencies, crisis help-lines etc.).

Did the individual, family and/or designee receive information about what the SC must do when an individual reports abuse, neglect, exploitation etc.?
   • *Tell him/her what you must do*
   • *To whom you must report*
   • *What you are going to report*

Did the individual, family and/or designee receive specific information about what may happen as a result of their disclosure?
   • *Medical exam* | ☐ Yes ☐ No

Comments:
If No: Advise the individual/surrogate of the right to be free from abuse, neglect, and exploitation in a location where she or he feels comfortable disclosing concerns. Provide information as to whom, and how, to report abuse, neglect and exploitation.

Follow-up/Action Needed:
Describe the immediate actions that will be taken to resolve any issues or barriers for the participant's well-being |

• *Meeting with law enforcement* • *Interviews with investigators* • *Meeting with victim's assistance advocates* • *Change in living arrangement (if they desire or due to overwhelmingly unsafe conditions)* • *Change in support staff* • *Change in routines, familiar places/people* *Document the conversation and the contact information, including names and phone numbers. Documentation must clearly indicate that the conversation took place in a location that affords privacy. As part of the monitoring process, SCs should revisit the discussion with the individual to ensure that they continue to feel safe, remember the handout, and have access to it.* *If an individual discloses any allegation, the SC must be prepared to take all necessary actions to ensure that the individual's immediate health and safety needs are being addressed per ODP policy and according to law.* *Reminder: The Right to be Free from Abuse handout needs to be reviewed at a monitoring prior to the participant's ISP meeting.*	
18. Abuse/neglect/exploitation information was discussed/provided (MM/DD/YYYY)	**Comments:** Record date that the SC and individual completed the guidance outlined in Question 17.

Individual Support Plan Status

Question	Answer
1. Are there any barriers to service delivery including provider availability, staffing and transportation? * ***All Settings:*** *Interview the participant, as well as the caregiver and/or support staff, if applicable, to determine if there are service barriers.* *Examples of barriers may include, but are not limited, to:* • *A provider is not available* • *Staff are not available* • *Transportation is not available* • *Lack of willing and qualified providers available*	☐ **Yes** ☐ No **Comments:** If Yes: Include information in detail about what barriers exist. **Follow-up/Action Needed:** • Describe the actions that will be taken to attempt to eliminate the barrier(s).

2a. Is the Individual Support Plan (ISP) readily available to support staff/caregivers? *	2a. ☐ Yes ☐ **No**
b. If yes, is the available ISP current?	2b. ☐ Yes ☐ **No**
Note that question 2b remains hidden unless the response to question 2a is "**Yes**".	
	Comments:
	2a. If No: Describe why the ISP is not available.
All Settings:	
Ask the participant, as well as the caregiver and/or support staff, if applicable, if they have a copy of their most recent approved ISP	2b. If No: Describe why the ISP is not current.
Licensed Settings:	**Follow-up/Action Needed:**
Check that the most recently approved and authorized ISP is at the site where authorized services are being provided.	Describe the actions that will be taken to ensure the current ISP is available to the participant as well as the caregiver and/or support staff.

3a. Have there been any changes in services since the last monitoring? *	3a. ☐ Yes ☐ No
b. If yes, was an ISP Critical Revision completed? Note that question 3b remains hidden unless the response to question 3a is "**Yes**". ***All Settings:*** *Ask the participant, as well as the caregiver and/or support staff, if applicable, if any of the following has occurred since the last monitoring:* • *Any new services started* • *Any services ended* • *Any providers stopped delivering services* • *Any new providers started delivering services* • *Any services increased or decreased in frequency or duration* • *Any other service changes that happened* *Note: All paid or unpaid supporters must be notified of changes to the ISP as well as receive a copy of the approved ISP.*	3b. ☐ Yes ☐ No **Comments:** 3a. If Yes: List the service changes since the last monitoring 3b. If Yes: List the status of the Critical Revision if it has not been approved and authorized. 3b. If No: Explain why a change in service occurred but a Critical Revision was not completed. **Follow-up/Action Needed:** • If there is an issue with the Critical Revision, such as a delay in approval, detail the actions that will occur in order to ensure service delivery is not interrupted. • Describe the actions as well as contacts with providers that will be taken to determine why services have been changed prior to the completion and approval of a Critical Revision.

4a. Was there a reduction or termination of services? b. If yes, was the participant notified of their right to appeal? Note that question 4b remains hidden unless the response to question 4a is "**Yes**". ***All Settings:*** *Discuss with the participant, as well as the caregiver and/or support staff, if applicable, if any services have been reduced or ended. Explain the participant's appeal rights if a participant's services were reduced or terminated and the participant says that they were not offered the right to appeal. The SC should then contact BSASP with this information. BSASP is responsible to offer participants the right to appeal.*	4a. ☐ Yes ☐ No 4b. ☐ Yes ☐ <mark>**No**</mark> **Comments:** 4a. If Yes: Describe what services were reduced and/or terminated and provide the reasons as to why these changes occurred. 4b. If Yes: Document if the participant is appealing the service change or if the participant has chosen to accept the change without appealing. <mark>4b. If No: Document issues expressed by the participant regarding no notification of his/her appeal Rights.</mark> **Follow-up/Action Needed:** <mark>Describe the actions that will be taken to notify BSASP that the participant did not receive appeal rights.</mark>

5. Does the overall level of support reflect what is called for in the approved ISP? ***All Settings:*** *Discuss with the participant, as well as the caregiver and/or support staff, if applicable, the staff support that the participant is receiving each week and compare it to the ISP. Review the individual's ISP, service notes, progress notes, observe and document the type of supervision the individual is receiving. Are supervision needs being met? Is the support provided helping the participant achieve the outcomes in the plan? Have there been any changes that would result in a need to change supervision needs?* ***Licensed Settings:*** *Observe the staffing level and compare it to the staffing level in the ISP that is located in the participant file.*	☐ Yes ☐ **No** **Comments:** If Yes: • List the staffing ratio that the SC has observed, if applicable. • Document the amount of services the participant reports they receive each week. If No: • Document the differences between what was observed and what is listed in the ISP. • Explain the reason why staff support does not match current ISP level **Follow-up/Action Needed:** Describe the actions that will be taken to ensure services are delivered as written in the ISP as it pertains to staff support.

6. Were all services and supports in the participant's approved ISP provided as specified (frequency and duration)? *	☐ Yes ☐ No
All Settings: *Interview the participant, as well as the caregiver and/or support staff, if applicable, to determine when and how often services are being delivered. Compare this information with the documented services and supports in the ISP.*	**Comments:** If Yes: Document what the participant, caregiver and or support staff reported. If No: Document the difference between what the participant, caregiver and or support staff reported versus what is approved and authorized in the ISP. **Follow-up/Action Needed:** Describe the actions that will be taken with the ISP team to address the services and supports not being provided as specified in the ISP.
7. Is there evidence that reflects progress is being made toward the desired outcomes as specified in the ISP? *	☐ Yes ☐ **No**
All Settings: *Discuss with the participant, as well as the caregiver and/or support staff, if applicable, the participant's progress towards goals and objectives.* **Licensed Settings:** *Review progress notes and other documentation within the participant's file to determine the participant's progress towards goals and objectives.*	**Comments:** If Yes: - Document what progress has occurred. - Document the evidence that reflects the progress. If No: - Document the findings regarding lack of progress **Follow-up/Action Needed:** Describe the actions that will be taken with the ISP team to address a lack of progress being made.

8a. Does the participant have more than one service provider? * b. If yes, is there evidence of coordination between them? Note that question 8b remains hidden unless the response to question 8a is "**Yes**". ***All Settings:*** *Interview the participant, as well as the caregiver and/or support staff, if applicable, to determine if the providers are coordinating service delivery as well as communicating well with one another.*	8a. ☐ Yes ☐ No 8b. ☐ Yes ☐ ==**No**== **Comments:** ==8b. If No: Document the evidence that indicates the providers are not coordinating and communicating well with one another.== **Follow-up/Action Needed:** ==Describe the actions that will be taken to ensure improved coordination and communication between providers.==
9. Is there appropriate support staff/participant interaction? * ***All Settings:*** *Ask the participant, as well as the caregiver and/or support staff, if applicable, if they feel comfortable and respected by his/her staff.* ***Licensed Settings:*** *Observe staff and participant communication (both verbal and nonverbal).*	☐ Yes ☐ ==**No**== **Comments:** If Yes: Document the observed support/interaction or what the participant, caregiver and/or support staff report. Indicate if interaction was appropriate. ==If No: Document the observations regarding poor interaction with support staff or what the participant, caregiver and/or support staff report.== **Follow-up/Action Needed:** ==Describe the actions that will be taken to ensure that support staff interact and support the participant appropriately.==

Contingency Plan Status

Question	Answer
1a. Does the participant have a contingency plan for their services? * b. If yes, do the participant and/or representative readily know the contingency plan if services are not provided as scheduled? Note that question 1b remains hidden unless the response to question 1a is "**Yes**". ***All Settings:*** *Ask the participant, as well as the caregiver, if applicable, if they know the contingency plan(s).* *If the participant has a contingency plan(s) but does not know what it is, take the time to explain what the contingency plan(s) means to the participant and/or caregiver and when it should be used.*	1a. ☐ Yes ☐ No 1b. ☐ Yes ☐ <mark>**No**</mark> **Comments:** 1a. If No: Document why the participant does not have a contingency plan. <mark>1b. If No: Document that you have explained the contingency plan(s) to the participant.</mark> **Follow-up/Action Needed:** <mark>Describe the actions that will be taken to obtain a contingency plan(s) for each service and to assure the participant and/or caregiver is aware of how to access the contingency plan.</mark>

2. Has the participant and/or representative had to use a contingency plan since the last review? If yes, how did the contingency plan work?
 	
All Settings:
Ask the participant, as well as the caregiver, if applicable, if the contingency plan was implemented since the last review. If the contingency plan(s) was used, discuss the following:
   • *How the plan(s) worked*
   • *If the plan implemented with ease*
   • *If there were any issues/concerns in implementing the plan as written*
   • *If any changes are needed to the plan*
	☐ **Yes** ☐ No
	
	Comments:
	If Yes: Document under what circumstances the contingency plan(s) was used, which service/provider it pertained to, and if it was effective.
	
	Follow-up/Action Needed:
	Describe the actions that will be taken to address any unresolved issues or changes in the contingency plan(s).

3. Does the provider staff readily know the contingency plan if services cannot be delivered as planned? (i.e. staff person is unavailable) ***All Settings:*** *If present, ask the support staff what the contingency plan is for the particular service delivered by provider agency.*	☐ Yes ☐ **No** **Comments:** If No: Document if the provider did not know the contingency plan as well as if the contingency plan was explained to the support staff. OR Document if the support staff was not present at the monitoring visit. **Follow-up/Action Needed:** Describe the actions that will be taken to ensure all ISP team members are aware of the contingency plan, how to ensure it is properly implemented, and how to prevent future issues related to the support staff's lack of awareness of the contingency plan.

| 4. Has the provider had to use the contingency plan since the last review? If yes, how did the contingency plan work?

All Settings:
If present, ask the support staff if the contingency plan was implemented since the last review. If the contingency plan was used, discuss the following:
   • *How the plan worked*
   • *If the plan implemented with ease*
   • *If there were any issues/concerns in implementing the plan as written*
   • *If any changes are needed to the plan*

Note: All paid or unpaid supporters must be notified of changes to the contingency plan as well as receive an updated ISP. | ☐ **Yes**　☐ No

Comments:
If Yes:
Document whether or not the contingency plan worked well.

OR

If the support staff is not present to report on the use of the contingency plan, document this information.

Follow-up/Action Needed:
Describe the actions that will be taken to ensure the contingency plan works easily and efficiently in the future. |

Behavioral Supports

Question	Answer
1a. Does the participant have a Behavioral Support Plan (BSP)? * b. If yes, is there evidence (through interview with support staff, participant, family; review of data, etc.) that the BSP is effective? Note that question 1b remains hidden unless the response to question 1a is "**Yes**". ***All Settings:*** *Review the ISP to determine if Behavioral Specialist Service is a current service being delivered. Review the Quarterly Summary Reports (QSRs) to determine if progress is being made.* *If BSS is on the plan, ask the participant, as well as the caregiver and/or support staff, if applicable, if it is believed that the BSP is effective in making progress in the participant's goals and objectives.*	1a. ☐ Yes ☐ No 1b. ☐ Yes ☐ **No** **Comments:** 1b. If No: Document what is and is not working in the BSP so that the participant can make progress towards their goals and objectives. **Follow-up/Action Needed:** Describe the actions that will be taken with the ISP team members and the BS service provider to ensure the provider is aware that the BSP is currently not effective to support the participant in making progress towards their goals and objectives.

2a. Is the current BSP readily available to support staff/caregivers? b. If yes, is the available BSP current? Note that question 2b remains hidden unless the response to question 2a is "**Yes**". ***All Settings:*** *The participant is not required to keep a copy of the BSP. If a caregiver and or support staff is available during the monitoring, verify the caregiver and/or support staff should have a current copy of the BSP.* ***Licensed Settings:*** *Ask the support staff to see the most current BSP. The provider is required to have a current copy of the BSP on site in the participant's file.* *Note: All paid or unpaid supporters must be notified of changes to the ISP, including the BSP section, as well as receive an updated ISP.*	2a. ☐ Yes ☐ **No** 2b. ☐ Yes ☐ **No** **Comments:** 2a. If No: Document the reason the BSP is not available the caregiver and/or the support staff, if known. 2b. If No: Document the reason the BSP available to the caregiver and/or support staff does not contain the most recent updates, if known. **Follow-up/Action Needed:** Describe the actions that will be taken to ensure the BSP is available to the caregiver and/or support staff as well as to ensure that it contains the most recent updates to the BSP.

3. Are there any barriers to implementation of the Behavioral Support Plan? ***All Settings:*** *Based on observation and discussion with the participant, as well as the caregiver and/or support staff, if applicable, document any barriers to the implementation of the BSP (e.g., lack of training, lack of staffing/resources, inconsistent implementation, too difficult/challenging to implement).*	☐ **Yes**　☐ No **Comments:** If Yes: Document the barriers to the BSP, providing the specific examples of what was observed or discussed during the monitoring visit. **Follow-up/Action Needed:** Describe the actions that will be taken to eliminate the barriers identified with the ISP team members
4a. Have there been any changes in behavioral related services since the last monitoring? 　b. If yes, was a General Update or Critical Revision completed? Describe changes in the Comments section. ***All Settings:*** *Ask the participant, as well as the caregiver and/or support staff, if applicable, if there have been any changes to behavioral services and if these changes were shared with the team as well as updated in the ISP in the various components impacted by behavioral services. Also ask if an updated ISP was received and reviewed with these updates.* *Licensed Settings: Ask support staff if an updated ISP was placed in the participant file for support staff to review.* *Note: All paid or unpaid supporters must be notified of changes to the ISP as well as receive an updated ISP.*	4a.　☐ Yes　☐ No 4b.　☐ Yes　☐ No **Comments:** 4a. If Yes: Document the changes that have occurred. 4b. If Yes: Document if the changes were made in the ISP as well as the status of the ISP update. 4b. If No: Document the reason, if known, the ISP was not updated. **Follow-up/Action Needed:** Describe the actions that will be taken to ensure any changes related to behavioral services have been updated within the various components of the ISP impacted by these services.

5a. Is there a Crisis Intervention Plan? *	5a. ☐ Yes ☐ No
b. Has the Crisis Intervention Plan been implemented?	5b. ☐ Yes ☐ No
Note that question 5b remains hidden unless the response to question 5a is "**Yes**".	5c. ☐ **Yes** ☐ No
c. If yes, have modifications been made to the BSP? Describe modifications in the Comments section.	**Comments:**
Note that question 5c remains hidden unless the response to question 5b is "**Yes**".	5a. If No: Document the reason why there is no CIP or that the participant does not receive BS services.
	5b. If Yes: Document the results of the CIP implementation
All Settings:	5c. If Yes: Document the changes made to the BSP
If BSS is on the plan, there should be a Crisis Intervention Plan entered in HCSIS. Prior to the monitoring visit, confirm that a CIP is entered.	5c. If No: Document why modifications were not needed to the BSP
Interview the participant, as well as the caregiver and/or support staff, (including the Behavioral Specialist), if applicable, to determine if the CIP has been implemented. If the CIP has been implemented, follow-up to determine if there have been any modifications to the BSP. If yes, determine whether the team was notified and trained on the changes.	**Follow-up/Action Needed:** • Describe the actions that will be taken to ensure the BSP is up-to-date in HCSIS.

6. Were all behavioral related services and supports in the participant's approved ISP provided as specified (frequency and duration)? ***All Settings:*** *Based on observation and interviews with the participant, as well as the caregiver and/or support staff, if applicable, determine if BSS is being provided at the frequency and duration as specified in the ISP. If not, determine what the issues are related to service delivery and whether the under or over utilization of services causes concern.*	☐ Yes ☐ **No** **Comments:** If No: - Document the frequency and duration that BSS is being provided. - Document the issues with service delivery - Document any concerns this may have caused **Follow-up/Action Needed:** - Describe the actions that will be taken to ensure that services are being provided as specified in the ISP, including an update to the ISP if necessary.
7. Is there evidence that reflects progress is being made toward the desired behavioral outcomes as specified in the ISP? ***All Settings:*** *Prior to the monitoring visit, the SC should determine if he/she has received Quarterly Summary Reports (QSR) from the Behavioral Specialist and whether the QSRs note where progress is being made on each of the desired behavioral outcomes.* *Based on observations, QSRs, and interviews with participant, as well as the caregiver and/or support staff, if applicable, document if there is evidence that progress is being made towards the desired behavioral outcomes in the BSP.*	☐ Yes ☐ **No** **Comments:** If Yes: Document the progress that has been made If No: - Document that there has been no progress made and why. - Document if the SC is not receiving QSRs from the BS **Follow-up/Action Needed:** - Describe the follow-up that will be made with the BS regarding the lack of progress or the need for the QSRs to be submitted.

Incident Reports

Questions	Answer
1. Have there been any incidents since the last monitoring that were not reported? * ***All Settings:*** *Ask the participant, as well as the caregiver and/or support staff, if applicable, if there have been any incidents since the last monitoring and give several examples.* ***Licensed Settings:*** *Review provider documentation/notes and look for any incidents that may have occurred. If it is discovered that an incident occurred, discuss it with the staff to ensure an incident was reported/filed and ensure that the appropriate actions were taken to address it.*	☐ **Yes** ☐ No **Comments:** If Yes: Document details of the incidents not reported. **Follow-up/Action Needed:** • Describe the actions that will be taken to report the incident in HCSIS and resolve any ongoing issues with the incident itself.

2. Were all reportable incidents completed, investigated (if required), and corrective action plans implemented? *	☐ Yes ☐ **No** **Comments:** If Yes: List all completed incidents that have been closed since the last monitoring visit. Record the corrective action steps listed in the completed incident report. If No: Document what was not completed, investigated and implemented. **Follow-up/Action Needed:** • Describe the actions that will be taken to follow-up on any incidents that have not been closed.

Employment Information

Questions	Answer
1. Is the individual working in a competitive integrated job? * Y/N? Note: The employment screen is configurable. When the SC first gets to the page questions 1 & 2 are all that is available. For questions 3-6 to populate, questions 1 or 2 must contain a "Yes" response. ***All Settings***: *Interview the participant, as well as the caregiver, if applicable, to determine whether the participant is working in a competitive integrated job.* Competitive integrated employment is defined as earning minimum wage or better, working in a setting where a majority of workers don't have a disability, and having the same benefits and access to advancement opportunities as co-workers without disabilities. The individual is paid directly by the employer and not by the service provider. Employment through the Day Habilitation service or Small Group Employment service is not considered competitive integrated employment. Self-employment is considered competitive integrated employment when the individual's net earnings from self-employment meet the Internal Revenue Service (IRS) requirements for filing taxes. In 2025 this amount is $400 or more. Individuals who earn less than this amount would not be considered to be working in a competitive integrated job.	☐ Yes ☐ No ☐ N/A **Comments:** If Yes: Document the name of the employer(s), whether the participant receives formal employment support, and by whom supports are provided (AAW or OVR). If No: Document whether the participant would like to seek employment in a competitive integrated job and list any barriers to finding such a job. N/A: Is not applicable for AAW participants. **Follow-up/Action Needed:** Describe the actions that will be taken to support the participant in finding competitive integrated employment, if the participant so chooses.

2. Is the individual self-employed? * Y/N	☐ Yes ☐ No ☐ N/A
Note: The employment screen is configurable. When the SC first gets to the page questions 1 & 2 are all that is available. For questions 3-6 to populate, questions 1 or 2 must contain a "Yes" response.	**Comments**: If Yes: Document the name of the participant's business or describe the type of business. Document whether the participant receives formal employment support and by whom supports are provided if not documented in question 1.
All Settings: *Interview the participant, as well as the caregiver, if applicable, to determine if the participant is self-employed. To be considered "self-employed" an individual cannot be employed by government, by a private company, or by a nonprofit organization.*	If No: Indicate whether the participant would like to be self-employed. N/A: is not applicable for AAW participants.
Self-employed is defined as earning income directly from one's own business, trade, or profession rather than as a specified salary or wages from an employer. This question should be answered yes regardless of the amount of income earned through self-employment. The earnings requirement in Question 1 only applies in determining whether self-employment meets the standard of competitive integrated employment.	**Follow-up/Action Needed**: Describe the actions that will be taken to support the participant in becoming self-employed, if the participant so chooses.

3. How many jobs is the individual working that meet the definition of competitive integrated employment?

All Settings:

Interview the participant, as well as the caregiver, to determine if the individual has more than one job. If the individual is working more than one job, please verify that all jobs meet the definition of competitive integrated employment.

Competitive integrated employment is defined as earning minimum wage or better, working in a setting where a majority of workers don't have a disability, and having the same benefits and access to advancement opportunities as co-workers without disabilities. The individual is paid directly by the employer and not by the service provider. Employment though Day Habilitation service or Small Group Employment service is not considered competitive integrated employment. Self-employment is considered competitive integrated employment when the individual's net earnings from self-employment meet the Internal Revenue Service (IRS) requirements for filing taxes. In 2025 this amount is $400 or more. Individuals who earn less than this amount would not be considered to be working in a competitive integrated job.

Example: If an individual is working 5 hours per week at Giant Food Stores as a stock clerk and 5 hours per week as a window washer in a mobile work crew, the answer would be one (1) because small group employment in a mobile work crew is not competitive integrated employment.

☐ 1   ☐ 2   ☐ 3   ☐ 4

Comments:

Document whether the participant is working full time or part time at each job. If the participant does work more than one job, include whether the participant would like to seek employment at one job with increased hours. List any barriers to finding such a job.

Follow-up/Action Needed:

- Review the Employment/Volunteer Information screen in the ISP to ensure it is up-to-date. Complete a General Update, if necessary.
- Describe the actions that will be taken to support the participant in seeking one job with increased hours, if the participant so chooses.

4. Estimated average hours worked in competitive integrated employment per work week
 	
All Settings:
Interview the participant, as well as the caregiver, to determine the number of hours worked. Document the weekly hours worked in competitive integrated employment.
 	
Questions you can ask to help answer this question:
    • *Are the hours usually consistent?*
    • *Is there a situation where there would be a significant change in the number of hours worked?*
	☐ 1-10
	☐ 11-20
	☐ 21-35
	☐ Over 35
	☐ Unknown
	
	Comments:
	Document whether the participant is satisfied with the number of hours that he or she is currently working.
	
	Follow-up/Action Needed:
	Describe the actions that will be taken to support the participant in increasing or decreasing work hours if the participant so chooses.

5. Job Type

All Settings:
Interview the participant, as well as the caregiver, if applicable, to determine what type of job the individual works. Select the job type that most closely matches the options below.

From the dropdown list, only select a job type for the individual's job that meets the definition of competitive integrated employment. If needed, please use the link for ONET job descriptions for guidance in selecting the most appropriate job type: https://www.onetonline.org/find/family

☐ Architecture and Engineering
☐ Arts, Design, Entertainment, Sports, and Media
☐ Building and Grounds Cleaning and Maintenance
☐ Business and Financial Operations
☐ Community and Social Service
☐ Computer and Mathematical
☐ Construction and Extraction
☐ Education, Training, and Library
☐ Farming, Fishing, and Forestry
☐ Food Preparation and Serving Related
☐ Healthcare Practitioners and Technical

☐ Healthcare Support
☐ Installation, Maintenance, and Repair
☐ Legal
☐ Life, Physical, and Social Science
☐ Management
☐ Military Specific
☐ Office and Administrative Support
☐ Personal Care and Service
☐ Production
☐ Protective Service
☐ Sales and Related
☐ Transportation and Material Moving

Comments:

Include more detailed information as to how the participant's job type fits into each category. For example, if "Building and Grounds Cleaning and Maintenance" is selected, the comments box could explain that the participant works as a landscaper.

Document whether the participant is satisfied working in this field.

Follow-up/Action Needed:
Describe the actions that will be taken to support the participant in exploring other fields of work if the participant so chooses.

6. Does the individual receive paid benefits?
 	
All Settings:
Interview the participant, as well as the caregiver, if applicable, to determine if the individual receives at least one or any combination or paid sick time, paid vacation time, paid health/life insurance, or other paid benefits by the employer
   • *Does the individual get time off that is paid?*
   • *Does the individual have health or life insurance for which they do not pay?*
	☐ Yes ☐ No ☐ Unknown
	
	Comments:
	If Yes: Provide a high-level overview If the individual pays a supplemental fee for health care benefits
	
	If No: Document if the individual pays the entire amount of benefits out of pocket or does not receive employer paid benefits
	
	If Unknown:
	
	Follow-up/Action Needed:
	Describe the actions that will be taken to support the participant in seeking employment that provides paid benefits, if the participant so chooses. Follow-up with team on if the individual receives paid benefits if that is unknown.

Participant Satisfaction

Questions	Answer
1. Does the individual feel that the services/supports they receive are all that they need? * **All Settings:** *Interview the participant, as well as the caregiver, if applicable, to determine If they are satisfied with the services, with the way the services are delivered, and with the provider/staff.* *Remind the participant of their right to change their services/supports at any time.*	☐ Yes ☐ **No** **Comments:** If No: Document what needs the participant feels are not being met. **Follow-up/Action Needed:** • Describe the actions that will be taken to ensure that the services/supports meet the needs of the participant.

2. Does the individual feel that they have the needed support by others in decision-making, planning and other activities? ***All Settings:*** *Interview the individual, family/caregiver and/or staff with an emphasis on whether the individual is supported in planning and decision-making. For example, if an individual likes bowling, the SC could ask whether the individual gets to choose when they go bowling, what bowling alley they prefer, and who they go bowling with.* *Remind the participant of their right to change their services/supports at any time*	☐ Yes ☐ **No** **Comments:** If Yes: Document what the participant reported If No: • ==Document what the participant reported== • ==Document that the SC has explained to the participant the opportunity to change their services/supports at any time.== If Yes: Document the options that were explored. ==If No: Document the reason other options have not been explored.== **Follow-up/Action Needed:** • ==Describe the actions that will be taken to increase participant satisfaction with services including changing providers if the participant so desires.==

3. Does the individual receive support to engage in meaningful relationships with friends and family? ***All Settings:*** *Interview the individual, Family/caregiver and/or staff beginning with questions about whether they would like to see friends and family more frequently. The individual's response will dictate follow-up questions. For example, if an individual says he would like to see his sister more often, the SC may ask "what happens when you tell staff that you would like to see your sister more often?"*	☐ Yes ☐ **No** **Comments:** If No: Document what needs the participant feels are not being met. **Follow-up/Action Needed:** • Describe the actions that will be taken to ensure that the services/supports meet the needs of the participant.
4. Are the individual's communications needs being met? ***All Settings:*** *Interview the individual, family/caregiver and/or staff to determine how the individual communicates expressively. Nonverbal is not an acceptable response. Is the individual's expressive communication her/his preferred mode of communication? Do others communicate with the individual in her/his preferred mode of communicate? Do team members understand what she/he is expressing?*	☐ Yes ☐ **No** **Comments:** If No: Document what needs the participant feels are not being met. **Follow-up/Action Needed:** • Describe the actions that will be taken to ensure that the services/supports meet the needs of the participant.

5. Does the Individual know how to report a concern or complaint? *	☐ Yes ☐ **No**
All Settings: *Interview the individual, family/caregiver, and/or staff to determine if the individual knows how to report a complaint, grievance or dissatisfaction. Does the individual want or need an advocate? Is the individual and/or family/caregiver aware of the SCOs and/or Provider's grievance policy and procedures? Is there someone who looks out for the best interest of the individual?* *Is the individual, family/caregiver or staff aware of how to bring forth a complaint or grievance about a service? Do they need support to bring forth a complaint/grievance? Has a complaint/grievance been submitted since the last monitoring that has not been resolved?* *• If yes, what support does the individual, family/caregiver and/or staff need for follow-up?* *• If no, was the resolution satisfactory to the individual, family/caregiver and/or staff? What support does the individual, family/caregiver and/or staff need for follow-up?* *Providers, SCO's and County ID programs/AEs must have policy and procedure in order to be able to receive, document and manage complaints/grievances*	**Comments:** <mark>If No: Document what was reported by the participant and/or caregiver.</mark> **Follow-up/Action Needed:** <mark>Describe the actions that were taken during the monitoring visit to explain the participant's right to file a complaint and how to do so.</mark>

Medication Log

This screen allows the user to capture information about all of the medications the participant is currently taking. The medication information entered on this screen does not automatically update in the participant's plan. If the participant's medications have changed, the plan must be updated via a General Update in HCSIS to match the information gathered during the SC Monitoring. Medications can be entered on this screen by clicking the first letter of the medication. If the medication does not exist under the letter's menu, click "Other" and manually enter the name of the medication. Click [Save] to enter another medication.

Medication Name: *	Diagnosis: *
Total Daily Dosage:	Blood Levels Available: * ☐ Yes ☐ No ☐ N/A
Desired Effect: *	Comments:

Medication Name: *	Diagnosis: *
Total Daily Dosage:	Blood Levels Available: * ☐ Yes ☐ No ☐ N/A
Desired Effect: *	Comments:

Medication Name: *	Diagnosis: *
Total Daily Dosage:	Blood Levels Available: * ☐ Yes ☐ No ☐ N/A
Desired Effect: *	Comments:

Medication Name: *	Diagnosis: *
Total Daily Dosage:	Blood Levels Available: * ☐ Yes ☐ No ☐ N/A
Desired Effect: *	Comments:

Medication Name: *	Diagnosis: *

Total Daily Dosage:	Blood Levels Available: * ☐ Yes ☐ No ☐ N/A
Desired Effect: *	Comments:

Medication Name: *	Diagnosis: *
Total Daily Dosage:	Blood Levels Available: * ☐ Yes ☐ No ☐ N/A
Desired Effect: *	Comments: