

HEALTH & WELFARE REVIEW & MONITORING TOOL

RECIPIENT'S NAME: _____ **DATE**
: _____

RECIPIENT'S MEDICAID ID: _____

ADDRESS LOCATION: _____

DOB: _____ **PHONE:** _____

NAME OF SERVICE AGENCY _____

NAMES OF PERSONS PARTICIPATING IN REVIEW: **Richard Clinch, RN CHC DSDS Quality Assurance**

GUARDIAN _____

DEVELOPMENTAL _____

DISABILITY NURSE: _____

CARE COORDINATOR: _____

REVIEW & HEALTH UPDATE:

Provide a description of the recipient's general appearance, level of orientation and affect. Review the recipient assessment with Recipient or Legal Representative. Is assessment and Level of Care consistent with Recipient at this visit?

Have there been any significant changes (improvement or deterioration) in the Recipient's physical or hands on care needs?

Current Height: _____ Current Weight: _____ Ideal Weight Range: _____

Have there been any hospitalizations since the last review? If so, how long was the Recipient hospitalized?

What is your hospital of choice? What clinic to you use?

Are there any projected hospitalizations? If so, of what duration?

Who are the Recipient's current health care professionals?

Primary Physicians: _____ Phone #: _____
 Other Physicians: _____ Phone #: _____
 Nutritionist: _____ Phone #: _____
 Audiologist: _____ Phone #: _____
 Ophthalmologist: _____ Phone #: _____
 Dentist: _____ Phone #: _____
 Other: _____ Phone #: _____

Therapies:

PT: _____
 (Name) (Location) (Phone) (Frequency)
 OT: _____
 (Name) (Location) (Phone) (Frequency)
 ST: _____
 (Name) (Location) (Phone) (Frequency)

Who are the Recipient's current agency and community service providers?

Date Time	Notes
	Current status: (document any changes in condition or medications.)
SERVICES PROVIDED	<i>Comments</i>
Chore Services	
Respite Services	
Adult Day Care	
Assisted Living Services	
Spec. Pvt Duty Nursing Svs	
Transportation Services	
Meal Services	
Special Equipment/Supplies	
Physician Visits	
PCA Services	
Hosp. Since last visit?	
Other:	

What is the status of the current care provision?

Is the recipient satisfied with services provided? YES NO

If no describe deficiency:

Are medications provided according to acceptable standards? YES NO If no describe.

Who is your current medical vendor?

Are there any changes in equipment needs?

Reviewer's comments:

SAFETY:

Has the EMS and Utility information been updated and verified?

Is there a safety checklist and when was it last reviewed?

Is the residence clean and sanitary? If questionable provide a verbal discretion of the residence. Photograph residence?

Are there corrective actions needed, if corrective actions are needed, who will do this and when can it be completed? (Please list)

Corrective actions: _____

Person Responsible: _____

Due dates: _____

If there is equipment has the vendor reviewed and serviced the equipment?

Does the Recipient have an appropriate car seat/ wheelchair with tie downs?

Reviewer's comments:

TRAINING:

Has the training checklist been updated and completed?

Are providers trained?

Has the medical vendor completed their training checklist?

Is there a copy of the medical vendor's training on file?

Has training been provided via a variety of methods or at least the method of the family's choice? (e.g. Audiovisual aids, tapes, videos)

Does the recipient, recipient's representative and agency have extra copies of the training checklist and manuals for training new providers?

Reviewer's comments:

SERVICES:

Are services identified in the plan of care provided? YES NO

If no describe deficiency:

Who is your care coordinator and how do you contact that person if you need their help? If unable to answer does caregiver know? If not, why not? (Explain)

How many in home support providers has the recipient had since the last year?

Do you like the people who are giving you care?

Are you satisfied with your living conditions? If not what would you want improved?

Does anyone ever do mean things to you, such as yell at you? YES NO If yes who yells at you? What would you want us to do about that?

Does anyone ever hit you or hurt your body? YES NO Who has hit or hurt you?

What natural and/or community supports does the recipient have?

Are there any non-funded, outstanding needs?

Reviewer's comments:

REVIEWER'S RECOMMENDATIONS/FOLLOW-UP SHEET	RESPONSIBLE PARTY	PROJECTED COMPLETED DATE	COMPLETION

SIGNATURE OF REVIEWERS: _____

GUARDIAN SURVEY W/SASE GIVEN TO FAMILY:

AGENCY SURVEY W/SASE GIVEN TO AGENCY REPRESENTATIVE:

NARRATIVE

Name: _____ **Date:** _____