

LCBMRDD Family and Community Support Service Monitoring

Individual's Name _____ ISP Consent Given/Date: _____

Service Provider _____ SASS _____ Span _____

Monitoring Location _____

		Date		Date		Date	
ISP	Is there a current ISP in the service site, or does staff have a current copy?	Yes	No	Yes	No	Yes	No
	Does the doc sheet in the service site match the ISP?	Yes	No	Yes	No	Yes	No
	Are skill development plans written?	Yes	No	Yes	No	Yes	No
	Do skill developments in the service site match the ISP?	Yes	No	Yes	No	Yes	No
BSP	Does the person have a behavior support plan?	Yes	No	Yes	No	Yes	No
	• <i>If yes, is there a copy of the BSP in the service site?</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
	• <i>Is there documentation that staff implementing BSP has been trained?</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
Safety	Are smoke detectors present in the home and functioning?	Yes	No	Yes	No	Yes	No
	Is the environment free of hazards?	Yes	No	Yes	No	Yes	No
Money management	Does a paid provider assist with money management/benefit management	Yes	No	Yes	No	Yes	No
	Is the Personal Finance Checklist available and up to date?	Yes	No	Yes	No	Yes	No
	• Are bills paid on time?			Yes	No	Yes	No
	• Is checkbook/account balanced?			Yes	No	Yes	No
	• Is checkbook/account reconciled monthly?			Yes	No	Yes	No
	• Do receipts/expenses appear appropriate?			Yes	No	Yes	No
	• Budget for household expenses?			Yes	No	Yes	No
	• Are benefit letters present and available?			Yes	No	Yes	No
	• Assets below \$1500?			Yes	No	Yes	No
	• Does individual have an "account" at day program site?			Yes	No	Yes	No
	• <i>Is that account balanced?</i>			<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
	• <i>Do receipts/expenses appear appropriate?</i>			<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
• <i>What is the amount in the account?</i>			<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	

Health	Are current medical consultation sheets available? Are current ISP services meeting medical needs? Was any specific follow up identified in the ISP? • <i>If yes, have consultations/ follow up been completed?</i>	Is MAR present? Yes No	Yes	No	Yes	No
	Does this person take medications? • If yes, does the provider administer meds? ○ <i>If yes, does MAR correspond to meds present in the home?</i> ○ <i>Is the person getting the medication as prescribed?</i>		Yes	No	Yes	No
	Does this person have special dietary or nutritional needs? • If yes, are current needs consistent with the ISP? • If yes, have special needs been communicated to all service locations?		Yes	No	Yes	No
			Yes	No	Yes	No
Outcome of visit: _____	Notes or comments Was corrective action requested? Yes No Date: Who was contacted: Action requested including timelines:		SSS Follow up Date: Satisfactory outcome? Yes No If no, forward copy of this form to Coordinator for review. Date sent to Coordinator: SSS initials:			
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