Developmental Services

Support Coordination

Monitoring Checklist

Provider Number: _____

Provider Name: _____ Review Date: _____

Provider Address: _____ Reviewer Name: _____

_____ District: _____

_____ Location: _____

☐ Agency Provider ☐ Solo Provider ☐ Onsite Review ☐ Desk

Cite		Met	Not Met	N/A
Explanation of Monitoring Tool Symbols/Codes 🔔 Alert: Denotes a critical standard or cite relating to health, safety and rights. A deficiency requires a more intense corrective action and follow-up cycle. **"W"** Weighted Element: A "W" followed by 2.0 or 4.0 in the Cite column denotes elements that have a greater impact on the monitoring score. **"R"** Recoupment: An "R" in the Cite column denotes an element that is subject to recoupment of funds by the State if the element is "Not Met."				
Standard: The Support Coordinator assists the individual in determining his or her personal goals and future needs through comprehensive Support Planning activities.				
The Support Coordinator:				
1 W2.0	Assists individuals with determining desired outcomes and supports needed using the Personal Outcome Measures (POM) and other techniques (e.g. person centered planning) during each support plan year.			
2	Assists individuals to identify needs using the assessment instrument approved by the APD prior to the development of the support plan.			
3 W2.0	Assists individuals to make decisions and informed choices as indicated by the person's situation throughout the support plan year.			
4 W2.0	Develops the support and cost plan to reflect the individual's desired personal outcomes and individual needs.			
5	Reviews with individuals, at least annually at the time of support plan development, available options for services and supports, (includes both paid and unpaid service options).			

Cite		Met	Not Met	N/A
6	Annually completes a report of progress for individuals as specified in APD policy.			
7 W2.0	Assists individuals to meet goals and outcomes through linkages with natural and generic supports.			
8	When natural and generic supports are not available, assist the individual in locating services available through local, state or federal sources, including Medicaid and the DS Medicaid waiver.			
9	Reviews with service vendors the goals to be achieved for the individual and notes these discussions in progress notes.			
10	Takes actions necessary to coordinate the continuity of supports and services among providers, family and others to achieve the goals and outcomes of the person.			
11	Documents all support coordination services, activities and contacts in clear and adequate progress notes.			
Standard: The Support Coordinator assists the individual to achieve personal goals and outcomes. (New 2003)				
12 W2.0	Has taken action on the results and recommendations reported through the person-centered review process. *Note: If there have been no person-centered reviews, score this element Not Applicable.*			
Standard: Support and Cost Planning information is submitted to the district and shared with the individual and other stakeholders within appropriate timeframes.				
13	Support and cost plans are provided to the individual or their guardian within 10 calendar days of the effective date, and at any time they are requested.			
14	Cost plans are signed by the individual or guardian.			
15	Copies of the support and cost plans are submitted to the Area Office no later than 20 calendar days prior to the effective date. Cost plans, amendments or addendums meeting exceptional cost review guidelines must be submitted to the Area Office within 90 calendar days prior to the effective date.			

Cite		Met	Not Met	N/A
16 W2.0	Service authorizations that accurately reflect the Area Office's approved service level on the cost plan, as well as copies of pertinent support plan information is given to other providers of services to authorize and initiate service delivery within ten calendar days of the effective date of the support plan.			
Standard: The Support Coordinator advocates for the individual and assists the individual to increase or maintain the capacity to direct formal and informal resources.				
The Support Coordinator:				
17 W2.0	Assists the individual in evaluating whether the purchased services meet the individual's expectations.			
18	Assists the individual in determining whether services are age and culturally appropriate.			
19 W2.0	Assists the individual in determining whether services address the desired goal(s) and/or need for which they are intended.			
20 W2.0	Assists the individual in determining whether services provide appropriate challenges, motivation and experiences to meet the individual's goals and expectations.			
21 W2.0	Reviews with individuals available options for places to live.			
22 W2.0	Reviews and assists individuals in ADTs with information and/or referral to rehabilitation, vocational habilitation, and other employment services and employment opportunities available in their community.			
23 W2.0	Provides service counseling for individuals currently in sheltered workshops or segregated work environments to apprise them of the options available to them for meaningful work activities and training.			
24	Discusses with the individual their concerns related to dissatisfaction, quality of service delivery, health and safety, or other issues in order to resolve differences.			
25 NEW	Provides information to recipients on residential options available to them including owning or renting their own home, with supports.			

Cite		Met	Not Met	N/A
26 W2.0	Discusses with providers concerns relating to individual dissatisfaction, the quality of service delivery, individual health and safety, or other issues in order to resolve differences, including recommendations and results from person-centered reviews.			
27 W2.0	Follows-up to provide closure on issues and resolution of problems or situations.			
28	Initiates contact with the Area Office to request assistance in resolving concerns that cannot be resolved through discussion or the normal grievance process.			
Standard: Changes in the individual's service and support needs are dealt with appropriately and timely by the Support Coordinator.				
29	Progress notes include sufficient information concerning any changes in an individual's service and support needs that require an update to the cost plan.			
30	Cost plan updates are initiated when support coordinators become aware of the need for change.			
31 W2.0	Service authorizations and adequate information concerning the individuals' goals and needs are sent to providers, as appropriate to the cost plan change, within 5 working days of receipt of Area Office approval.			
Standard: The Support Coordinator assists the individual to build linkages to natural and generic supports and, when necessary, appropriate paid services.				
The Support Coordinator:				
32	Recruits and locates potential service vendors who are acceptable to the individual, are qualified to meet the individual's needs in the most cost-efficient manner possible, and assists them with waiver enrollment procedures.			
33 W2.0	Notifies other paid service providers when it is determined that an individual receiving services is no longer Medicaid eligible.			
34	Works with providers and Area Office to plan for possible continuation of services and funding options when an individual's eligibility is in jeopardy.			

Cite		Met	Not Met	N/A
35	Assures that purchased supports and services are not billed in excess of the annual limits of current approved cost plan(s) for individuals.			
For individuals residing in supported living arrangements or licensed residential facilities who are taking any psychiatric or anti-epileptic medications review cites 35-39. Refer to Medication Review Criteria.				
Standard: The Support Coordinator assures that individuals will be free of risks associated with prescribed medication.				
36 W2.0	Provider assures a comprehensive psychiatric (for psychiatric medication) review is completed annually by a licensed psychiatrist/neurologist or an A.R.N.P., who acts pursuant to a protocol with the psychiatrist/neurologist.			
37 W2.0	Provider assures a medication review by a Licensed Consultant Pharmacist is conducted at least annually when individual is on two or more medications or meets the criteria for medication review as defined in the handbook.			
38	Provider assures the individual receives follow-up reviews by the psychiatrist, neurologist or A.R.N.P. at a frequency established by these practitioners.			
39	Provider works with Area Office Health Care coordinators to obtain documentation from psychiatric or neurological practitioners if frequency of the follow up review is less frequent than every 90 days.			
40	Provider maintains documentation of medical practitioner rationale regarding frequency of follow-up visits in the individual's central record.			
Standard: The Support Coordinator assures that information relating to the individual is current, correct and transferred appropriately to other providers.				
41 R W2.0	Providers enter, update and assure the accuracy of information pertinent to the individual in the ABC system, including demographic information.			
42	Provider assures that all appropriate central record information is transferred to new vendors or to the Area Office, within two weeks of the effective date of actions such as new vendor selection by the individual or termination of support coordination services.			
Standard: The Support Coordinator is fully qualified and trained to provide support coordination services.				

Cite		Met	Not Met	N/A
43 W4.0	Level two background screenings are complete for all direct service employees.			
44 W4.0	All employees undergo background screening every 5 years.			
45	All solo and agency waiver support coordinators (WSCs), directors, managers and supervisors have a Bachelor's degree from an accredited college or university.			
46	All solo WSCs and agency supervisors, directors and managers have three years of professional experience in developmental disabilities, special education, mental health, counseling, guidance, social work or health and rehabilitative services (a master's degree can substitute for one year of experience).			
47	All agency WSCs have two years of professional experience in developmental disabilities, special education, mental health, counseling, guidance, social work or health and rehabilitative services (a master's degree can substitute for one year of experience).			
48	All solo and agency WSCs, directors, managers and supervisors have a minimum of 34 hours of statewide pre-service training.			
49	All solo and agency WSCs, directors, managers and supervisors have a minimum of 26 hours of district-specific pre-service training within 90 days of completion of statewide pre-service training.			
50 NEW	All support coordinators have district training and certification in the proper administration of the department approved assessment tool for ascertaining the recipient's level of need within 90 days of completion of statewide pre-service training. The provider must re-certify every two years.			
51 W2.0	All solo and agency WSCs have Personal Outcome Measures training conducted by the department or a department certified trainer within 90 days of receiving Area Office certification.			

Cite		Met	Not Met	N/A
52 W2.0	All solo and agency WSCs who have not completed Personal Outcome Measures training have a trained waiver support coordinator in attendance when using the Personal Outcome Measures as part of the initial and annual support planning process.			
53	All solo and agency WSCs, agency supervisors, directors and managers attend 24 hours of job-related in-service training annually.			
54	The provider attends mandatory meetings and training scheduled by the Area Office and/or Department.			
55 NEW	The provider and/or agency staff has received training in the Agency's Direct Care Core Competencies Training.			
56	The provider and each of its employees receive training on responsibilities and procedures for maintaining health, safety and well-being of individuals served.			
57	The provider and each of its employees receive training on required documentation for service(s) rendered.			
58	The provider and each of its employees receive training on responsibilities under the Core Assurances.			
59	The provider and each of its employees receive training on responsibilities under the requirements of specific services offered.			
60	The provider and each of its employees receive other training specific to the needs or characteristics of the individual as required to successfully provide services and supports.			
61	Proof of required training in recognition of abuse and neglect and the required reporting procedures, to include domestic violence and sexual assault, is available for all independent vendors and agency staff.			
62	Agency trainers attend a train-the-trainer session conducted by the Department and mandatory refresher courses as required by the Department.			
63	Agency trainers and the agency training plan are approved by the Area Office prior to training of staff.			

Cite		Met	Not Met	N/A
Standard: Support Coordinators maintain caseloads within established limits.				
64	Waiver support coordinators maintain a caseload of no more than 36 individuals.			
65 R	When a vacancy occurs the provider may exceed the 36 maximum caseload size for 60 days for each vacancy.			
66 R	Provider must notify the Area Office of any vacancies or leaves of absence within 5 days of the vacancy.			
67	Provider accepts all individuals who select them for support coordination services or are referred to them within the geographic boundaries previously approved by the Area Office.			
68	Provider expansion or downsizing has been accomplished in a manner that prevents, as much as possible, a negative impact on the individuals served.			
Standard: The support coordinator is accessible to the individual and is available to perform required and needed supports.				
69 W2.0	Provider has an on-call system in place that allows individuals to access support coordination services 24 hours per day, 7 days per week. Access to the provider or back-up are available without toll charges to the individual.			
70	Back-up waiver support coordinators are certified and enrolled waiver support coordinators.			
71	Name(s) and contact information for back-up waiver support coordinators are clearly communicated to the individual and to the Area Office.			
72	Contacts with individuals in community settings are planned in advance of the visit and not incidental.			
73 W2.0	Contacts with individuals are scheduled based on the individual's choice and are at a time and in a location convenient to the individual receiving services.			

Cite		Met	Not Met	N/A
Standard: The support coordinator provides the amount and type of contact and supports needed to meet the individual's goals and needs as evidenced by progress notes and other information.				
The individual's central record contains:				
74	The individual's current support planning information including Personal Outcome Measures information and notes.			
75	The individual's current support planning information including the assessment instrument approved by the Department, and any other assessment information used in planning.			
76	The individual's current support planning information including the current Waiver Eligibility Worksheet.			
77 R	The individual's current support planning information including the **current support plan.**			
78 R	The individual's current support planning information including the **current approved cost plan.**			
79	The individual's current support planning information including progress notes.			
80 R	One face-to-face contact with the individual, at a frequency based on living situation of the individual, related to or accomplishing one or more of the following: ❑ Assisting individual to reach goals of support plan, including gathering information to identify outcomes ❑ Monitoring health and well-being of the individual ❑ Obtaining, developing and/or maintaining resources needed or requested by the individual, including natural supports, generic community supports and other types of resources ❑ Increasing the individual's involvement in the community ❑ Promoting advocacy or informed choice for the individual ❑ Following up on the individual's or family's concerns			

Cite		Met	Not Met	N/A
81 R	Progress notes reflect results of face-to-face visits in the place of residence every three months for individuals residing in supported living, licensed facilities or in his or her own home.			
82 R	Progress notes reflect results of face-to-face visits in the place of residence at six-month intervals or more frequently if requested by the family, for individuals living with his or her family.			
83 R	Progress notes reflect at least one other contact/activity (non-incidental and non-administrative) per month related to the individual if a face-to-face contact was made. If no face-to-face contact occurred for the month, at least one other contact/activity (non-incidental and non-administrative) per month related to the individual should be reflected in the progress notes.			
84	Central records contain copies of annual or professional reports and individual implementation plans submitted by other providers as required and appropriate to each service.			
85 W2.0	Central records contain current and correct demographic information, including current health and medical information and emergency contacts.			
86	Central records or provider records contain results of annual satisfaction surveys.			
87	Central records or provider records contain performance data on the Projected Service Outcomes.			
88	Central records contain documentation through progress notes of all other support coordination services, activities or contacts that assisted individuals to: ❑ Meet their support plan outcomes/personal goals ❑ Become more integrated into their communities and/or ❑ Address individual's or family's concerns.			

Cite		Met	Not Met	N/A
89 NEW	The WSC shall provide a copy of the notice of privacy practices required by HIPAA regulations to the individual or legal guardian upon initial contact and at any time there is a significant change that necessitates the protection of a recipient's healthcare information.			
90 NEW	If the provider transports the recipient in his private vehicle, the provider has proof of valid driver's license, car registration, and insurance.			
For individuals receiving supported living coaching, complete elements 90 – 93. Score these elements as Not Applicable if no individual in the sample receives this service.				
91 W2.0	Progress notes reflect results of quarterly meetings with individuals and supported living coaches for individuals receiving supported living coaching services			
92	Progress notes reflect review of supported living services to determine that they are meeting the individual's needs.			
93 W2.0	Progress notes indicate a review of the individual's health, safety and well-being and an updated housing survey.			
94 W2.0	Progress notes support a review of the individual's fiscal status to include a review of the individual's bank statement and other financial information if the supported living coach is acting as fiscal agent.			
Standard: The support coordinator meets projected outcomes for service delivery.				
95	The provider has established a systematic method of data collection to measure success on projected service outcomes.			
96	There is evidence that projected service outcome data are reviewed periodically and that corrective measures are put in place if the data indicates the service outcomes are not being achieved.			
97 W2.0	Individuals receiving support coordination services have freedom of choice in all areas of their lives, including setting personal goals, being fully informed about service options and making all possible decisions with regard to the conduct of their lives.			

Cite		Met	Not Met	N/A
98 W2.0	Individuals receiving services demonstrate an increase in abilities, self-sufficiency and changes in their lives consistent with their support plan.			
99 W2.0	All Individuals served who have responded to an annual satisfaction survey are satisfied with their support coordination services based on the results. or the provider has addressed any concerns raised during the survey.			
100 NEW	There is evidence that the provider advocates for the individual on an on going basis to achieve a personally identified goal.			
NOTE: Score the following elements only when determined appropriate. This service is only for those individuals moving from institutional settings and is billed as transitional support coordination at a higher monthly rate. ***Score these elements as Not Applicable when this service has not been provided during the review period.***				
Standard: The Support Coordinator assists the individual to successfully transition from an institutional setting to community services, safeguarding the individual's health, safety and support needs.				
The Support Coordinator:				
101	Works with the individual to arrange for the provision of community-based services and supports upon discharge (waiver and other).			
102	Works with the institutional provider and staff and coordinating their activities with facility's discharge planning process.			
103	Develops an initial support plan to assist the individual in adjusting to their new living environment, based on the person's goals and needs and current assessments (including the facility's summary of the individual's developmental, behavioral, social, health and nutritional status and post-discharge plan).			
104	Assures community supports and services are in place at the time of discharge, and reflect the individual's desired goals and identified needs.			
105 R	Maintains at a minimum weekly face-to-face contact with the individual for the first 30 days following discharge to ensure community supports and services meet the individual's needs.			
106	Updates the support plan at the end of the 30-day period from discharge, identifying progress made with transition to community-based living and changes to supports and services as appropriate.			

Support Coordination Checklist 2-16-06.doc

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