Support Coordinator Monitoring Tool

Identifying Information		
Individual Name: Click here to enter text.	DDD ID: Click here to enter text.	Date of Contact: Click here to enter a date.
Support Coordinator: Click here to enter text.	Support Coordination Agency: Click here to enter text.	Individual's Contact #: Click here to enter text.
Name/Relationship of Person Providing Information to Support Coordinator: Click here to enter text.	Contact Period: Choose an item. Contact Method: Choose an item. Contact Location: Choose an item. If other, please specify: Click here to enter text.	Date of Approved Plan: Click here to enter a date. Reporting Period: Click here to enter text.

Please complete all of the following sections based on your observations/conversations. Please include in your comments the type of service you are commenting about, including but not limited to employment, day, transportation, individuals supports, etc.

Outstanding Issues/Outcomes of Corrective Actions

- **Were there any outstanding issues from the last point of contact?** Choose an item.
- **Provide an update of the status of the issue and progression of corrective action:** Click here to enter text.

Medicaid Eligibility Status

- **Is your Medicaid/waiver eligibility still maintained (Redetermination)?** Choose an item.
- **Describe corrective actions to be taken:** Click here to enter text.

Budget & Assessment

- **Are you continuing to operate within your budget?** Choose an item.
- **Describe corrective actions to be taken:** Click here to enter text.
- **Has there been any change that warrants a reassessment of need?** Choose an item.
- **Please describe:** Click here to enter text.

Service Plan (Review all services indicated on the ISP)

Needs:

- **Are all of your assessed needs being met through the current service plan?** Choose an item.
- **Do the services in the plan continue to meet your needs?** Choose an item.
- **Describe any issues and the corrective action(s) including any modifications that need to be made to the service plan:** Click here to enter text.

Services:

- **Are the services being delivered in accordance with the service plan?** Choose an item.
- **Are there any issues or barriers to your service delivery?** Choose an item.
- **Describe any issues and the corrective action(s) including any modifications that need to be made to the service plan:** Click here to enter text.

Progress:

- **Is progress being made towards the planning goals/outcomes? Choose an item.**
- **Describe any issues and the corrective action(s) including any modifications that need to be made to the service plan:** **Click here to enter text.**

Provider Satisfaction

- **Are you having any issues with providers or staff who work with you or other people around you?** Choose an item.
- **Explain and describe follow up needed:** Click here to enter text.

Behavior

- **Have there been any changes in type/frequency of behaviors?** Choose an item.
- **Are there any trends or concerns needing follow-up?** Choose an item.
- **Description of behaviors:** Click here to enter text.
- **Follow-up/corrective action to be taken:** Click here to enter text.

Community Involvement

- **Do you have the supports you need to access your community as frequently as you would like?** Choose an item.
- **Describe follow up needed:** Click here to enter text.

Friendships and Social Interactions

- **Do you have the supports you need to make and maintain your friendships as much as you would like?** Choose an item.
- **Describe follow up needed:** Click here to enter text.

Choice and Decision Making

- **Are you making your own choices and are your choices being respected?** Choose an item.
- **Do you have the supports you need to make your own decisions?** Choose an item.
- **Describe follow up needed:** Click here to enter text.

Employment

- **Do you have the supports you need to reach your employment goals?** Choose an item.
- **Was the ISP approved with employment follow up required?** Choose an item.
- **Describe follow up needed:** Click here to enter text.

Communication

- **Contact with the Interdisciplinary Team:** Choose an item.
- **Date of contact:** Click here to enter a date.
- **Reason for contact:** Click here to enter text.

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- **Reason for contact:** Click here to enter text.

Health & Safety

- **Are you protected from abuse, neglect, exploitation, physical harm, emotional distress (as reported by the individual family and/or service providers/DSP or based on observations)?** Choose an item.
- **Description:** Click here to enter text.
- **Describe corrective actions to be taken:** Click here to enter text.
- **Date reported to DDD:** Click here to enter a date.

- **Indicate if there have been any changes in your health status (e.g. changes in seizure or aspiration frequency, sleep patterns, bowel/bladder function, activity level, mood, or other typical behavior/routines that may indicate a health concern, significant weight gain or loss, wounds, signs of pain- including dental pain, medication changes, hospital or ER since last visit, etc.):** Choose an item.
- **Description of change in health status:** Click here to enter text.
- **Date reported to medical professional (as applicable):** Click here to enter a date.
- **Follow-up/corrective action to be taken, including name of medical professional involved:**
  Click here to enter text.

- **Indicate if there is any health, welfare or safety related needs or issues that need attention at this time:** Choose an item.
- **Description of issue/need:** Click here to enter text.
- **Follow-up/corrective action to be taken:** Click here to enter text.
- **Date reported to DDD:** Click here to enter a date.

- **Do any of the above health and safety issues require a change to the service plan? If so, describe and update plan:**
  Click here to enter text.

Unusual Incident Reports (UIR)

- **Please indicate if any UIRs occurred since the last point of contact:** Choose an item.

New Incident Report:
- **Type/description of incident(s):** Choose an item.
- **Date of incident:** Click here to enter a date.
- **Description of incident:** Click here to enter text.
- **Follow-up actions taken:** Click here to enter text.
- **Resolution(s):** Click here to enter text.

New Incident Report:
- **Type/description of incident(s):** Choose an item.
- **Date of incident:** Click here to enter a date.
- **Description of incident:** Click here to enter text.
- **Follow-up actions taken:** Click here to enter text.
- **Resolution(s):** Click here to enter text.

Pending Incident Report:
• **Indicate if there are any UIRs still pending this month:** Choose an item.
• **Type/description of incident(s):** Choose an item.
• **Date of Incident:** Click here to enter a date.
• **Description of incident:** Click here to enter text.
• **Follow-up actions taken:** Click here to enter text.
• **New/additional information on this incident report:** Click here to enter text.

Summary of Contact (Required Narrative)
Click here to enter text.

Quarterly Face-to-Face Review (if applicable)
• **Summary of observations and impressions of individual:** Click here to enter text.
• **Please describe any concerns or issues that you identified during the course of the face to face visit related to the individual and/or program site visited:** Click here to enter text.
• **Have you noticed any ongoing issues or trends within the quarter that need to be addressed?** Choose an item.
• **Please describe:** Click here to enter text.

Annual In-Home Review (if applicable)
• **Summary of observations and impressions of individual:** Click here to enter text.
• **Please describe any concerns or issues that you identified during the course of the in-home visit related to the individual and/or the home visited:** Click here to enter text.
• **Have you noticed any ongoing issues or trends within the year that need to be addressed?** Choose an item.
• **Please describe:** Click here to enter text.

Annual Reminder: Advise individual to attend medical and dental visits at least once a year.

Acknowledgements	
Completed by: Click here to enter text.	**Title:** Click here to enter text.
Date: Click here to enter a date.	
Reviewed by (if applicable): Click here to enter text.	**Title:** Click here to enter text.
Date: Click here to enter a date.	