

Quality of Services Review Summary

Missouri Department of Mental Health-Division of Developmental Disabilities

Please provide measureable action steps to be taken within an established timeframe.

Individual Name:

DMH ID #:

Provider Name:

Date of Quality Review:

Date of Interdisciplinary Team Meeting:

Interdisciplinary Team Participants:

Date Summary Sent to Team Participants:

Quality Outcome	HCBS	Findings / Observations	Action Step Narrative (Positive Findings: NA)	Responsible Person	Projected Completion Date	APTS	APTS Resolution Date
Social and Spiritual	The setting is integrated in and supports full access to the greater community.						
Daily Life	The setting optimizes autonomy and independence in making life choices as well as facilitates choice regarding services and who provides them.						
Healthy Living	Service planning process is conducted to ensure the health and welfare of individuals.						
Safety & Security	The setting ensures individual rights of privacy, dignity and respect, and freedom from coercion and restraint.						
Advocacy & Self-Determination	Individuals have the freedom and support to control their own schedule and activities and have access to food at any time.						

APPENDIX B

Community Living	The individual can have visitors of their choosing at any time. The setting is physically accessible to the individual and is selected by the individual from among setting options.						
Service Plan	The services authorized in the individual's plan matches the individual's needs based upon observation and conversation with the individual.						

Enhancements for Consideration: _____

Instructions for the Support Coordinator:

1. This form is used as written notification about the outcome of the Quality of Services Review and the interdisciplinary team meeting.
2. When each of the agreed upon Action Steps is completed, please notify _____, _____ Regional Office QE.

CC: Support Coordinator
 Technical Assistance Coordinator
 Advocacy Specialist
 QE Lead