

DMH-DD Individual Support Plan Review Form

(Revised July 15, 2015)

Designated staff who have received training shall monitor individual support plans, including subsequent amendments and all documentation of progress per month, in accordance with Division Directive 4.060 – Individual Support Plan and Level of Care. This review tool includes mandatory components of plans and is utilized to complete an agency’s internal review of a random sample of individual support plans.

State DMH ID: _____ Waiver: <u>Comprehensive</u> Participant First & Last Name: _____ TCM Entity: _____	Reviewer Name/Date: _____ Plan Imp. Date (mm/dd/yy): _____ Plan Written By: <u>RO/SB40/Other TCM Entity/SOP</u>
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For any response that is answered NO select one (1) of the action taken options.

1. Is the required demographic information completed? _____
Action Taken: Individual Support Plan recommendation/revision
 Follow up has been scheduled (to make revision)
Resolve Date: **Comments:**
2. Is the plan approved by the person/guardian prior to the plan implementation date? _____
Action Taken: Training/education completed with staff, guardians, and/or providers
 Follow up has been scheduled (for training/education)
Resolve Date: **Comments:**
- 3a. Does the plan reflect who is important to the person? _____
Action Taken: Individual Support Plan recommendation/revision
 Follow up has been scheduled (to make revision)
Resolve Date: **Comments:**
- 3b. Does the plan reflect what is important to the person? _____
Action Taken: Individual Support Plan recommendation/revision
 Follow up has been scheduled (to make revision)
Resolve Date: **Comments:**
- 3c. Does the plan reflect the health and wellness needs of the person? _____
Action Taken: Individual Support Plan recommendation/revision
 Follow up has been scheduled (to make revision)
Resolve Date: **Comments:**
- 3d. Does the plan reflect the safety needs of the person? _____
Action Taken: Individual Support Plan recommendation/revision
 Follow up has been scheduled (to make revision)
Resolve Date: **Comments:**

- 3e. Have assessments been completed for identified needs (i.e., speech, neurological, OT, PT, psych, etc.; if not applicable select NA)? _____
- Action Taken:** Individual Support Plan recommendation/revision
 Follow up has been scheduled (to make revision)
- Resolve Date:** **Comments:**
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- 3f. Does the plan address the career planning and job development preferences of the individual (applicable for ages 16-64)? _____
- Action Taken:** Individual Support Plan recommendation/revision
 Follow up has been scheduled (to make revision)
- Resolve Date:** **Comments:**
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- 3g. Has there been a significant change in need, such as new services or equipment, a new diagnosis, new or discontinued medications/treatments, etc., since the implementation date of the current plan, and has that update been added to the plan? _____
- Action Taken:** Individual Support Plan recommendation/revision
 Follow up has been scheduled (to make revision)
- Resolve Date:** **Comments:**
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- 4a. Does the plan describe what people need to know or do in order to support the person? _____
- Action Taken:** Individual Support Plan recommendation/revision
 Follow up has been scheduled (to make revision)
- Resolve Date:** **Comments:**
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- 4b. If the person self directs, is there a backup plan for services and supports (if not applicable select NA)? _____
- Action Taken:** Individual Support Plan recommendation/revision
 Follow up has been scheduled (to make revision)
- Resolve Date:** **Comments:**
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- 5a. Does the action plan contain outcomes that relate back to the profile? _____
- Action Taken:** Individual Support Plan recommendation/revision
 Follow up has been scheduled (to make revision)
- Resolve Date:** **Comments:**
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- 5b. Does the action plan contain functional outcomes/action steps that are written in measurable terms? _____
- Action Taken:** Individual Support Plan recommendation/revision
 Follow up has been scheduled (to make revision)
- Resolve Date:** **Comments:**
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- 5c. Does the action plan contain actions steps for each outcome? _____
- Action Taken:** Individual Support Plan recommendation/revision
 Follow up has been scheduled (to make revision)
- Resolve Date:** **Comments:**
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- 5d. Does the action plan contain reasonable timelines? _____
- Action Taken:** Individual Support Plan recommendation/revision

Follow up has been scheduled (to make revision)
Resolve Date: **Comments:**

5e. Does the action plan contain person(s) responsible for the outcome? _____
Action Taken: Individual Support Plan recommendation/revision
 Follow up has been scheduled (to make revision)
Resolve Date: **Comments:**

6. Is the plan signed by the support coordinator? _____
Action Taken: Individual Support Plan recommendation/revision
 Follow up has been scheduled (to make revision)
Resolve Date: **Comments:**

7. Is the support coordinator signature dated prior to the plan implementation date? _____
Action Taken: Training/education completed with staff, guardians, and/or providers
 Follow up has been scheduled (for training/education)
Resolve Date: **Comments:**

8. Is the Waiver Choice Statement (DMH-8733) / DD Medicaid Waiver, Provider, and Services Choice Statement in the file (completed once upon entrance to a waiver)? _____
Action Taken: Form corrected or completed
 Follow up has been scheduled (to make revisions or complete the document)
Resolve Date: **Comments:**

9. Is the Waiver Choice of Provider Statement (DMH 9001) / DD Medicaid Waiver, Provider, and Services Choice Statement in the file (Original form in file and if there was a change in provider or service there is a new form)? _____
Action Taken: Form corrected or completed
 Follow up has been scheduled (to make revisions or complete the document)
Resolve Date: **Comments:**

10. Did the individual attend the planning meeting? _____
Action Taken: Training/education completed with staff, guardians, and/or providers
 Follow up has been scheduled (for training/education)
Resolve Date: **Comments:**

11. Is there evidence of progress towards outcomes (review past 12 months)? _____
Action Taken: Training/education completed with staff, guardians, and/or providers
 Follow up has been scheduled (for training/education)
Resolve Date: **Comments:**

Note: LOC questions 12 and 13a-f have been eliminated effective January 2013.

13g. Does the individual's record contain documentation that the consumer/guardian was provided information annually on consumer rights without limitations as described in 630.115 RSMo as well as information on how to notify appropriate authorities, including DMH Office of Constituent Services, when abuse, neglect or exploitation may have been experienced? _____

Action Taken: Form corrected or completed
 Follow up has been scheduled (to make revisions or complete the document)

Resolve Date: **Comments:**
