**HMCDDO Annual Functional Assessment Checklist**

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| --- | --- | --- | --- |
| **Name** |  | **DOB:** |  |
| **Due Date:** |  | **Meeting Date:** |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **TCM / CSP** | | **Instructions: Mark X if attached; N/A if does not apply** | | | | | **HMCDDO Received** | | **HMCDDO Reviewed** | | | **QA Follow-Up Needed** | | | |
|  | | Current PCSP/Addendum and signature sheet | | | | |  | |  | | |  | | | |
|  | | PAS Back-Up Plan, if applicable | | | | |  | |  | | |  | | | |
|  | | Psychotropic/behavior/mood altering medication plan | | | | |  | |  | | |  | | | |
|  | | Psychotropic/behavior/mood altering medication plan consent signature sheet | | | | |  | |  | | |  | | | |
|  | | Behavior Committee review signature sheet if psychotropic med plan is present | | | | |  | |  | | |  | | | |
|  | | Risk assessment, if applicable | | | | |  | |  | | |  | | | |
|  | | Risk support plan and consent signature sheet, if applicable | | | | |  | |  | | |  | | | |
|  | | Behavior Committee review signature sheet if rights restrictions are present in risk support plan | | | | |  | |  | | |  | | | |
|  | | Positive behavior support plan | | | | |  | |  | | |  | | | |
|  | | Positive behavior support plan signature sheet | | | | |  | |  | | |  | | | |
|  | | Behavior Committee review signature sheet if behavior support plan includes rights restrictions | | | | |  | |  | | |  | | | |
|  | | Behavior data – 12 consecutive months | | | | |  | |  | | |  | | | |
|  | | Current medications/physician’s orders/health procedures | | | | |  | |  | | |  | | | |
|  | | Current physicians’ orders for conditions not listed on the MAR, if applicable | | | | |  | |  | | |  | | | |
|  | | Seizure reports/tracking | | | | |  | |  | | |  | | | |
|  | | Documentation of absence due to illness, medical hospitalization, if applicable | | | | |  | |  | | |  | | | |
|  | | IEP, if applicable | | | | |  | |  | | |  | | | |
|  | | Mental health treatment plan, if applicable | | | | |  | |  | | |  | | | |
|  | | Individual justice plan, if applicable | | | | |  | |  | | |  | | | |
| **Provider Name:** | | |  | | | | | | | | | **Date:** |  | | |
| **Case Manager:** | | |  | | | | | | | | | **Date:** |  | | |
| ***Assessment Meeting Verification*** | | | | ***HMCDDO USE ONLY*** | | | | | | ***Yes/No/NA*** | | | | | |
| Were TCM, Providers, and MCO, if applicable, invited to the assessment meeting? | | | | | | | | | |  | | | | | |
| Were representatives present for input at the assessment meeting? Verify signature sheet. | | | | | | | | | |  | | | | | |
| Was individual present at the meeting? | | | | | | | | | |  | | | | | |
| If not, is there documentation of accommodation? | | | | | | | | | |  | | | | | |
| Question Review Request: Was there a request for Question review? | | | | | | | | | |  | | | | | |
| If yes, what is response due date? | | | | | | | | | |  | | | | | |
| Date Completed / Approved for Entry: | | | | |  | Approved By: | | | | |  | | | | |
| Date Entered in KAMIS: | | | | |  | Entered By: | | | | |  | | | | |
| Date Options Counseling Uploaded in KAMIS: | | | | |  | Date NOA Uploaded: | | | | |  | | | | |
| Date 3160 Uploaded in KAMIS (if applicable): | | | | |  | Documents Uploaded By: | | | | |  | | | | |
| ***KAMIS #:*** |  | | | | ***FA Meeting Date:*** |  | | ***7-Day*** | | |  | | | ***365-Day*** |  |