**HMCDDO Quality Indicators**

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| **NAME:** | | |  | | | | **SERVICES:** | | | | **PROVIDER:** | | |
| **DOB:** | | |  | | | | Initial TCM: | | | |  | | |
| **Interview Date:** | | |  | | | | TCM: | | | |  | | |
| **Screener:** | | |  | | | | Day: | | | |  | | |
| **Location:** | | |  | | | | Residential: | | | |  | | |
| **Guardian:** | | |  | | | | PCS: | | | |  | | |
| **Address:** | | |  | | | | Wellness: | | | |  | | |
| **Phone:** | | |  | | | | Med Alert: | | | |  | | |
| **Email:** | | |  | | | | FMS/PCS: | | | |  | | |
| * ***PCSP Back-up Plan Review:*** Review of all PCSPs & all Self-Directed back up plans | | | | | | | | | | | | | |
| Date of Current Annual PCSP: | | | | |  | Receiving Self-Directed Services: | | | | | | |  |
| Date of Previous PCSP: | | | | |  | Has Self-Directed Back-Up Plan: | | | | | | |  |
| Within 365 days: | | | | |  | Back-Up Plan Date: | | | | | | |  |
| * ***Employment Questionnaire:*** *Complete this question annually on all people of working age, age 18 to 65* | | | | | | | | | | | | | |
| **1.** | **Is the person currently in competitive employment?** *Competitive Employment*means work in the competitive labor market that is performed on a full-time or part-time basis in an integrated setting; and for which the person is compensated at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same of similar work performed by persons who are not disabled. | | | | | | | | | | | | |
|  | Yes | Employer: | |  | | | | | | # Hours/Week: | |  | |
|  | No | *(If “No,” proceed to question #2)* | | | | | | | | | | | |
| **2.** | **If no on question #1, *if person has IDD TCM,* does the PCSP describe barriers to competitive employment and plans to overcome identified barriers?** | | | | | | | | | | | | |
|  | TCM not involved at this time | | | | | | | | | | | | |
|  | Yes *(If “Yes,” proceed to question #3)* | | | | | | | | | | | | |
|  | No *(If “No,” do not complete the remainder of the questionnaire)* | | | | | | | | | | | | |
| **3.** | **If yes to question #2, choose one primary barrier from the list below:** | | | | | | | | | | | | |
|  | Person is currently in school | | | | | |  | Ongoing behavioral challenges | | | | | |
|  | Person is near retirement age | | | | | |  | Transportation is not available | | | | | |
|  | Fear of loss of government benefits | | | | | |  | Appropriate jobs are not available | | | | | |
|  | Lack of support from guardian, family member, or staff | | | | | |  | Workplace modifications/supports are not available | | | | | |
|  | Dislikes work | | | | | |  | Person works on sub-min wage work crew | | | | | |
|  | Enjoys current work/day environment more than competitive employment | | | | | | | |  | Other: | | | |
|  | Ongoing health concerns, fragile condition | | | | | | | | | | | | |

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| --- | --- | --- | --- |
| ***Person completing form:*** |  | ***Date:*** |  |