**HMCDDO Monthly TCM Monitoring Quality Assurance Checklist**

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| --- | --- |
| ***Individual Name:***  |  |
| ***Month/Year of QA:***  |  |

***Please complete this form for the month that has just ended and email the completed checklist to HMCDDO Funding Coordinator by the 10th of the following month.***

***Service: Date of On-Site Visit:***

|  |  |
| --- | --- |
| **Day** |  |
| **Residential** |  |
| **PCS / Agency Directed** |  |
| **PCS / Self-Directed** |  |
| 1. Were the approved service units used the previous month? | Yes |  | No |  | If no, why not?  |
| 2. Is the current person-centered support plan at all sites? | Yes |  | No |  | If no, steps to correct issue? |
| 3. Is the current positive behavior supports plan, and/or psychotropic medication plan at all sites? | Yes |  | No |  | If no, steps to correct issue? | N/A |  |
| 4. Are PCSP goals implemented and tracked? | Yes |  | No |  | If no, steps to correct issue? | N/A |  |
| 5. Is behavior data tracked? | Yes |  | No |  | If no, steps to correct issue? |
| 6. Are logs or service documentation available for review? | Yes |  | No |  | If no, steps to correct issue? | N/A |  |
| 7. Have all adverse incidents been reported in AIR, to CDDO, & MCO? | Yes |  | No |  | If no, steps to correct issue? | N/A |  |
| 8. Does site meet basic health/safety and emergency preparedness requirements? | Yes |  | No |  | If no, steps to correct issue? | N/A |  |
| 9. Does the staff interact respectfully with the person? | Yes |  | No |  | If no, steps to correct issue? |
| 10. Concerns/unmet needs to address, and steps to take, if applicable: |  |
| KUDOS/Goal Completions/Positive Steps for increased Independence, Integration, Inclusion, Productivity: |
| **TCM Name:** |  | **Date Completed:**  |  |