

**SERVICE REVIEW CHECKLISTS
COVERSHEET**

Name of Individual:

Agency(ies)

Date of Review:	Facility Name	Location of review	Section Reviewed	Records Reviewed/Method of Review
			Medical	<input type="checkbox"/> ISP <input type="checkbox"/> MAR <input type="checkbox"/> Progress notes <input type="checkbox"/> Protocols <input type="checkbox"/> Intake/Output <input type="checkbox"/> Seizure Record <input type="checkbox"/> Behavior Plan <input type="checkbox"/> Fire Evacuation Record <input type="checkbox"/> Behavior Data <input type="checkbox"/> Incident Reports <input type="checkbox"/> Face to Face <input type="checkbox"/> Walk through of House <input type="checkbox"/> Other:
			Behavior	<input type="checkbox"/> ISP <input type="checkbox"/> MAR <input type="checkbox"/> Progress notes <input type="checkbox"/> Protocols <input type="checkbox"/> Seizure Record <input type="checkbox"/> Behavior Plan <input type="checkbox"/> Fire Evacuation Record <input type="checkbox"/> Behavior Data <input type="checkbox"/> Incident Reports <input type="checkbox"/> Face to Face <input type="checkbox"/> Walk through of House <input type="checkbox"/> Other:
			Financial	<input type="checkbox"/> ISP <input type="checkbox"/> MAR <input type="checkbox"/> Progress notes <input type="checkbox"/> Behavior Plan <input type="checkbox"/> Financial Management Plan <input type="checkbox"/> Incident Reports <input type="checkbox"/> Face to Face <input type="checkbox"/> Walk through of House <input type="checkbox"/> Other:
			Financial	<input type="checkbox"/> ISP <input type="checkbox"/> MAR <input type="checkbox"/> Progress notes <input type="checkbox"/> Behavior Plan <input type="checkbox"/> Financial Management Plan <input type="checkbox"/> Incident Reports <input type="checkbox"/> Face to Face <input type="checkbox"/> Walk through of House <input type="checkbox"/> Other:
			ISP	<input type="checkbox"/> ISP <input type="checkbox"/> MAR <input type="checkbox"/> Progress notes <input type="checkbox"/> Protocols <input type="checkbox"/> Intake/Output <input type="checkbox"/> Seizure Record <input type="checkbox"/> Behavior Plan <input type="checkbox"/> Financial Management Plan <input type="checkbox"/> Fire Evacuation Record <input type="checkbox"/> Behavior Data <input type="checkbox"/> Incident Reports <input type="checkbox"/> Face to Face <input type="checkbox"/> Walk through of House <input type="checkbox"/> Other:
			Facility	<input type="checkbox"/> Face to Face <input type="checkbox"/> Walk through of House <input type="checkbox"/> Other:

Medical Service Review

Name of Individual:

Date:

Agency:

Facility Name:

Agency staff name & title if assisting in review:

Location of Review:

Service Coordinator Conducting Review:

	Yes	No	N/A	Date	Notes/Concern/Need
1. Supports & Protocols in place as identified on the ISP and there is documentation that evidences their use?					
a. Aspiration					
b. Constipation					
c. Dehydration					
d. Seizures					
e. Diabetes					
f. Other:					
2. Are routine appointments happening? Did follow through occur?					
3. Are there other emerging medical concerns? Is there follow up needed?					
4. Did you review the Medication Administration Record?					
a. Are medications given as directed?					
b. Are psychotropic medications being used and is their use in compliance with the appropriate OAR's?					
5. Is durable medical equipment:					
a. Clean?					
b. In good repair?					
c. Being used?					
d. Is a change in equipment needed? Does the program need assistance from the service coordinator?					
6. If you had the opportunity to see the individual, were there observations of note?					

Date	Comments	Follow Up Necessary	Responsible Party	Timeline

Behavior Service Review

Name of Individual:

Date:

Agency:

Facility Name:

Agency staff name & title if assisting in review:

Location of Review:

Service Coordinator Conducting Review:

	Yes	No	N/A	Date	Concern/Need
1. Is a Functional Assessment present?					
2. Is a Behavior Support Plan (BSP) in place?					
a. Is documentation of team approval present?					
b. Is required data current?					
c. Is there documentation that data is being reviewed for continued need of the Behavior Support Plan?					
3. If consultation was identified as a need by the team, has it been provided?					
4. Do Incident Reports reflect appropriate OIS interventions?					
5. If an OIS maneuver is used, is it clearly described in the BSP?					
6. Are there emerging behavioral concerns that should be discussed with the team?					
7. If you had the opportunity to see the individual, were there observations of note?					
8. From your observations, were behavior plans implemented as described?					

Date	Comments	Follow Up Necessary	Responsible Party	Timeline

Financial and Personal Property

Name of Individual: _____ Date: _____

Agency: _____ Facility Name: _____

Agency staff name & title if assisting in review: _____ Location of Review: _____

Service Coordinator Conducting Review:

	Yes	No	N/A	Concern/Need
1. Is there a team approved financial management plan as a part of the ISP, that indicates the ability of the individual to manage their own funds?				
2. Records were available and included:				
a. The date, amount and source of income received;				
b. The date, amount and purpose of funds disbursed;				
c. A signature of the staff making each entry.				
3. Savings Account:				
a. Review of latest reconciled bank statement?				
b. Savings account balance accurate?				
4. Checking Account:				
a. Review of latest reconciled bank statement?				
b. Checking account balance accurate?				
5. Individual Petty Cash/ Cash on Hand:				
a. Review individual petty cash/cash on hand?				
b. Are tracking methods in place?				
c. Petty cash/cash on hand balance accurate?				
6. If any discrepancy is noted, is there documentation of follow-up?				
7. Is there a personal Property Record?				
a. Is there evidence that the personal property record has been updated annually?				
b. Are items purchased reflected on the personal property record as required by rule or ISP?				

Date	Comments	Follow Up Necessary	Responsible Party	Timeline

ISP REVIEW

Name of Individual:

Date:

Agency:

Facility Name:

Agency staff name & title if assisting in review:

Location of Review:

Service Coordinator Conducting Review:

	Yes	No	N/A	Date	Concern/Need
1. Is there a current ISP in conformance with the applicable rules governing individual plans?					
2. Is the ISP being implemented?					
3. Are addendum's to the ISP present, documenting changes & adjustments?					
a. Is there evidence that the addendum was sent to all members of the team?					
b. Do the services provided for in the plan continue to meet what is important to and for the individual?					
4. If you had the opportunity to see the individual, were there observations of note?					
5. Are the personal desires of the individual, the individual's legal representatives or the individual's family addressed in the ISP?					
6. Has there been a serious event that requires additional follow up or support?					

Date	Comments	Follow Up Necessary	Responsible Party	Timeline

Facility Service Review Checklist

Date:

Agency: _____ Facility Name: _____

Agency staff name & title if assisting in review: _____ Location of Review: _____

Service Coordinator Conducting Review: _____

	Yes	No	Date	N/A
1. Is facility clean and free from offensive odors?				
2. Is facility well maintained?				
3. Are grounds maintained?				
4. Are staff interactions with consumers respectful, attentive and positive?				

Date	Comments	Follow Up Necessary	Responsible Party	Timeline

Additional Notes

Date	General Comments	Follow Up Necessary	Responsible Party	Timeline