MAXABILITIES Residential Supports

# Monthly Review *for the Month of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

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| --- | --- | --- | --- | --- | --- |
| ***INDIVIDUAL*** |  | ***REVIEW DATE*** |  | ***PROGRAM*** |  |

***HEALTH ISSUES***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Medical Visits****(include review of Nursing notes and THERAP system to ensure all appointments are included***)** | ***Date*** | ***Results of appointment*** *(i.e. status of issue seen for; meds prescribed, treatment provided…)* | ***Needed Follow Up*- (***include date of next appointment INCLUDE completion of post acute care issues/documentation)* | ***Resident Was Involved With Appointment Process*** *(ie: set or confirmed appt, signed in at dr. office, interacted with doctor…)* **(*if no what barrier prevented involvement – if yes include what was done/said*)** |
|  |  |  |  |  *YES* |  *NO* |
|  |  |
|  |  |  |  |  *YES* |  *NO* |
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| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  *YES* |  *NO* |
|  |  |

 ***MONTHLY VITAL SIGNS:***

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***Last B/P Reading*** | ***Date******taken*** | ***Reading Results*** | ***Have results been entered into Therap?*** |  | ***Last Temperature Reading*** |  ***Date******taken*** | ***Reading Results*** | ***Have results been entered into Therap?*** |
|  |  | ***□ Yes □ No***  |  |  |  | ***□ Yes □ No***  |
| ***Last Respiration Reading*** | ***Date******taken*** | ***Reading Results*** | ***Have results been entered into Therap?*** | ***Last Pulse Reading*** | ***Date******taken*** | ***Reading Results*** | ***Have results been entered into Therap?*** |
|  |  |  |  | ***□ Yes □ No***  |
| ***□ Yes □ No***  |

***CURRENT HEALTH STATUS***

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| ***Date of last annual physical exam (PE)*** | ***Is PE form entered into Therap?*** | ***Date of last annual TB test or Chest X-ray*** | ***Annual TB or Chest X -ray entered into Therap?*** | ***Date of last flu shot*** | ***Is date of Flu shot entered into Therap?*** | ***Date of last pneumonia shot*** | ***Is date of pneumonia shot entered into Therap?*** |
|  | ***□ Yes □ No***  |  | ***□ Yes □ No***  |  | ***□ Yes □ No***  |  | ***□ Yes □ No***  |
| ***Previous months Weight*** |  ***Date******Taken*** | ***Wt.******Reading***  | ***Current months weight*** |  ***Date******Taken*** | ***Wt.******Reading***  | ***Weight Increase or Decrease?***  | ***□ Yes □ No***  | ***# pounds gained*** |  |
|  |  |  |  |
| ***# pounds lost*** |  |
| ***Weights entered on Therap?*** | ***□ Yes □ No***  | ***Bowel******Movement entered in Therap?*** | ***□ Yes □ No***  | ***Finger Stick******Blood Sugars entered in Therap?*** | ***□ Yes □ No***  | ***N/A*** |
|  |
| ***List Wellness Activities: (I.e. Y, walking, exercise etc.)*** |

***ADAPTIVE NEEDS***

|  |  |  |  |
| --- | --- | --- | --- |
| ***List All Current Adaptive Equipment: (examples: glasses, hearing aid, shoe inserts, walker, weighted spoon, bed alarm, shower chair)*** | ***Adaptive Equipment*** | ***Date Verified In Operable Condition*** | ***Replacement and/or repairs needed*** |
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***DIETARY NEEDS:***

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| --- | --- |
| ***Diet Order:*** |  |
| ***Modified Diet?*** | ***□ Yes □ No*** | ***Thickened Liquids?*** | ***□ Yes □ No*** | **□ *Honey* □ *Nectar* □ *Pudding*  □ *Other***  |
| ***Supplies Available:*** | ***□ Yes □ No*** | ***Swallowing Checklist*** | ***Date of Last Checklist****:*  | ***Swallowing checklist uploaded to Therap?*** | *□ Yes □ No* |
|  |
| ***Most recent Swallowing Assessment uploaded into Therap?******(If Applicable)*** | ***□ Yes □ No □ N/A*** |

***HEALTH RELATED CONSENTS/ ASSESSMENTS***

|  |  |  |  |
| --- | --- | --- | --- |
| ***Health Care Consent (Pink Form)*** | **□ *Yes* □ *No*** | ***Doctor Signature Date:*** |  |
| ***Next Due Date:*** |  |
| ***Is Resident Adjudicated Incompetent?***  | **□ *Yes* □ *No*** | ***POA?*** | **□ *Yes* □ No□ *N/A*** |
| ***Surrogate:***  | ***DNR?*** | **□ *Yes* □ No□ *N/A*** |
| ***Date DNR reviewed and signed by Physician and Family (should be re – addressed every 30 days)*** | ***Date:*** |
| ***Fall Prevention Tool?******(annually and update if falls occur)*** | **Date Fall Tool Completed?** | **Fall Tool uploaded to Therap?** | **Fall Prevention Plan (FPP)?****(updated annually and as needed when falls occur)** | ***Date Fall Prevention Plan completed?*** | ***Fall Tool uploaded to Therap?*** |
|  | ***□ Yes □ No*** |  | ***□ Yes □ No*** |
| ***Injury/Illness Reports on Therap*** | ***Date*** | ***Post-Acute Completed*** |
|  | **□ *Yes* □ *No*** |
|  | **□ *Yes* □ *No*** |
|  | **□ *Yes* □ *No*** |
|  | **□ *Yes* □ *No*** |

***PSYCHOTROPIC MEDICATION INFORMATION & PMR (Psychotropic Medication Review)***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Did Quarterly Review of Psychotropic Medications Occur this month?***  | **□ *Yes* □ *No*** | ***Date of Last PMR Review:***  | ***Month of next PMR review?*** | ***PMR documentation uploaded to Therap?*** |
|  |  | **□ *Yes* □ No** |
| ***Date of last AIMS (Tardive Dyskinesia) Assessment*** | ***List date of last psychotropic med reduction*** | ***Have there been a psychotropic medication reduction in the last 12 months? If NO- explain below*** |  **□ *Yes* □ No** | ***List changes made during Last PMR review:*** |
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| ***If NO- explain:***  |
| ***Psychotropic Medication***  | ***HRC Approval Date*** | ***Informed Consent Date*** |
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***BEHAVIOR PLANS***

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| --- | --- | --- | --- |
| ***On Formal BSP?*** *(Behavior Specialist writes and maintained BSP)* | ***Current Formal Signed BSP uploaded to Therap?*** | ***On Behavior Guidelines?*** *(Coordinator writes and maintained guidelines)* | ***Current Signed Guidelines uploaded to Therap?*** |
| ***□ Yes □ No*** | **□ Yes □ No** | ***□ Yes □ No*** | **□ Yes □ No** |
| ***Target Behavior Dates Current?*** | **□ *Yes* □ No** | ***Date BSP or Guidelines Signed by Consumer*** |  |
| ***BSP Informed Consent Date:******(consent from consumer/family)***  |  | ***Guidelines Informed Consent Date:***  |  |
| ***HRC Consent Date for BSP:***  |  | ***Guidelines Target Behavior Date Current?***  | **□ *Yes* □ No** |
| ***Last date of Behavioral Training?*** |  | ***Number of behavior incidents this month*** |  |
| ***Have behavioral training and signature sheet been uploaded to Therap?*** | **□ Yes □ No** |
| ***Any Plan Objectives Met This Month?***  | **□ *Yes* □ No** | ***Any Plan Objective Revisions This Month?***  | **□ *Yes* □ No** |
| ***List Any Revisions Made to objectives:*** |  |

***FINANCIAL SUMMARY [NOTE: Medicaid Asset Limit is $2000.00)***

|  |  |
| --- | --- |
| Who is Representative Payee? | □ MaxAbilities of York Co. □ Family serves as Representative Payee  |
|  Beginning Bank Balance (Check Register) |  | Amount Deposited In Month |  |
| Amount Spent?  |  | Ending Balance (Check Register) |  |
| Above Asset Limit?  | □ Yes □ No | If Over Asset Limit- List Plan To Reduce Assets  |  |
| Signed Financial Rights Statement on File | □ Yes □ No | Date of Financial Plan | Financial Plan uploaded to Therap? |
|  | □ Yes □ No |
| Special Needs Trust?  | □ Yes □ No | Current Care and Maintenance Waiver?  |  □ Yes □ No |
| STABLE Account?  | □ Yes □ No | Most recent reconciliation statement signed & uploaded to Therap | List Date: |
| Pre-Need Burial/ Pre- Need Burial Insurance?  | □ Yes □ No | Pre-Need Burial/ Insurance Details (Amount/ With What Company?) |  |
| Date of Most Recent Personal Property Inventory |  | Date of Resident Review of Financial Information |  |
| Signed current lease on file? | □ Yes □ No | Date of current lease? |  |

 ***SKILLS TRAINING INFORMATION***

|  |  |  |  |
| --- | --- | --- | --- |
| ***Current Residential Plan Date*** |  | ***Current & Previous Residential Plan Uploaded to Therap?*** | ***□ Yes □ No*** |
| ***Current Assessment Packet Date*** |  | ***Residential Assessment Uploaded to Therap?*** | ***□ Yes □ No*** |
| ***Date Planning For Next Plan Needs To Begin (must have plan every 365 days)***  |  | ***Called Team Meetings This Month*** | ***□ Yes □ No*** |
| ***Plan Amendments This Month*** | **□ *Yes***  **□ *No*** |
| ***ICP Current? (CRCF ONLY)*** | **□ *Yes***  **□ *No*** | ***Date:*** | ***Due date of next ICP (identify if annual and/or 6 month review):*** |

|  |  |  |
| --- | --- | --- |
|  ***Objectives*** | ***Steady Progress Noted*** ***Y N*** | ***Modifications/Changes*: *Modifications must be made if there is no progress for 2 months - document those changes. Modifications must be made for any new objective started at 100% independence in the first month! Indicate recommendations for continuation of objectives based on training data. Write a complete progress note and any necessary plan amendments.***  |

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***INDIVIDUAL INTERVIEW: Please review the following information with the individual and document pertinent information.***

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| --- | --- |
| ***Area***  | ***Individual’s Comments/ Needed Follow Up******Comments required for all sections*** |
| **1*. In the last house meeting, did you participate in the discussion of general topics to include shared spaces, participation in menu and shopping preparation, house rules?***  |  |
| **2.** **In the last house meeting, did you participate in the discussion of *rights and safety training and tell staff things you are interested in doing?*** |  |
| **3. *What do you like to do- are you getting to do those things at home?***  |  |
| **4. *Do you get to make decisions about your doctors and medications? What medical decisions do you make? What medical decisions would you like to make?***  |  |
| **5. *Do you feel your privacy needs are being met?***  | ***□ Yes □ No*** | ***Comment(s):*** |
| **6. *Are your staff interactions conducted in a positive manner?*** | ***□ Yes □ No*** | ***Comment(s):*** |
| **5. *Can you tell me what your current objectives are?*** |  |
| **7. *Did you have opportunities this month to talk to family and friends on the phone?***  | ***□ Yes □ No*** | ***Comment(s):*** |
| **8. *What is an example of abuse, neglect or exploitation and who do you report to if it happens to you? (please use language the resident understands)*** |  |
| **9. *Do you have a key to your bedroom and codes to enter the facility?*** | ***□ Yes □ No*** | ***Comment(s):*** |

***RESIDENT SATISFACTION***

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| --- | --- | --- | --- |
| ***Does the Resident Have Complaints/ Concerns?***  | **□ *Yes*  □ *No*** | ***List Any Complaints/Concerns and Remediation Attempted*** |  |
| ***Family Contact This Month?***  | **□ *Yes***  **□ *No*** | ***List Any Family Concerns and Remediation Attempted*** |  |

***RESIDENT SUPERVISION NEEDS***

|  |  |  |  |
| --- | --- | --- | --- |
| ***Does Individual Receive Enhanced Staffing?***  | **□ *Yes*  □ *No*** | ***Date of Tier Change Request or Single Case Agreement?*** |  |
| ***If Yes- Was Staffing Appropriate To Support Funding Request?***  | **□ *Yes*  □ *No*** | ***If No- What Remediation Was Implemented?***  |
| ***Comments:*** |
| ***Shift Log Entries and/or Therap Are Complete To Support Tier Change/Single Case Agreement?***  | **□ *Yes*  □ *No*** |

###### *SOCIAL/ RECREATION/ SCHOOL*

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| --- | --- | --- |
| ***Home Visits (Days)*** | ***General Attitude*** | ***Interagency Activities (In-house and organized by MaxAbilities)*** |
|  |  |  |
| ***Community Activities*** |
|  |
| ***Individual School Aged?***  | **□ *Yes*  □ *No*** | ***List Any Unmet School Needs*** |  |

***NEEDED REVISIONS/CHANGES***

|  |
| --- |
|  ***Notable Changes or Concerns Not Listed Above:***  |
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***TEAM ACTION***

|  |  |
| --- | --- |
| ***Is Team Action Required Based On The Information Gathered During This Monitorship?***  |  **□ *Yes*  □ *No*** |
| ***Problem Noted*** | ***Corrective Action Needed*** | ***Target Date To Complete*** |
|  |  |  |
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***VERIFICATIONS***

|  |  |  |
| --- | --- | --- |
| ***Monitorship Completed By:***  |  | ***Completion Date:***  |
| ***Copy Forwarded to Case Manager?***  | **□ *Yes*  □ *No*** | ***Date Forwarded To Case Manager:***  |
| ***Completed monthly monitorship uploaded to THERAP?*** | **□ *Yes*  □ *No*** |

*Revised: 4/2016 MS*

Revised 1/2019 SM

Revised 01/2025 SM

Revised 06/05/2025 SM/LH