MAXABILITIES Residential Supports

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ***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* |
|  |  |
|  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  | *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*** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

***DIETARY NEEDS:***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ***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:*** |
|  |
|  | |
|  | |
| ***If NO- explain:*** | | |
| ***Psychotropic Medication*** | | ***HRC Approval Date*** | | ***Informed Consent Date*** | | |
|  | |  | |  | | |
|  | |  | |  | | |
|  | |  | |  | | |
|  | |  | |  | | |
|  | |  | |  | | |

***BEHAVIOR PLANS***

|  |  |  |  |
| --- | --- | --- | --- |
| ***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.*** |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

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

|  |  |  |  |
| --- | --- | --- | --- |
| ***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***

|  |  |  |  |
| --- | --- | --- | --- |
| ***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*

|  |  |  |  |
| --- | --- | --- | --- |
| ***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:*** |
|  |
|  |
|  |

***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*** |
|  |  | |  |
|  |  | |  |

***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