TRAINING CENTER
POST MOVE MONITORING REPORT

SECTION A:

Individual: **Monitoring Staff:** M**onitor Date:**

Discharge Date: Time Frame: ☐ 1-3days ☐ 4-10days ☐ 11–17days ☐ Other

Discharge Coordinator: **CIM:** **Social Worker:**

Residential Support: **Vocational/Day Program:**

Authorized Representative: **CSB Support Coordinator:**

SECTION B:

Source of Information and Name of Contact:	Contact Date	Method of Contact	Person Responsible	Others Involved
Individual		☐ Face-to-Face		
CSB Support Coordinator		☐ By Phone ☐ Face-to-Face		
Residential Provider/staff		☐ By Phone ☐ Face-to-Face		
Supported Employment/Day Provider		☐ By Phone ☐ Face-to-Face		
AR/Guardian		☐ By Phone ☐ Face-to-Face		

Contact Notes:

SECTION C:

Describe type of Employment or Day Support Activities:

Follow Training Center Protocol for reporting emergencies and health and safety concerns to ensure compliance with mandated reporting.

1. Are all of the Essential Supports identified in the Discharge Plan being provided?

Essential Support	Document Observation and/or Evidence	Observed		Additional Training		
		YES	NO	Needed	Date Completed	Person Responsible
		☐	☐	☐Yes ☐No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		

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Continued - Are all of the Essential Supports identified in the Discharge Plan being provided?

Essential Support	Document Observation and/or Evidence	Observed		Additional Training		
		YES	NO	Needed	Date Completed	Person Responsible
		☐	☐	☐Yes ☐No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		
		☐	☐	☐ Yes ☐ No		

ID Waiver PC ISP Requirements (Completed by CRC Only)	Document Observation and/or Evidence	Observed		Training Needed	Date Completed	Person Responsible
		YES	NO			
Supports Intensity Scale (Long Report)		☐	☐	☐ Yes ☐ No		
PC ISP Parts I-IV		☐	☐	☐ Yes ☐ No		
Plan for Supports/General Schedule (Ongoing or 60-Day Assessment)		☐	☐	☐ Yes ☐ No		
Ongoing Documentation		☐	☐	☐ Yes ☐ No		
Other:		☐	☐	☐ Yes ☐ No		

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Please describe any 1) outstanding issues or concerns under each question, 2) list evidence reviewed to verify information 3) request related documentation and attach:

2. Does the Individual and/or AR express satisfaction with his/her new life? ☐ Yes ☐ No

3. Are there any relationship or family concerns? ☐ Yes ☐ No

4. Are there any medical needs that require further support? ☐ Yes ☐ No

5. Has the individual remained free of injury/illness? ☐ Yes ☐ No
   (If no, request incident reports and/or ID Notes)

6. Were the medical and other provider appointments kept as stated in the discharge plan? ☐ Yes ☐ No

   Please provide written documentation verifying the appointment.

Medical Appointment	Date of Appointment	Medical Provider

7. Are there any behavioral needs that require further support? ☐ Yes ☐ No

8. Were there any behavioral incidents? ☐ Yes ☐ No
   (If yes, request incident reports and/or ID Notes)

9. If so, did staff feel equipped to manage them? ☐ N/A ☐ Yes ☐ No

10. Additional Areas of concern: ☐ Yes ☐ No

11. Have there been any medication changes? ☐ Yes ☐ No

(If response is yes, list the medications changed, date of change and reason for changes, request copy of Physicians Orders **regardless review individuals MAR**)

Medications Changed	Date of change	Reason for Change

12. Are there additional supports that can be provided for the individual or provider?

Support	Date requested	Target Date	Date completed	Person/s	Additional

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requested/needed				Responsible	information

SECTION D:

ACTION PLAN FOR AREAS OF CONTINUED MONITORING OR FOLLOW-UP

Action Item *Note: If this is an action item from previous monitoring report	Target Date	Date Completed	Person Responsible	Others Involved

Additional Comments:

Signature of Person Completing Monitor

Date

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