For form instructions Ctrl+Click to follow the link here
Examples can be viewed by hovering over the link under each question or through Ctrl+Click to locate guidance.

On-Site Visit Tool

Individual's Name:

Location of visit: ☐ home ☐ community ☐ work ☐ day support ☐ Other:

Date of visit:

Service being provided (if applicable):

	Focus Area Questions:	Check:
Change in Status		
1	**Are there new or increased concerns with the environment being clean, safe and appropriate to the person's needs?** *examples*	☐ Yes ☐ No ☐ Unable to assess
2	**Are environmental modifications or assistive technologies lacking, but needed to increase independence or prevent institutionalization?** *examples*	☐ Yes ☐ No ☐ Unable to assess
3	**Are there new or increased concerns with the person's health and safety?** *examples*	☐ Yes ☐ No ☐ Unable to assess
4	**Have there been any significant life changes that impact services?** *examples*	☐ Yes ☐ No ☐ Unable to assess
5	**Are there any concerns related to potential abuse, neglect, or exploitation?** *examples*	☐ Yes ☐ No ☐ Unable to assess
Change in Status Determination		
6	Was a change in status identified?	☐ Yes ☐ No **NOTE:** an answer of "yes" to any question 1 to 5 indicates a change in status. *Document changes and actions to address concerns in the contact note from this visit.*
Services Implemented Appropriately		
7	**Does the person express satisfaction with services and the progress being made?** *examples*	☐ Yes ☐ No ☐ Unable to assess
8	**Are the paid supporters knowledgeable about the person and understand their role in providing support?** *examples*	☐ Yes ☐ No ☐ Unable to assess

9	**Are professional behavioral services (e.g. Therapeutic Consultation, ABA) needed?**	☐ **Yes** ☐ **Already Provided** ☐ **No** *If answered "yes" proceed to 9a* *If answered "already provided" proceed to 9b* *If answered "no" skip to question 10*
9a	**Are professional behavioral services authorized?** **Provider listing available online at:** https://dbhds.virginia.gov/developmental-services/behavioral-services/	☐ **Yes** ☐ **No** *If answered "yes" proceed to 9b* *If answered "no" offer, and if desired, refer and ensure authorization within 30 days. Proceed to question 10.*
9b	**If answered "yes" or "already provided" to 9 or 9a, confirm the following:** • An onsite assessment was completed or is in progress? ☐Yes ☐ No • A behavioral plan designed to decrease negative behaviors and increase functional replacement behaviors is available or is being developed? ☐Yes ☐ No • Caregivers are trained to implement the behavior plan or a plan for training is in progress? ☐Yes ☐ No • Presence of data collection/analysis to improve supports? ☐Yes ☐ No • Changes were made to the behavioral plan as needed? ☐Yes ☐ No	
10	**Are professional nursing services (i.e. Skilled or Private Duty Nursing) needed?** *examples*	☐ **Yes** ☐ **Already Provided** ☐ **No** *If answered "yes" proceed to 10a* *If answered "already provided" proceed to 10b* *If answered "no" skip to question 11*
10a	**Are professional nursing services authorized?**	☐ **Yes** ☐ **No** *If answered "yes" proceed to 10b* *If answered "no" offer, and if desired, refer and ensure authorization within 30 days. Proceed to question 11.*
10b	**If answered "yes" or "already provided" to question 10 or 10a confirm the following:** • Services were provided consistently for past 90 days? ☐Yes ☐ No • The hours provided are sufficient to ensure health and safety? ☐Yes ☐ No • The services provided meet the person's identified needs? ☐Yes ☐ No	
11	**Has the service being provided during this visit been occurring as needed, and as authorized?** *examples*	☐ **Yes** ☐ **No** ☐ **N/A** **NOTE:** N/A only utilized if not receiving a service at the time of the visit.
12	**Does the service being provided during this visit include skill-building if required?** *examples*	☐ **Yes** ☐ **No** ☐ **N/A**
13	**Does community involvement occur as described in the ISP?** *examples*	☐ **Yes** ☐ **No** ☐ **Unable to assess**
Services Implemented Appropriately Determination (To be completed following questions 7 through 13)		
14	Are **services implemented appropriately**?	☐ **Yes** ☐ **No** **NOTE:** an answer of "no" to any question 7 to 13 indicates services are not appropriately implemented. *Document changes and actions to address concerns in the contact note from this visit.*

Home and Community-Based Services Review (To be completed following questions 1 through 14)			
15	**All Home and Community-Based (HCBS) Settings must meet basic standards. Consider the items to the right and confirm all that apply during the visit.** *examples*	**The setting:** • was selected by the individual/SDM? ☐ Yes ☐ No • is accessible to the person? ☐ Yes ☐ No • is integrated into the larger community? ☐ Yes ☐ No • gives person ability to move freely & make choices? ☐ Yes ☐ No • provides person with dignity and respect? ☐ Yes ☐ No **If a no** is indicated for any item listed above, list reporting below and proceed as required by mandated reporting requirements, state requirements, and agency policies and procedures.	
16	**Is the visit occurring in one of the following provider-controlled or owned settings: Group Home Residential, Sponsored Home, or Supported Living?**	☐ **Yes** ☐ **No** If answered "yes", proceed to question 16a If answered "no", proceed to question 17	
16a	**Provider-controlled or owned HCBS residential settings must meet additional standards. Consider the items to the right and confirm all that apply during the visit.** *examples*	**The individual:** • has been provided a key to their home? ☐ Yes ☐ No • has been provided a key to their bedroom? ☐ Yes ☐ No • can have visitors? ☐ Yes ☐ No • can have overnight guests? ☐ Yes ☐ No • can decorate his room? ☐ Yes ☐ No • can access food at any time? ☐ Yes ☐ No • can choose own schedule and activities? ☐ Yes ☐ No **If a no** is indicated for any item listed above and a modification is **not** in place, list reporting below and proceed as required by mandated reporting requirements, state requirements, and agency policies and procedures.	
Reporting and Plan Changes (To be completed following questions 1 through 16)			
17	**Do any concerns observed or reported require reporting to the family or any providers?**	☐ **Yes** ☐ **No**	**If yes, list who will be informed below. Provide details in the contact note from this visit.**
18	**Do any concerns observed or reported require reporting to DBHDS or other state agency or your supervisor?**	☐ **Yes** ☐ **No**	**If yes, list who will be informed. Provide details in the contact note from this visit.**
19	**Is a change in the plan needed (additional outcomes, changes in steps or provider instructions)?**	☐ **Yes** ☐ **No**	**If yes, list where changes will be made. Provide details in the contact note from this visit.**
Support Coordinator (printed name): Support Coordinator Signature: _____ Date:_____			

Helpful checklist for generally accepted practices

- ❑ A current assessment is available (within 1 year and for behavioral services conducted in the setting)
- ❑ A written plan is available
- ❑ Targeted changes are addressed (e.g. plans that focus on skill-development, increased independence, or targeted behavioral change)
- ❑ Paid and unpaid supporters are adequately trained as applicable
- ❑ Data collection is available
- ❑ Data is summarized and reviewed as required
- ❑ Changes have been made as needed and requested
- ❑ Routine documentation in notes and reviews correspond with the person's desired outcomes and describe progress and/or methods related to increasing a person's independence, integration, and/or quality of life

Instructions

Complete this tool monthly for people with Enhanced Case Management and quarterly for people with Target Case Management only. It is a means to ensure that consistency is applied when assessing for any "change in status" and to confirm that the services are "implemented appropriately." Based on observation and report, include specific, detailed notes in the person's record about the findings and any actions that will be taken (including the need for any additional assessments or root cause analysis, such as behavioral and/or medical reviews, to understand and address identified concerns). If the person has lost a service as a result of behavioral or medical issues or a provider's perception of increased needs, additional assessment is necessary. **Information from the completion of this tool should be incorporated into the quarterly Person-Centered Review.**

Definitions

"**Change in status**" refers to changes related to a person's mental, physical, or behavioral condition and/or changes in one's circumstances to include representation, financial status, living arrangements, service providers, eligibility for services, and type of services or waiver.

"**Services implemented appropriately**" means that services identified in the ISP are delivered consistent within generally accepted practices and have demonstrated progress toward expected outcomes, and if not, have been reviewed and modified.

Guidance

Question	Examples	Action Considerations
1. Are there new or increased concerns with the environment being clean, safe and appropriate to the person's needs?	(e.g., new or worsening evidence of infestation or unpleasant odor, observable concerns such as torn carpets, unsafe throw rugs, a lack of toilet paper, food, soap or other needed supplies, and the setting is physically is accessible with no barriers noted, etc.)	Determine the severity of the issue; Ask about recent changes; Assist with referrals as needed; Call 911 if emergency; Inform Adult Protective Services if abuse, neglect, or exploitation is suspected; Contact the DBHDS Offices of Licensing and Human Rights; Inform your supervisor and document; Update ISP as necessary
2. Are environmental modifications or assistive technologies lacking, but needed to increase independence or prevent institutionalization?	(e.g., there is an appropriate integration of setting and supports available to promote the individual's independence and/or access to the greater community, wheelchair, walker, communication device, etc.)	Assess whether there are any immediate health or safety needs that must be addressed; Convene a team meeting to discuss the need for an AT or EM evaluation; Assist with linking the individual to a specialist to receive the evaluation; Support the individual to obtain any items recommended by the specialist; Update ISP as necessary
3. Are there new or increased concerns with the person's health and safety?	(e.g., is there a new diagnosis from the past 90 days that could increase risk, such as going to the emergency room for an accident, injuring oneself and without effective behavioral services, signs of inadequate care like skin breakdown or choking that could have been avoided, or other changes in physical appearance: hygiene, weight, physical marks, etc.)	Determine the severity of the issue; Ask about recent changes; Assist with referrals as needed; Call 911 if emergency; Inform Adult Protective Services if abuse, neglect, or exploitation is suspected; Contact the DBHDS Offices of Licensing and Human Rights; Inform your supervisor and document; Update ISP as necessary
4. Have there been any significant life changes that impact services?	(e.g., the loss of a day, residential, or behavioral service provider, change in financial status, benefits, eligibility for services, or a change in waiver status, etc.)	If moved to a less integrated setting, ensure informed choice and complete an RST referral; If individual has lost a needed service, determine and initiate next steps; if guardianship has changed, obtain

		paperwork; if income has decreased, discuss employment and reconfirm eligibility; Update the ISP as needed
5. Are there any concerns related to potential abuse, neglect, or exploitation?	(e.g., apparent bruising, unexplained scratches or pain, evidence of significant untreated health issues such as dental pain, body odor, soiled clothing, missing funds are reported, etc.)	Call 911 if health and safety is at immediate risk; notify the Department of Social services Adult or Child Protective Services Hotline to file a report; Submit a report to the DBHDS Office of Human Rights and if there is an injury or the allegation involves sexual abuse, submit a report to the DBHDS Office of Licensing Report to your supervisor per agency policies; Document the issue; Convene a team meeting if necessary; Ensure any concerns have been addressed and resolved; Confirm corrective actions have been taken to reduce chances of reoccurrence and offer alternate service options as needed; Make referrals if needed; Update the ISP as needed.
6. Was a change in status identified?	NOTE: an answer of "yes" to any question 1 to 5 indicates a change in status. **Provide a note to support observations/discussions regardless of there being an identified change in status.**	
7. Does the person express satisfaction with services and the progress being made?	(e.g., pleased with all services, locating new services in a timely manner developing increased abilities, opportunities for inclusion, having more independence, etc.)	Convene a team meeting to discuss improving or exploring new opportunities and/or considering alternate service options; Make referrals if needed; Update the ISP as needed
8. Are the paid supporters knowledgeable about the person and understand their role in providing support?	(e.g., do the DSPs know the individual's needs and understand their role in providing support? Are meal plans followed to include special equipment, preparation, and preferences?)	Refer the provider to their Community Resource Consultant; Convene a team meeting to discuss improving current services and/or considering alternate service options
9. Are behavioral services available and occurring as needed, and as authorized?	(i.e., number of days and hours authorized)	Convene a team meeting to discuss improving current services and/or considering alternate service options; make referrals as necessary; if needed, request an updated plan from the provider
9 Are professional behavioral services (e.g. Therapeutic Consultation, ABA) needed?	(e.g. there has been an increase in behavioral events, a person is experiencing higher levels of frustration or struggles when relating to others, his or her employer, providers, friends or family report concerns with repetitive or disruptive behavior, a behavior plan needs to be updated, etc.)	If needed, confirm whether these services are being provided. If not, offer to refer the individual to a behavioral provider and ensure that services begin within 30 days. **Providers can be located at** https://dbhds.virginia.gov/developmental-services/behavioral-services/
9a Are professional behavioral services authorized?	(e.g. there is an authorization in WaMS for behavioral consultation or the individual, family, or other person report that behavioral services are being provided)	This question determines if a response if needed for question 9b.

9b. If answered "yes" or "already provided" to 9 or 9a, confirm the following: [series of yes/no questions]	(e.g. the plan is not updated, there is no evidence that the plan is being implemented or that supporters are being trained, documentation does not chart progress in a visual way, the plan doesn't show efforts to decrease and replace negative behavior.)	If any of the items are marked no, inquire about the person's desire to select a different provider - consider if reporting should be made to protective services, the office of Licensing or the Office of Human Rights. Speak with your supervisor as needed and follow your agency policies and procedures for reporting.
10. Are professional nursing services (e.g. Skilled or Private Duty Nursing) needed?	(e.g. there is an identified condition, which is known to require a nurse due to the complexity or invasive nature of treatment, a doctor has ordered nursing services, but no referral has occurred, or medically-related supports appear to be needed, so a referral to primary care should occur to determine if nursing is appropriate)	Refer the provider to their Primary Care Physician; contact 911 if an emergency, follow agency policies and procedures for reporting, convene a team meeting to discuss improving current services and/or considering alternate service options to help reduce or address any risk.
10a Are professional nursing services authorized?	(e.g. there is an authorization in WaMS for nursing or the individual, family, or other person report that nursing services are being provided)	This question determines if a response if needed for question 9b.
10b. If answered "yes" or "already provided" to 10 or 10a, confirm the following: [series of yes/no questions]	(e.g. the person's order requires 15 hours a week of skilled nursing, but the individual family say only 5 hours a week is usually provided and 15 hours a week is usually needed, the person or family express that the nursing services are insufficient)	If any of the items are marked no, inquire about the person's desire to select a different provider - consider if reporting should be made to protective services, the office of Licensing or the Office of Human Rights. Speak with your supervisor as needed and follow your agency policies and procedures for reporting.
11. Has the service being provided during this visit been occurring as needed, and as authorized?	(i.e., number of days and hours authorized) N/A only utilized if not receiving a service at the time of the visit.	Convene a team meeting to discuss improving current services and/or considering alternate service options; make referrals as necessary; if needed, request an updated plan from the provider
12. Does the service being provided during this visit include skill-building if required?	(e.g., progress is occurring as expected, data is collected and reviewed by the provider; this is a required element in certain services to focus on increasing independence based on the ISP) N/A only utilized if service being provided at the time of the visit does not require skill-building	Refer the provider to their Community Resource Consultant; Convene a team meeting to discuss improving current services and/or considering alternate service options; Make referrals if necessary; Request an updated plan from the provider
13. Does community involvement occur as described in the ISP?	(e.g., person has natural supports, do individual activity schedules and reports confirm going out to places they choose and like as indicated in the ISP, has access to reliable transportation, any modifications are supported as documented in the plan)	Convene a team meeting to discuss improving current services and/or considering alternate service options; Make referrals if necessary

14. Are **services implemented appropriately**?	**NOTE:** an answer of "no" to any question 7 to 13 indicates services are not appropriately implemented. **Provide a note to support observations/discussions regardless of services being implemented appropriately.**	
15. All Home and Community-Based (HCBS) Settings must meet basic standards. [series of yes/no questions]	(e.g. the person does not have the ability to move about the space as they choose, they can't access certain places as needed, or they are isolated in some way from others or the larger community.)	If any of the items are marked no, consider if the reporting should be made to protective services, the office of Licensing or the Office of Human Rights. Speak with your supervisor as needed and follow your agency policies and procedures for reporting.
16. Is the visit occurring in one of the following provider-controlled or owned settings: Group Home Residential, Sponsored Home, or Supported Living?	The visit is occurring in one of these settings, which is controlled or owned by a provider: Group Home Residential, Sponsored Home, or Supported Living	A yes to this question determines if you need to answer 16a.
16a. Provider-controlled or owned HCBS residential settings must meet additional standards. [series of yes/no questions]	(e.g. the person has been provided keys to his home and bedroom, he can access food when he wants, he can have visitors and overnight guests, decorate his room and choose his own schedule and activities).	If any of these items are "no" confirm if there is a modification in place to address a restriction. If there is not, consider if the reporting should be made to protective services, the office of Licensing or the Office of Human Rights. Speak with your supervisor as needed and follow your agency policies and procedures for reporting.
17. **Do any concerns observed or reported require reporting to the family or any providers?**	**NOTE:** Some observations/reports require informing the family or one or more waiver providers. For this question, list who will be contacted and describe what will be shared in the contact note from this visit.	
18. **Do any concerns observed or reported require reporting to DBHDS or other state agency or your supervisor?**	**NOTE:** Some observations/reports require reporting to the Department of Social Services, DBHDS, DMAS, or your supervisor. For this question, list who will be contacted and describe what will be shared in the contact note from this visit.	
19. **Is a change in the plan needed (additional outcomes, changes in steps or provider instructions)?**	**NOTE:** If results of the completion of this tool indicate that a change in the person's ISP Parts I to IV or the provider-completed Part V, list the parts of the plan that will be updated. Describe the changes that will be discussed with the person and Substitute Decision-Maker and made to the plan in the contact note from this visit.	

Reference Chart for DD Waiver Services

Service	WaMS Part V Required	Skill-building Required	Back-up Plan Required
Assistive Technology	No	No	No
Benefits Planning	Yes	No	No
Center-Based Crisis Supports	No	Yes	No
Community-Based Crisis Supports	No	Yes	No
Crisis Support services	Yes	Yes (prevention optional; required for stabilization and intervention)	No
Community Coaching	Yes	Yes	No
Community Engagement	Yes	Yes	No
Community Guide (general)	Yes	No	No
Community Guide (housing)	Yes	Optional	No
Companion	Yes	No	Yes (AD & CD)
Electronic Home Based Supports	No	No	No
Employment and Community Transportation	No	No	No
Environmental Modifications	No	No	No
Group Day	Yes	Yes	No
Group Home Residential	Yes	Yes	No
Independent Living Supports	Yes	Yes	No
In-Home Supports Residential	Yes	Yes	Yes
Personal Assistance	Yes	No	Yes (AD & CD)
Personal Emergency Response System	No	No	No
Peer Mentor Supports	Yes	No	No
Individual and Family Caregiver Training	No	Optional	No
Private Duty Nursing	Yes	No	No
Respite	Yes	No	Yes (AD & CD)
Shared Living	No	No	Yes
Skilled Nursing	Yes	No	No
Sponsored Residential	Yes	Yes	No
Supported Employment (Individual & Group)	Yes	Yes	No
Supported Living Residential	Yes	Yes	No
Therapeutic Consultation	Yes (initial Part V in WaMS)	Yes	No
Transition Services	No	No	No
Workplace Assistance	Yes	Yes	No