



DIVISION OF MENTAL HEALTH

***INDIVIDUALIZED
COMPREHENSIVE SERVICE PLAN
GUIDE***

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INDIVIDUALIZED COMPREHENSIVE SERVICE PLAN

The Individualized Comprehensive Service Plan is a detailed plan for transitioning an individual from an institutional setting, such as a nursing home, institution for mental disease (IMD), or state or community hospital, into a community placement. The Plan describes the characteristics of the individual, including strengths as well as needs, and the services and supports necessary for transitioning the individual and sustaining their tenure in a community setting.

A Comprehensive Service Plan covers all aspects of an individual's community living situation, as contrasted with a treatment plan which focuses on specific needs or disorders, such as medical, substance use or mental health conditions.

OVERVIEW

Requirements for a comprehensive individualized service plan

Underlying principles

Service plans are to be individualized, recovery-oriented, person-centered, and based on the principles of community inclusion and self-determination. The service plan is to detail a designed path for the movement of the individual toward their personal goals and preferences.

Assuring individual choice

The foundation of the service plan should be based on the individual's preferences regarding their life, including where and how they want to live and what services and supports they wish to access and from which providers. As appropriate, the preferences of the guardians, if any, family members or other significant others to the individual should also be considered in the development of the plan.

The plan should describe how the opportunities for choice were made available to the individual and their significant others, including the provision of support and, as necessary, instruction or training in understanding and exercising choice as well as determining, evaluating and understanding the advantages as well as the disadvantages and risks of specific choices. Included are to be details of how

any poor or inappropriate choices are to be addressed, such as implementing means of minimizing harm or adverse consequences, or explaining why the choice cannot be honored safely.

Characteristics and components of a service plan

The comprehensive service plan is a single, all-inclusive document, based on the individual's choices and preferences, that prioritizes and structures the delivery of all services and supports across all environments as required for the individual to transition to and be sustained in a community placement living situation.

The service plan can be time limited, focused principally on the individual's transition to the community and assuring that the individual can access the needed or desired services, supports and activities during their first few months in the community. It's anticipated that if an individual has difficulties accessing and sustaining engagement with needed services or supports due to their mental illness, that this need would be reflected in their Mental Health Treatment Plan and addressed through the provision of needed services (e.g., Case Management-Mental Health, Community Support).

Although specific components are required to be included in an individual's service plan, the provider may use their preferred documentation format and forms and/or forms made available by the Department of Human Services' Division of Mental Health (DHS/DMH) for documenting the components of the service plan.

The service plan identifies the individual's strengths, resources and assets, as well as service needs and supports required for transition and community placement. The plan details any mental health or substance abuse disorder needs that the individual wishes to address, any other special needs of the individual (e.g., communication, ambulation, self-care needs), any other health needs, such as dental, physical health and medication needs, and any educational, vocational, interpersonal or community living goals of the individual.

The service plan describes how the individual will be transitioned from an institutional setting to a community placement, any immediate or ongoing risks that need to be addressed, mitigated or managed, any necessary plans in case of an emergency, and the services, supports and activities planned to assure sustained community tenure.

The plan then details the services and supports that will be accessed for the individual, how these will be accessed, and how the services and supports will be prioritized, structured, and coordinated across all environments. Thus, Medicaid, non-Medicaid and any generic services may be included and detailed, as well as educational, vocational or community services. Also included will be the planned utilization and planned role of any entitlements or other benefits. The specific type of each service or support is to be described, along with planned frequency and duration of the service or support and identification of the staff or provider responsible for the service or support. All services and supports to be provided are to be identified in the service plan, regardless of provider or funding source.

Processes for developing and maintaining a service plan

The service plan is to be the product of discussions and meetings amongst the individual, their significant others and the provider staff member charged with transition coordination services for the

individual. Other key staff, other providers and any others who are to be instrumental in supporting and serving the individual as they transition and establish community placement should be invited and encouraged to participate in the development of the plan if they are able to do so.

The staff member charged with transition coordination services for the individual is responsible for convening service planning meetings and for arranging and assuring the involvement of the individual and their significant others in these and all other meetings and discussions leading to the development and formation of the service plan. Staff responsible for transition coordination services for the individual should contact the individual and their significant others prior to any formal service plan meeting in order to identify areas of concern, answer questions and help them prepare for the meeting. This staff member is also responsible for the actual documentation and distribution of the finalized service plan.

The service plan is to be based on current and timely assessments and other information, including interviews and discussions with the individual regarding their goals, preferences and choices as well as their perceived strengths, abilities and needs. The plan should be as simple as possible, but also comprehensive and sufficiently clear that all participants and providers understand and fulfill their roles and responsibilities, and ensure that any available funds or other resources are efficiently used in the best interest of the individual.

The initial service plan is to be completed within 14 calendar days of the first face-to-face contact and initiation of transition coordination services. A Service Plan is an evolving document expected to be modified and updated on an ongoing basis. Thus, an "initial service plan" is considered complete when it has identified all of the individual's currently assessed needs that have to be addressed for their successful transition to their community placement; that is, the initial plan does not have to specify precisely how each need will be met (i.e., by which provider with what services on what date) as these details are expected to be developed later. Rather the initial plan should detail the Class Member's needs and the plan for exploring or developing a means for how each need will be specifically met.

The service plan is to include the name, title, credentials, agency affiliation and relationship to the individual for all participants in the service plan development. At a minimum, the plan is to be signed by the individual and, if applicable, their guardian, and the staff member providing transition coordination services documenting their participation in the plan's development. Other individuals providing services and supports to the individual who participated in the plan's development should also be encouraged to sign the plan as a means of documenting their participation and involvement.

The staff member responsible for providing transition coordination services for the individual is to also ensure that the service plan is reviewed and revised or amended when needed.

Monitoring implementation and effectiveness of the service plan

Although the service plan can be time limited, to make certain that all aspects of an individual's service plan are being implemented, as well as to assess the overall effectiveness of an individual's service plan, a designated staff member from a provider agency will be expected to assure that monitoring of the individual and their service plan occurs at least at the minimum frequency prescribed by DHS/DMH. This schedule requires more frequent monitoring during the individual's first few months in the community, followed by less intense monitoring through the individual's twelfth month in the

community. In addition, the DHS Division of Mental Health Quality Bureau will monitor service plans and their implementation on a periodic basis.

INFORMATION SOURCES

Several sources of information should be accessed and reviewed in developing an individualized service plan that accurately reflects the current status and desired plans of the individual. Some of the principle sources of information are described below, and informed consent must be obtained from the individual and guardian, if any, to access these records.

PAS/RR evaluations

Individuals transitioning from a nursing facility or other institution, including institutions for mental disease (IMDs), will have on file an individualized evaluation completed as part of the Pre-Admission Screening/Resident Review (PASS/RR) process. This evaluation may be the initial evaluation establishing that the individual met the criteria for appropriate placement in a nursing facility, or it may be a later “resident review” or re-evaluation of whether the individual meets the criteria for nursing facility placement and/or community placement. These reviews can be obtained from the files of the nursing facility and, at times, from the DHS Division of Mental Health.

If at all possible, it may be very beneficial if staff charged with developing the Service Plan could meet with the individual(s) who completed the PAS/RR evaluation in order to obtain any additional information or background that may be useful in formulating the Plan.

Hospital/nursing facility treatment plans, discharge summaries and other records

In addition to the PASS/RR evaluations, hospitals and nursing facilities will have additional records useful for formulating a service plan, including treatment plans, discharge summaries, case reviews, progress notes, special reports and other materials.

Other provider information

If the individual has received services or supports from other providers, either currently or within the last several months, these providers can be requested to share information and records they have on the individual relative to the development of a comprehensive service plan.

Note that recent service and other billing information on the individual from state agencies that have funded services for the individual, including DHS/DMH and HFS, are expected to be reflected in the Resident Review Report and can guide which, if any, other providers records may be beneficial to review.

Interview of the individual, their guardian (if any) and significant others

A primary source of information for the development of an individualized service plan must be an interview with the individual and, as appropriate, their significant others. In some cases, the interview may only need to reconfirm the findings, choices and preferences of the individual as documented in a PAS/RR report. In other instance, more than one interview may be required to obtain sufficient information for service plan development, and the interviews may have to utilize clinical techniques, such as motivational interviewing, to help clarify and prioritize an individual's preferences and goals. As part of the interview process, the individual must be able to evaluate and understand the advantages as well as the disadvantages and risks of specific choices. In preparing for the interviews, plans should be established for how poor or inappropriate choices will be addressed.

SERVICE PLAN

Introduction

Although the format of an individualized service plan may vary, each plan should contain the following sections:

- Demographic information on the individual
- The individual's goals and preferences
- Clinical information about the individual, including strengths, needs and treatment or support plans
- The plan for executing the actual transition to community placement and assuring coordination
- The plan for mitigating risks and assuring access to emergency services when needed

The following sections detail the information expected to be included, addressed or considered in each individualized service plan.

Demographic information

The demographic section of the service plan aims to minimize redundancy with similar information required or available in other documents, such as a mental health assessment, yet still provide information that is important in planning and executing a transition from institutional living to community placement.

Much of the following information may be available from the PAS/RR report and may simple need to be reconfirmed with the individual.

The following information should be documented at the start of development of the Comprehensive Service Plan after staff providing transition services have completed their first meeting with the individual:

- Date of the documentation
- Individual's name (last, first, middle, suffix, if any)
- Gender
- Alias or previously used names
- Primary or preferred language

- DHS Recipient Identification Number (RIN #)
- Individual's current address (the facility name and address)
- Individual's phone number
- Emergency contact name, address, phone numbers
- Emergency contact's relationship to the individual
- Whether the individual is under guardianship and if so, what type and the name, address and phone number of the guardian
- Names, addresses and phone numbers of significant others to the individual
- Name of the primary staff member providing transition services for the individual and their agency's name

The following information should be added as soon as possible to assist in planning and executing transition services:

- Date of the documentation
- Approximate planned date for the actual discharge from the facility and transition and move into community placement
- Whether the individual will be living alone and, if not, who will the individual be living with
- The current status of the individual relative to Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)
- Current or planned supports for the individual to manage their finances (such as representative payee, money management training, etc.)
- Other income sources, if any
- Current status of the individual relative to Medicaid health insurance
- Other health insurance, if any
- Whether the individual has had any unpaid rent or utility bills in the last twelve months and, if so, a description of these occurrences
- Whether the individual has had any evictions within the past five years and, if so, a description of the circumstances
- Whether the individual has a history of criminal activity and, if so, a description of this history

The agency's own format can be used for documenting the above information or a form for capturing this information is available in the Appendix.

Preferences and goals

Process for obtaining individual's preferences and goals

The service plan should describe the processes used to obtain the individual's preferences regarding their planned community placement, including the involvement of significant others to the individual and the solicitation of their input. In addition, how the individual was involved on an ongoing basis in the development and revisions of the service plan should also be described. Any specific obstacles encountered in obtaining the individual's preferences and goals for community living should be described, along with how these obstacles were managed, including individual choices that had significant risks or that could not be honored. In summary, this section of the service plan should demonstrate the validity of the individual's preferences and goals detailed in the plan.

Geographical location for community placement preferences

The plan should specify the geographical locations the individual would prefer to live.

Housing preferences

The plan is to specify the housing preferences of the individual, including what housing options were presented and considered by the individual.

Living arrangement preferences (e.g., alone, roommates)

The plan should detail the preferred living arrangements of the individual, including whether they wish to live with family members, have certain roommates, live alone, etc.

Entitlements and benefits options and preferences

The plan should describe the entitlement and benefits the individual is interested in maintaining or applying for, and include a description of the options that were presented to the individual. Some of these would include:

- Social Security/Retirement
- Social Security/Disability
- Supplemental Security Income
- Social Security Funds
- Public Assistance/Other Public Resources
- Medicare
- VA
- TRICARE
- Health Insurance
- Other Personal Resources

Community living aspirations

Finally, with respect to individual preferences and goals, the plan should describe the individual's aspirations with respect to the following dimensions of community living:

Work or vocational

What vocational goals, if any, does the individual have?

Educational

What educational goals, if any, does the individual have?

Social

What social, socialization or interpersonal goals does the individual have?

Spiritual/religious

What spiritual or religious goals and activities, if any, does the individual wish to pursue?

Other

Describe any other goals, aspirations or expectations the individual has with respect to their community placement and community living.

Identified strengths and assets

The individual's identified strengths and assets, as identified by the individual themselves or their significant others, should be noted, and compared to those identified in other assessment information or by the service plan development staff.

Identified needs and supports

The individual's identified service needs and supports, as identified by the individual themselves or their significant others, should be noted, and compared to those identified in other assessment information or by the service plan development staff.

Treatment providers preferences

The individual's preferences for providers, both at the agency and individual staff member level (e.g., perhaps a specific staff member or type of staff member, such as male, female, certain age or ethnicity, etc.), for the individual's needed treatments are to be noted. These should be specified for mental health services, physical and dental health services as well as any other likely needed services specific to this individual (such as substance abuse services, vocational services, etc.).

Support providers preferences

The individual's preferences for support providers, such as church or support groups, social service agencies, etc., both at the agency and individual staff member level are to be noted. These should be specified for likely needed or desired supports particular to this individual.

Clinical information and treatment and support needs and plans

This section of the individualized service plan details the clinical profile of the individual as well as identified treatment and support needs and plans.

Clinical Profile

The primary diagnoses for the individual, including physical, psychiatric and substance abuse diagnoses, if any, are to be listed.

In addition, all the medications the individual is currently taking are to be listed along with the dosage, whether it is a prescribed medication (versus an over-the-counter medication), the purpose of the medication, any special instructions, when the medication is to be taken, if any lab testing or other monitoring is required, the prescriber's name and phone number, and the dispensing pharmacy's name and phone number

The Clinical Profile information should be updated throughout the transition process should any changes occur, including changes in medications.

Mental health and psychiatric

Describe the plans for the individual to receive mental health treatment and psychiatric services during and following their transition to a community setting. Include the planned providers of mental health treatment and psychiatric services, the location(s) where treatment will be provided and the types of treatment to be delivered. Include the planned psychotropic medications the individual will receive if different from those listed in the clinical profile.

Once established, the date, time, and location of the individual's initial scheduled contact with these providers once the individual has made the actual move into their community placement should be recorded in the individual's service plan.

Substance use disorders, if applicable

If such services will be needed by the individual, describe the plans for the individual to receive substance use services during and following their transition to a community setting. Include the planned providers of these services, the location(s) where treatment will be provided and the types of treatment to be delivered.

Once established, the date, time, and location of the individual's initial scheduled contact with these providers once the individual has made the actual move into their community placement should be recorded in the individual's service plan.

Medical/physical health

Describe the plans for the individual to receive medical/physical health services following their transition to a community setting, including periodic general physical health exams. Include the planned providers of these services, the location(s) where treatment will be provided and the types of treatment, if any, to be delivered.

Once established, the date, time, and location of the individual's initial scheduled contact with these providers once the individual has made the actual move into their community placement should be recorded in the individual's service plan.

Dental health

Describe the plans for the individual to receive dental services following their transition to a community setting (note that periodic general dental exams and prophylactic teeth cleaning are not covered services under Medicaid; if appropriate, describe how such services will be obtained and paid for). Include the planned providers of these services, the location(s) where treatment will be provided and the types of treatment, if any, to be delivered.

Once established, the date, time, and location of the individual's initial scheduled contact with these providers once the individual has made the actual move into their community placement should be recorded in the individual's service plan.

Other

If any other treatment services will be needed by the individual, describe the plans for the individual to receive these services following their transition to a community setting. Include the planned providers of these services, the location(s) where treatment will be provided and the types of treatment to be delivered.

Once established, the date, time, and location of the individual's initial scheduled contact with these providers once the individual has made the actual move into their community placement should be recorded in the individual's service plan.

Support needs and plans

This section of the plan details the non-clinical or non-treatment-oriented supports needed by the individual in order to successfully transition and sustain tenure in their chosen community placement living situation.

Description of support needs

Describe the individual's community support needs. These may include such things as:

- Ongoing assistance with accessing and maintaining entitlements and benefits, such as disability payments, Supplemental Nutrition Assistance Program (SNAP), low income home energy assistance, rental assistance, etc.;
- Assistance with accessing social or recreational activities;
- Assistance with accessing religious or spiritual activities or groups;
- Assistance with handling financial issues;
- Assistance with handling legal issues (such as terms of probation, etc.)
- Assistance with personal care or hygiene;
- Assistance with home furnishings, housekeeping, home repairs, etc.
- Assistance with shopping;
- Assistance with meal planning and preparation.

Current and planned supports

Describe any support services the individual is currently receiving and the name and address/location of each individual or agency providing these support services.

Describe changes, if any, planned for addressing the support needs of this individual during and after their transition to their chosen community placement, including the addition of support services, who will provide these supports and how.

Transition coordination plan

Plans for additional training or treatment prior to move to the community

If the individual will need additional skills training or treatment prior to executing their actual move into the community (e.g., training on how to self-administer an injectable medication), describe the service that is needed and how this need was communicated to the staff of the individual's current nursing facility, IMD or hospital, as well as what monitoring and follow-up actions will occur to ensure the individual's readiness for community placement. In most cases, these needs should be communicated to the staff responsible for PAS/RR.

Plans for entitlements and benefits

Describe what entitlements and benefits, including SSI, SSDI, and health insurance, that the individual currently has and any steps and actions that are planned or have occurred as necessary to maintain these entitlements and benefits in the community.

Describe the entitlements and benefits that will be applied for and the plans and timeline for completing the application process and achieving finalization of these entitlements and benefits.

Plans for handling finances in community placement

Describe how the individual's finances will be handled in the community, such as what banks and bank accounts will be opened, if a representative payee or guardian of estate will be maintained or applied for, any money management training to be provided, etc.

Plans for securing housing in the community

Describe how the individual's preferred housing arrangement will be sought and secured, as well as any assistance with securing and maintaining housing, such as application for DHS/DMH Bridge subsidies, HUD vouchers, etc.

Plans for securing utilities, equipment, supplies and groceries

Describe the plan for ensuring the readiness and availability of services and items needed for living in the community housing, including utilities (electric, gas, water, trash, phone), cleaning supplies and equipment, and groceries. Also any specialized equipment or materials needed by the individual (e.g., wheelchair, cane, grab bars installed in the bathroom, etc.)

Plans for transportation in the community

Describe how the individual will get about in the community, including to doctor and service appointments, recreational, social and religious activities, etc.

Plans for obtaining medications in the community

Describe how the individual's medications, maintenance as well as one-time prescriptions, will be obtained in the community.

Plans for implementing the actual move to community placement

Describe the tentative date and plans for the actual move from the institution to the community placement.

Inventory and plans for handling personal property and assets

Detail the individual's personal property and any other assets that need to be transferred to the community living situation or other community facility (e.g., changes in bank savings accounts, etc.). Describe how these transfers will be accomplished.

Change of address and personal identification

Describe how the change of address notices will be given and to which entities. Describe the type of personal identification that will be obtained or maintained by the individual in the community.

Initial medications supply

Describe if any current medication supply will be handled and transferred to the community and, if necessary, how the individual's initial medications in the community will be made available on the day of the individual's actual move into their community placement.

Schedule and participants in the actual move into the community

Describe the planned date of the move and who will be involved in assisting and transporting the individual and their belongings to the new living arrangement in the community.

Risk assessment and mitigation plan

To enhance the likelihood of successful and sustained community placement, likely risks to the individual and their community placement should be assessed and plans developed to eliminate or at least mitigate these risks. Once each risk is identified, the plans to address the risk should be detailed, including the specific tasks and activities that will occur, when and by whom. In addition, the plans for follow-up and monitoring of the planned tasks and activities as well as re-assessment of the risk should be described, including an assessment of how well managed the risk appears to be.

To complete the risk assessment a listing of possible risks for an individual transitioning into an independent community living placement, as well as some possible mitigation strategies for the risks, are provided at the University of Illinois College of Nursing "Money Follows the Person" web site at:

<https://mfp.nursing.uic.edu/mfpweb/process.shtml>

Ongoing efforts are being made to improve the completeness and facilitate the risk assessment process, so you may see this web-based form and tool being updated and enhanced over the coming months.

Emergency plans and personal resources list

With the individual, develop a plan for any possible emergencies that may occur for the individual in their new community placement situation, and document these plans in the service plan as well as in a format that can be given to the individual and used by them in their community placement. The

emergency plan should describe what the individual should do (e.g., who they should call or what action they should do) for the following situations:

- Medical emergency, serious injury or accident
- Fire (evacuation route and who to call)
- Crime incident
- Tornado or severe storms
- Reporting abuse or neglect
- Problems with landlord or other tenants
- Problems with utilities, food or transportation
- Mental health crisis
- Other critical numbers, care givers or other supports than can be called or contacted

In addition to the emergency plan, a description of the specific personal resources for the individual in the community should also be documented in the service plan as well as in a format that can be provided to the individual. This listing of resources should include:

- The individual's designated emergency contact name and contact information, such as address and phone number
- The phone number for a mental health crisis
- The primary mental health service staff names and phone numbers
- The names and contact information, such as address and phone numbers, of medical providers for the individual (primary care physician, specialists)
- The name and contact information, such as address and phone number, of the individual's community pharmacy
- The names and contact information, such as address and phone numbers, of any suppliers of needed medical equipment
- The names and phone numbers of transportation services or providers
- The names and contact information, such as address and phone number, of the individual's representative payee, if any
- The names and contact information, such as address and phone number, of the individual's bank
- The individual's legal guardian's name, if any, and contact information, such as address and phone number
- The names and contact information, such as address and phone numbers, of involved family members and significant others for the individual
- The names and contact information, such as address and phone numbers, of neighbors of the individual
- The names and contact information, such as address and phone numbers, of any support individuals (such as a church and/or pastor), support group or resource, such as a drop-in center, library, etc.

Listing and signatures of Service Plan Development Team and date of signing

Each time the Comprehensive Service Plan is developed, amended or revised, the names, titles, agency affiliations and relationships to the individual of those who participated in meetings and drafting of the Service Plan should be listed along with the dates of the meetings and the completion of the documentation of the Plan itself.

Attachments (e.g., treatment plans)

As deemed appropriate, it may be of benefit to attach copies of specific treatment plans, assessments, lab results or other reports to the Service Plan for ready reference.

Appendix: Forms for Comprehensive Service Plans

Since community service agencies may have their own versions and requirements for electronic and paper clinical records, specific forms for the Comprehensive Service Plan are not prescribed. However, some forms that staff providing transition coordination may find useful are attached and also available from DHS Division of Mental Health.

In addition, staff may use the following outline template for completion of an Individualized Comprehensive Service Plan:

- I. Demographic information
- II. Preferences and goals
 - A. Process used to obtain the individual's preferences and goals
 - B. Geographical location preferences
 - C. Housing preferences
 - D. Living arrangement preferences
 - E. Entitlements and benefits options and preferences
 - F. Community living aspirations
 1. Work or vocational
 2. Educational
 3. Social
 4. Spiritual/religious
 5. Other
 - G. Identified strengths and assets
 - H. Identified needs and supports
 - I. Treatment provider preferences
 - J. Support providers preferences
- III. Clinical information and treatment and support needs and plans
 - A. Clinical profile
 1. Diagnoses
 2. Medications
 - B. Plans for accessing mental health and psychiatric services
 - C. Plans for accessing substance use disorder treatment services, if needed
 - D. Plans for accessing medical/physical health services
 - E. Plans for accessing dental services
 - F. Plans for accessing other treatment services
- IV. Support needs and plans
- V. Transition coordination plan
 - A. Plans for securing preferred entitlements and benefits
 - B. Plans for handling finances in the community
 - C. Plans for securing housing in the community
 - D. Plans for securing utilities, equipment, supplies and groceries
 - E. Plans for handling transportation in the community
 - F. Plans for obtaining medications in the community
 - G. Plans for implementing the actual move into community placement

- VI. Risk assessment and mitigation plan
- VII. Emergency plans and personal resources list

Letter of Introduction for Individuals Transitioning

moving on made possible by the Williams Consent Decree

Date _____

Dear _____

My name is _____. I work for _____,

a community mental health agency, located at _____

in _____. My telephone number is _____.

I have been assigned to assist you with moving to community-based housing with supports and services. It is my pleasure to play such an important role in making your transition to the community a success. This will be the first of a series of meetings I will have with you with the overall goal being your successful transition and move into a place in the community. Your signature below confirms my introduction and the beginning of the transition process.

Class Member Signature

Date

Signature of Staff Providing Transition Coordination Services

Date

Copies:

- Transitioning individual
- Nursing facility
- Community Mental Health Agency

Demographic/Face Sheet for Individuals Transitioning



Demographic/Face Sheet for Individuals Transitioning to Community Placement

The items on page 1 should be completed during or immediately after the first transition service contact with the individual:					
Date:		Individual's name (last, first, middle, suffix):			Gender <input type="checkbox"/> M <input type="checkbox"/> F
Alias or previously used names:		Individual's primary or preferred language:		RIN #:	
Individual's current address (i.e., facility name and address)			Individual's phone #:		
Emergency contact name, address and phone number:			Emergency contact relationship to the individual:		
Individual under guardianship? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of guardian- ship:		Guardian's name, address and phone number:		
Names, addresses and phone numbers of significant others for the individual:					
Name of primary staff providing transition services:			Agency of primary staff:		

The following items can be completed as the information is obtained:			Date this section completed:
Approximate/ Planned date of discharge & transition:		Will the individual be living alone? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, who will the individual be living with?
Supplemental income eligibility		Current or planned support to manage finances (select all that apply):	
<input type="checkbox"/> SSI <input type="checkbox"/> Eligible, receiving <input type="checkbox"/> Eligible, not receiving <input type="checkbox"/> Eligibility pending, Date: _____ <input type="checkbox"/> Not eligible, Date: _____ <input type="checkbox"/> Unknown		<input type="checkbox"/> SSDI <input type="checkbox"/> Eligible, receiving <input type="checkbox"/> Eligible, not receiving <input type="checkbox"/> Eligibility pending, Date: _____ <input type="checkbox"/> Not eligible, Date: _____ <input type="checkbox"/> Unknown	
Other sources and amounts of income, if any:			
<input type="checkbox"/> Medicaid status <input type="checkbox"/> Eligible <input type="checkbox"/> Not eligible Date: _____ <input type="checkbox"/> Eligibility decision pending, Date: _____ <input type="checkbox"/> Application in process, Date: _____ <input type="checkbox"/> Unknown		Other insurance, if any:	
Unpaid utility bills or rent within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No, If yes, explain: _____ _____			
History of eviction within the past five years: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain cause of eviction: _____ _____			
History of criminal activity <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: _____ _____			

Listing of Current Medications



Listings of Current Medications

DIVISION OF MENTAL HEALTH

Date: _____ Participant's Name: _____ RIN #: _____

Primary Pharmacy Name: _____ Number _____

Secondary Pharmacy Name: _____ Number _____

Laboratory Name _____ Number: _____

Allergies/Adverse Reactions: _____

List ALL prescription medications (oral, injections, creams, sprays) and over the counter medications, vitamins, and supplements (including herbals)

Example:

Medication	Dosage	Purpose	AM	NOON	PM	BEDTIME	Lab Monitoring/Frequency (check if yes, leave blank if none required)
EXAMPLE: Lisinopril	20 mg	Blood pressure	1 at 8 am		1 at 4 pm		<input type="checkbox"/> Yes How Often:

Medication #: _____

Medication	Dosage	Purpose	AM	NOON	PM	BEDTIME	Lab Monitoring/Frequency (check if yes, leave blank if none required)
							<input type="checkbox"/> Yes How Often:

Special Instructions:

Prescribing Physician:

Phone:

Date added:

Discontinued? Date:

Participant's name: _____

Medication #: _____

Medication	Dosage	Purpose	AM	NOON	PM	BEDTIME	Lab Monitoring/Frequency (check if yes, leave blank if none required)
							<input type="checkbox"/> Yes How Often:
Special Instructions:							
Prescribing Physician:					Phone:		
Date added:				Discontinued? <input type="checkbox"/> Date:			

Medication #: _____

Medication	Dosage	Purpose	AM	NOON	PM	BEDTIME	Lab Monitoring/Frequency (check if yes, leave blank if none required)
							<input type="checkbox"/> Yes How Often:
Special Instructions:							
Prescribing Physician:					Phone:		
Date added:				Discontinued? <input type="checkbox"/> Date:			

Medication #: _____

Medication	Dosage	Purpose	AM	NOON	PM	BEDTIME	Lab Monitoring/Frequency (check if yes, leave blank if none required)
							<input type="checkbox"/> Yes How Often:
Special Instructions:							
Prescribing Physician:					Phone:		
Date added:				Discontinued? <input type="checkbox"/> Date:			

Participant's name: _____

Medication #: _____

Medication	Dosage	Purpose	AM	NOON	PM	BEDTIME	Lab Monitoring/Frequency (check if yes, leave blank if none required)
							<input type="checkbox"/> Yes How Often:
Special Instructions:							
Prescribing Physician:					Phone:		
Date added:				Discontinued? <input type="checkbox"/> Date:			

Medication #: _____

Medication	Dosage	Purpose	AM	NOON	PM	BEDTIME	Lab Monitoring/Frequency (check if yes, leave blank if none required)
							<input type="checkbox"/> Yes How Often:
Special Instructions:							
Prescribing Physician:					Phone:		
Date added:				Discontinued? <input type="checkbox"/> Date:			

Medication #: _____

Medication	Dosage	Purpose	AM	NOON	PM	BEDTIME	Lab Monitoring/Frequency (check if yes, leave blank if none required)
							<input type="checkbox"/> Yes How Often:
Special Instructions:							
Prescribing Physician:					Phone:		
Date added:				Discontinued? <input type="checkbox"/> Date:			

Risk Assessment and Sample Mitigation Strategies

The risk assessment and possible mitigation strategies are available at the University of Illinois College of Nursing “Money Follows the Person” website at:

<https://mfp.nursing.uic.edu/mfpweb/process.shtml>

Ongoing efforts are being made to improve the completeness and facilitate the risk assessment process.

Risk Mitigation Plan

Risk Mitigation Plan for Individuals Transitioning into the Community

Date:		Participant Name:		RIN #:	
Participant Address:				Participant 's Phone #:	
Name of staff providing transition coordination services:				Staff's Phone #:	

Procedure: This Mitigation Plan is to be used to assist in planning a successful transition from an institutional setting, such as a nursing facility or hospital, to independent living in the community. Complete this form during the initial planning phase, while the participant is still in the institutional facility, and then it is to be updated at subsequent contacts, once the participant is living in the community. Once risks have been identified on though a risk assessment and mitigation strategies have been developed and selected this Mitigation Plan should be completed with the participant and any significant others who are involved in the participant's transition.

- Identify and describe the risks identified through the risk assessment. To keep track of risks and for easy reference, you may number each risk.
- Identify and describe the mitigation strategy and the plans, tasks or activities that will occur to implement the strategy.

Note: A mitigation strategy may address more than one risk. It may be possible to list the mitigation strategy only one time and list ALL the risks that reference that strategy IF and only the tasks, services and activities associated with that strategy address more than one risk question. Otherwise the strategy may need to be listed more than once.

- Document the title and name of the individual(s) who will complete each task (service provider, participant, significant other, caregiver, etc.).
- Document the date the task/service is to start and the schedule the task/service is to be performed on.
- Document planned follow-up dates and/or a schedule for monitoring.
- Document the date of the follow-up and the code that evaluates the status of the strategy using the following codes.
 - MRO - Managed Risk: Ongoing – staff will use this code if the task/service is successful for the participant and is ongoing and will write the date this evaluation occurred.
 - MRC - Managed Risk: Complete – staff will use this code if the task/service was successful and is complete and will write the date this evaluation occurred.
 - PM - Partially Managed – staff will use this code if the task/service did not manage the risk as intended and will write the date this evaluation occurred.
 - NM - Not Managed – staff will use this code if the task/service did not manage the risk or that it was never implemented and will write the date this evaluation occurred.
 - P - Pending – staff will use this code if the participant chose not to address this risk at this time and will write the date this evaluation occurred.

Participant's name: _____

Risk #	Risk description	Mitigation strategy and plan/task/activity to complete strategy (Be Specific)	Who will complete task	Task/Service Start Date and Schedule	Planned Monitoring (Dates)	Follow-Up	
						Date	Code

Follow-up codes: Managed Risk Ongoing = MRO Managed Risk Complete = MRC Partially Managed = PM Not Managed = NM Pending = P
 Attach additional pages if needed.

Participant's name: _____

Risk #	Risk description	Mitigation strategy and plan/task/activity to complete strategy (Be Specific)	Who will complete task	Task/Service Start Date and Schedule	Planned Monitoring (Dates)	Follow-Up	
						Date	Code

Follow-up codes: Managed Risk Ongoing = MRO Managed Risk Complete = MRC Partially Managed = PM Not Managed = NM Pending = P
 Attach additional pages if needed.

Participant's name: _____

Risk #	Risk description	Mitigation strategy and plan/task/activity to complete strategy (Be Specific)	Who will complete task	Task/Service Start Date and Schedule	Planned Monitoring (Dates)	Follow-Up	
						Date	Code

Follow-up codes:
 Managed Risk Ongoing = MRO Managed Risk Complete = MRC Partially Managed = PM Not Managed = NM Pending = P
 Attach additional pages if needed.

Participant's name: _____

Notes:

Follow-up codes:

Managed Risk Ongoing = MRO

Managed Risk Complete = MRC

Partially Managed = PM

Not Managed = NM

Pending = P

Attach additional pages if needed.

Emergency/24 Hour Back-up Plan



DIVISION OF MENTAL HEALTH

**Emergency/24 Hour Back-up Plan
for Individuals Transitioning into the Community**

Place near all telephones and on the refrigerator

Date created:	Participant Name:	Participant address:	Participant phone #:
Participant RIN #:	Emergency contact name & relationship:	Emergency contact address:	Emergency contact phone #:

EMERGENCY <i>IF, There is...</i> A Fire -- A Medical Emergency -- A Serious Injury/Accident - A Crime -- Life Support Equipment Failure Call 911	MENTAL HEALTH CRISIS If there is a need for mental health crisis services, call: _____	REPORT ABUSE, NEGLECT OR EXPLOTATION TO: 1-800-368-1463
FIRE EVACUATION ROUTES: #1: _____ #2 : _____ IN CASE OF A TORNADO or severe storm, follow these instructions: _____ _____ _____	PROVIDER STAFF CONTACTS: Name: _____ Phone#: _____ Name: _____ Phone#: _____ Name: _____ Phone#: _____	MEDICINES, preferred pharmacies: Name: _____ Address: _____ Phone#: _____ Name: _____ Address: _____ Phone#: _____
LANDLORD PHONE #: _____ EMERGENCY MAINTENCANCE: _____	TRANSPORTATION For medical Medicaid funded (NON-emergency) call contracted provider: _____	TRANSPORTATION For non-medical transportation: _____

<p>ADVANCED DIRECTIVES:</p> <p><input type="checkbox"/> Power of attorney, Name: _____</p> <p><input type="checkbox"/> Living will <input type="checkbox"/> Do not resuscitate</p> <p><input type="checkbox"/> Other <input type="checkbox"/> None</p> <p><input type="checkbox"/> REPRESENTATIVE PAYEE:</p> <p>Name: _____</p> <p>Phone#: _____</p>	<p>UTILITIES (e.g., outages)</p> <p>Name: _____</p> <p>Phone#: _____</p> <p>Name: _____</p> <p>Phone#: _____</p> <p>MEDICAL EQUIPEMENT and emergency home response equipment:</p> <p>Name: _____</p> <p>Phone#: _____</p>	<p> MEALS AND FOOD, special instructions: _____</p> <p>_____</p> <p>_____</p> <p>BANK:</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone#: _____</p>
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OTHER RESOURCES:

<p>FAMILY, GUARDIAN, OTHER CAREGIVERS:</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone#: _____</p>	<p>MEDICAL PROVIDERS:</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone#: _____</p>	<p>SUPPORTS (friends, neighbors, support groups, church, library, etc.):</p> <p>Name: _____</p> <p>Address: _____</p> <p>Phone#: _____</p>
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Checklist for Transition from Institutions to Community Placement

Checklist for Transition from Institutions to Community Placement

This Transition Checklist must be updated each week throughout the Class Member's transition process. Submit updated Transition Checklists to the DMH Associate Deputy Director for Transition Coordination by the close of business every Friday.

Participant's Name: _____ RIN # _____

Planned date of move from nursing facility/ IMD, state or community hospital): _____

WQA Name: _____ Agency: _____

Date Transition Checklist updated and sent to DMH: _____

TRANSITION ENGAGEMENT

Staff person responsible for transition engagement tasks: _____

- Obtain and review the Resident Review report.

Date completed and staff initials: _____

- Teleconference discussion of Resident Review Report with Reviewer.

Date completed and staff initials: _____

- Meet with Class Member (must occur within 7 business days of referral from DHS/DMH to community agency).

- Review letter introducing transition coordination process and staff with Class Member and his/her significant others.

- Obtain Class Member's signature on introductory letter.

- Provide copies of signed letter to Class Member, IMD, and community agency.

Date completed and staff initials: _____

- Set up transition planning meetings schedule with Class Member and significant others.

Date completed and staff initials: _____

- Collect information needed for transition and Comprehensive Service Plan

- Interview Class Member and significant others regarding housing, providers, services and supports preferences and choices.

Date completed and staff initials: _____

- Obtain Class Member's informed consent to access information and records necessary to complete transition and community placement process.

Date completed and staff initials: _____

- Share Resident Review Report with other service providers as authorized and appropriate.

Date completed and staff initials: _____

- Review IMD's clinical records, evaluations and other documentation on Class Member.

Date completed and staff initials: _____

- Interview IMD staff (e.g., social service staff, discharge planner) about Class Member's preferences, strengths and needs for community placement.

Date completed and staff initials: _____

- Based on documentation in the Resident Review Report:

- If service and billing information from state agencies is not sufficient or current in the Report, request updated or additional information from the Resident Review staff.

- Review available service and billing information from state agencies.

- Request and review records and other documentation from other service providers.

- Or Not Appropriate/Not Applicable

Date completed and staff initials: _____

Checklist for Transition from Institutions to Community Placement

LINKAGES TO COMMUNITY SERVICES

Staff person responsible for community services linkages tasks: _____

Working with Class Member:

- Identify needed community services and supports.
- Contact and initiate discussions with providers.

Date completed and staff initials: _____

Mental health assessment is initiated.

- Assessment documents recommended services to be provided.

Date completed and staff initials: _____

Mental health treatment plan is initiated.

- Submit documentation for services requiring pre-authorization.

Date completed and staff initials: _____

- Mental health treatment plan completed. Note: If plan is not completed prior to move-out date, list incomplete plan sections: _____

Date completed and staff initials: _____

PERSONAL IDENTIFICATION AND ADDRESS CHANGES

Staff person responsible for obtaining personal identification & address changes: _____

Obtain state ID

Date completed and staff initials: _____

Obtain birth certificate

or Obtain notification from Illinois Department of Public Health Vital Statistics that no birth certificate is available.

Date completed and staff initials: _____

Address change with Post Office.

Date completed and staff initials: _____

Address change for voter's registration,

Date completed and staff initials: _____

or Not applicable.

Address change for state ID or driver's license.

Date completed and staff initials: _____

Address change with Social Security.

Date completed and staff initials: _____

Address change for Medicaid through the Department of Human Services' Family Community Resource Center (FCRC) (formerly called Public Aid or local office).

Date completed and staff initials: _____

Checklist for Transition from Institutions to Community Placement

Address change for Medicare

Date completed and staff initials: _____

or Not applicable: Participant does not have Medicare.

HOUSING

Staff person responsible for completing housing tasks: _____

Application for the DHS/DMH model of permanent supportive housing (PSH) completed,

Date completed and staff initials: _____

or Not applicable.

Application for PSH Transition Fund (form # 6) completed,

Date completed and staff initials: _____

or Not applicable.

Applications for other housing rental assistance (e.g., HUD Section 8, IHDA low income assistance) completed,

Date completed and staff initials: _____

or Not applicable.

Referral to DRS Home Services Program

Date completed and staff initials: _____

or Not applicable.

Housing lease signed by participant and landlord,

Date completed and staff initials: _____

or Not applicable.

Housing "reasonable accommodations" letter submitted (if housing becomes available and services still need to be arranged for participant to safely transition),

Date completed and staff initials: _____

or Not applicable.

Home furnishings purchased and available.

Date completed and staff initials: _____

Moving date verified.

Date completed and staff initials: _____

Moving van or other assistance with moving scheduled.

Date completed and staff initials: _____

Required home modification(s) completed.

Date completed and staff initials: _____

or Not applicable.

Telephone service obtained (cell phone or land line).

Date completed and staff initials: _____

or Not applicable.

Checklist for Transition from Institutions to Community Placement

- Utilities (e.g., electric, natural gas, water, trash removal) activated.

Date completed and staff initials: _____

- Life Line/Emergency Response System installed and activated (if needed),

Date completed and staff initials: _____

or Not applicable.

- Emergency evacuation plan created and reviewed with participant and caregiver(s), if any.

Date completed and staff initials: _____

- Obtain order from nursing facility physician and arrange for physical therapy home safety assessment,

Date completed and staff initials: _____

or Not applicable.

MEDICATIONS

Staff person responsible for completing medications tasks: _____

- Obtain a complete list of medications from the institution.

Date completed and staff initials: _____

- Obtain active/valid prescriptions for all medications on the medication list from the physician in the institution.

Date completed and staff initials: _____

- Complete a list of all current medications, doses, and schedule, and review with the participant and their significant others.

Date completed and staff initials: _____

- Medication management education provided.

Date completed and staff initials: _____

- Sufficient initial supply of medications available so participant does not go without medications while waiting for new scripts. To assure everything will be in place on day of discharge you must hand deliver or fax a letter to the pharmacy with the date of planned discharge 5 business days **PRIOR** to planned discharge date.

See "Provider notice" and "cover letter". (Note: The "Provider Notice" will inform the pharmacy of the Community Placement program and advises that the 'Refill Too Soon' approval requests will be granted to Community Placement participants upon entering the community. There will be a standard cover letter that will be faxed to the pharmacist with the provider notice. The 5 business day period is needed to lift the edits and to assure everything will be in place on day of discharge.)

Date completed and staff initials: _____

- Back-up plan established if pharmacy will not dispense.

Date completed and staff initials: _____

- Make arrangements to obtain remaining medications from institution that participant is entitled to (show letter from HFS, if needed).

Date completed and staff initials: _____

Checklist for Transition from Institutions to Community Placement

Assist participant with planning how medications will be stored and organized in new residence.
Date completed and staff initials: _____

Arrange for home health nursing services for medication and disease management, if needed,
Date completed and staff initials: _____
or Not applicable.

Obtain a prescription for home health nursing services from institution's physician,
Date completed and staff initials: _____
or Not applicable.

PHARMACY

Staff person responsible for completing pharmacy tasks: _____

Convenient pharmacy in the participant's local community identified.
Date completed and staff initials: _____

Determine if pharmacy will deliver or if participant will need to pick up medication.
Date completed and staff initials: _____

Determine if pharmacy will fill pill organizers on a monthly basis.
Date completed and staff initials: _____

Pharmacy (and available second pharmacy) listed on the 24 Hour Back-up Plan in participant's
Comprehensive Service Plan.
Date completed and staff initials: _____

NEEDED SUPPLIES

Staff person responsible for completing needed supplies tasks: _____

Groceries available and means of getting food on move-in day determined.
Date completed and staff initials: _____

Durable medical equipment ordered and available on move-in day.
Date completed and staff initials: _____
or Not applicable.

Other essential medical supplies ordered and available on move-in day.
Date completed and staff initials: _____
or Not applicable.

Medications complete, accurate and available on move-in day (See MEDICATIONS above).
Date completed and staff initials: _____

Checklist for Transition from Institutions to Community Placement

- Medical supply and equipment companies listed on the 24 Hour Back-up Plan in participant's Comprehensive Service Plan.

Date completed and staff initials: _____
or Not applicable.

COMMUNITY HEALTH CARE SERVICES

Staff person responsible for completing community health care services tasks: _____

- Community physician identified.

Date completed and staff initials: _____

- First appointment scheduled with primary physical health care provider in the community within 3-5 days of the date of the move into the community.

Date completed and staff initials: _____

- Needed mental health services identified.

- Appointment with psychiatrist scheduled and transportation to appointment arranged.

Date completed and staff initials: _____

- Intake appointment scheduled if not previously scheduled and transportation to services arranged.

Date completed and staff initials: _____

- Needed substance abuse services identified,

Date completed and staff initials: _____

or Not applicable.

- Intake appointment scheduled if not previously scheduled and transportation to services arranged.

Date completed and staff initials: _____

- Needed dental services identified,

Date completed and staff initials: _____

or Not applicable.

- Intake appointment scheduled if not previously scheduled and transportation to services arranged.

Date completed and staff initials: _____

- Other community services identified (e.g., audiology, optical, podiatry, speech, occupational, physical therapy)

Date completed and staff initials: _____

or Not applicable.

- Intake appointment scheduled if not previously scheduled and transportation to services arranged.

Date completed and staff initials: _____

- All health care providers listed on the 24 Hour Back-up Plan in participant's Comprehensive Service Plan.

Date completed and staff initials: _____

Checklist for Transition from Institutions to Community Placement

- Arrange for institution's physician to order a neuropsychological evaluation on participant if he/she has multiple mental health and/or neurological disorders,
Date completed and staff initials: _____
or Not applicable.

TRANSPORTATION

Staff person responsible for completing transportation tasks: _____

- "Disabled Person Identification Card" obtained for public transportation.
Date completed and staff initials: _____
- Means of accessing transportation for both medical and non-medical needs identified and discussed with participant (e.g., Access, First Transit, bus application, etc.).
Date completed and staff initials: _____
- Transportation providers listed on 24 Hour Back-up Plan in participant's Comprehensive Service Plan.
Date completed and staff initials: _____

OTHER SUPPORTS

Staff person responsible for completing other supports tasks: _____

- Support persons and groups listed on the 24 Hour Back-up Plan in participant's Comprehensive Service Plan.
Date completed and staff initials: _____

FINANCIAL ARRANGEMENTS

Staff person responsible for completing financial tasks: _____

- Income to be available once in the community determined.
Date completed and staff initials: _____
- SSI or SSDI benefits applied for and secured or payments transferred to new address—
- If payments are made electronically, new bank account information communicated to Social Security.
 - Same procedures completed for retirement payments from social security.
- Date completed and staff initials: _____

IMPORTANT NOTE:

If a person notifies the Social Security Administration (SSA) office that they have returned to the community prior to the 22nd day of the month or cut-off date, his or her SSI payment will be reinstated on the first of the following month. If SSA is notified after the cut-off date, the person will get their \$30 SSI payment on the first of the month and a subsequent check making up the difference will come later in the month. Full benefits will begin the first of the next month.

Checklist for Transition from Institutions to Community Placement

- Budgeting and money management training provided if needed,

Date completed and staff initials: _____

or Not applicable due to Representative Payee services.

- Bank identified and needed accounts established and listed in participant's Comprehensive Service Plan.

Date completed and staff initials: _____

- Representative Payee identified (if needed) and listed on 24 Hour Back-up Plan in participant's Comprehensive Service Plan,

Date completed and staff initials: _____

or Not applicable.

- Education provided on paying rent and bills, if needed,

Date completed and staff initials: _____

or Not applicable due to Representative Payee services.

- Application for Medicaid completed and submitted,

Date completed and staff initials: _____

or Not applicable due to:

Existing Medicaid eligibility;

Other health insurance applicable (e.g., VA benefits).

- Medicaid (Medical Eligibility Card – formerly Public Aid) transferred to the new Family Community Resource Center (FCRC-formerly called “Public Aid” and/or “local office.”

Date completed and staff initials: _____

or Not applicable due to remaining at same FCRC

- Determine if participant will be subject to Medicaid spend down requirements and, if so, participant trained on what qualifies for spend down (including medical transportation) and how spend down will be handled in the community,

Date completed and staff initials: _____

or Not applicable.

- If participant is employed: Determine if participant is eligible for Health Benefits for Workers with Disabilities program

Date completed and staff initials: _____

or Not applicable: Participant is not employed.

- Determine if participant will be required to enroll in an HFS Managed Care Program (such as the Integrated Care Program in suburban Cook County and DuPage, Kane, Kankakee, Lake and Will Counties),

Date completed and staff initials: _____

or Not applicable.

- Ensure the participant enrolls in any required HFS Managed Care Program (such as the Integrated Care Program in suburban Cook County and DuPage, Kane, Kankakee, Lake and Will Counties),

Date completed and staff initials: _____

or Not applicable.

Checklist for Transition from Institutions to Community Placement

- Determine if participant has Medicare,

Date completed and staff initials: _____

- If participant has Medicare:

- Determine if Medicare B (“outpatient” Medicare) is in place
- Determine if Medicare D (Drug or Pharmaceutical Plan) is in place ,

Date completed and staff initials: _____

or Not applicable: Participant does not have Medicare

- Application for Supplemental Nutrition Assistance Program (SNAP or LINK Card) completed, submitted and LINK Card received.

Date completed and staff initials: _____

- Application for Low Income Home Energy Assistance Program (LIHEAP) completed, submitted and approved.

Date completed and staff initials: _____

or Not applicable/needed (e.g., utilities included in rent)

- Ensure the participant understands how important letters (such as from Illinois Department of Human Services, Healthcare and Family Services or Social Security) should be identified and how they are to be handled in a timely manner and what should be safely retained for future use.

Date completed and staff initials: _____

KEY ELEMENTS OF COMPREHENSIVE SERVICE PLAN COMPLETED

Staff person responsible for completing key elements of the Service Plan: _____

- Convene initial planning meeting with Class Member and his/her significant others:

- Invite key service providers who will have weekly contact with Class Member to planning meeting.

- Date completed and staff initials: _____

- Convene additional planning meetings as needed.

Date completed and staff initials: _____

- Comprehensive Service Plan synchronizes and coordinates the transition as well as all services and supports.

Date completed and staff initials: _____

- 24 hour Back-up plan.

Date completed and staff initials: _____

- Personal resource list.

Date completed and staff initials: _____

Checklist for Transition from Institutions to Community Placement

IMPORTANT NOTE: A comprehensive risk assessment and mitigation plan must be in place prior to the Class Member's actual move into community placement.

Risk assessment.

Date completed and staff initials: _____

Risk mitigation strategies and plan.

Date completed and staff initials: _____

Listing of all current medications.

Date completed and staff initials: _____

Participant provided copy of their Comprehensive Service Plan.

Date completed and staff initials: _____

Participant provided copy of Power of Attorney and out-of-hospital Do Not Resuscitate form,

Date completed and staff initials: _____

or Not applicable.

DISCHARGE

Staff person responsible for completing discharge tasks: _____

Institution discharge paperwork completed and received.

Date completed and staff initials: _____

Disability card obtained (if needed),

Date completed and staff initials: _____

or Not applicable.

OTHER

Transition Funds Checklist

PERMANENT SUPPORTIVE HOUSING
 FORM #6 (CHECKLIST ALLOWABLE PURCHASES)

Transition Funds Checklist

Category	Resource Needed	Estimated Cost	Amended Item Cost	RHSF Initial to Approve Amended Item	Actual Cost	Resource Received *To be initialed by both consumers and care managers
Bedroom						
<input type="checkbox"/>	Bed (mattress, box spring, frame)					
<input type="checkbox"/>	Bed linens (sheets, blankets, bedspread)					
<input type="checkbox"/>	Dresser					
<input type="checkbox"/>	Nightstand					
<input type="checkbox"/>	Alarm Clock					
<input type="checkbox"/>	Radio					
<input type="checkbox"/>	Mirror					
Bathroom						
<input type="checkbox"/>	Bath linens (towels, washcloths, bathmat)					
<input type="checkbox"/>	Shower curtain and rod					
<input type="checkbox"/>	Personal hygiene products (soap, shampoo, toothpaste, etc.)					
Kitchen						
<input type="checkbox"/>	*Food (maximum \$200)					
<input type="checkbox"/>	Pots and Pans					
<input type="checkbox"/>	Dishes (plates, cups, bowls, utensils)					
<input type="checkbox"/>	Coffee Pot					
<input type="checkbox"/>	Microwave					
<input type="checkbox"/>	Garbage can					
Living and Dining Room						
<input type="checkbox"/>	Couch or Futon					
<input type="checkbox"/>	Dining room or kitchen table and chairs					

PERMANENT SUPPORTIVE HOUSING
FORM #6 (CHECKLIST ALLOWABLE PURCHASES)

Category	Resource Needed	Estimated Cost	Amended Item Cost	RHSF Initial to Approve Amended Item	Actual Cost	Resource Received *To be initialed by both consumers and care managers
<input type="checkbox"/>	Armchair					
<input type="checkbox"/>	Small area rugs					
<input type="checkbox"/>	Lamp(s)					
<input type="checkbox"/>	End table(s)					
<input type="checkbox"/>	Bookcase					
<input type="checkbox"/>	Curtains					
Miscellaneous Household Items						
<input type="checkbox"/>	Iron and ironing board					
<input type="checkbox"/>	Fan					
<input type="checkbox"/>	Vacuum cleaner/sweeper					
<input type="checkbox"/>	Cleaning supplies (mop, broom)					
<input type="checkbox"/>	Cleaning products (dish soap, disinfectant)					
<input type="checkbox"/>	Small television (maximum allowable amount for this item is \$200)					
Other: Please list and describe any additional items needed. An example of "other" would be an item needed to accommodate a medical condition and supported by a physician's note**.						
<input type="checkbox"/>						
<input type="checkbox"/>						

*Food is an allowable expense only if there are no other resources available. This may occur if a consumer is in the process of waiting for a LINK card or other food benefit source.

**You may request approval from your DMH RHSF for a prepaid cell phone under the "Other" category only if you have documentation from a physician or psychiatrist that it is medically necessary. If approval of this expense is granted, the maximum amount allowed under this item is \$100.

***Please note that the purchase of a computer is not an allowable transition fund expense.

Critical Incident Reporting

DHS/DMH Requirements for Reviewing and Reporting Incidents for Williams Class Members Transitioning or Transitioned from IMDs to Community Placements¹

DHS/DMH Incident Review Requirements

DHS/DMH will conduct a review of each critical incident that occurs for Williams Class Members transitioning or transitioned from IMDs to community placements. If DHS/DMH were to learn that a critical incident occurred for a Class Member, but no incident report was submitted by the community agency staff, then DHS/DMH would contact the community agency quality assurance and improvement staff and copy the agency Executive Director to facilitate completion of the incident report and the review process. Critical incident reports will be protected to the extent allowed under State and Federal law. DHS/DMH will prepare aggregate summaries, inclusive of action plans and progress, every six months as part of its overall quality improvement efforts.

The Mental Health Community Services Agency, through its Executive Director, is responsible for:

1. Assuring compliance with DHS/DMH requirements for reporting and handling critical incidents, as outlined below, and
2. Assuring that staff of their community mental health service agency are appropriately informed and trained on these requirements and the handling of clinical incidents.

Mental Health Community Services Agencies contracted to provide services to Williams Consent Decree Class Members are responsible for monitoring and reporting critical incidents involving Class Members for as long as these participants receive services from the agency. The agency's Williams Quality Administrator (WQA) is required to monitor and report critical incidents for the first year of the Class Member's transition to the community. It is expected that any critical incidents that occur for Williams Class Members one year post-transition will be reported by the staff person who has primary responsibility for the participant and/or agency quality assurance and improvement staff.

What is a Critical Incident?

A critical incident is a serious or traumatic event which causes, or is likely to cause, physical and/or emotional distress, risk or change in a participant's health and well-being.

Why are Incidents Reported?

- To meet requirements of Williams Consent Decree Implementation Plan
- To prevent new critical incidents from happening
- To understand the causes of critical incidents
- To improve the care, treatment and services for participants
- To change systems and processes to improve outcomes

¹ Adapted from the University of Illinois at Chicago College of Nursing "Money Follows the Person" materials based on the National Association for Regulatory Administration and the Muskie School of Public Service © 2008

What Incidents Must Be Reported for DHS/DMH?

- Unexpected or suspicious death (accidental death, suicide, unusual circumstances, other unexpected or sudden death)
- Suicide attempt (first known or repeated attempt)
- Hospital admission, emergency department visit or psychiatric hospital admission
- Nursing facility placement
- Fire (accidental or intentional; started by participant or other person)
- Sexual or physical assault (whether participant is alleged victim or alleged perpetrator)
- Suspected abuse, neglect or exploitation of participant
- Alleged fraud or misuse of funds (by participant, provider or both)
- Missing person
- Serious injury (e.g., burn, cut, bruising, or a fall requiring medical attention)
- Serious injury that results in permanent loss of limb and/or functioning
- Behavioral incident (e.g., participant injures or threatens others)
- Property damage or destruction
- Criminal activity resulting in police involvement, participant arrest or incarceration
- Vehicle accident
- Physical altercation
- Eviction

What Are Sentinel Events?

A sentinel event is a critical incident that involves actual or potentially serious physical or psychological injury or death. The following critical incidents are sentinel events:

- Unexpected or suspicious death
- Suicide attempt
- Sexual or physical assault
- Missing person
- Fire
- Serious injury that results in permanent loss of limb and/or functioning
- Repeated critical incidents
 - 3 or more hospitalizations in a 2-month period
 - 5 or more critical incidents in a 3-month period

Reporting to DHS Office of the Inspector General

Mental Health Community Service Agency staff are obligated to report suspected abuse, neglect or exploitation of Class Members to the DHS Office of the Inspector General (OIG).

Take Action!

Reporting critical incidents involving Williams Class Members to DHS/DMH does not negate the Mental Health Community Agency's responsibility to notify law enforcement, call an ambulance or take other necessary actions. Take action first: respond to the event, and then notify DHS/DMH of the incident.

Incident Investigation Guidance

An investigation of a critical incident should be conducted:

- (a) In response to a report of an incident;
- (b) In reaction to a finding of a critical incident identified during routine monitoring.

An investigation is a method for uncovering or otherwise identifying the facts of a potential critical incident and then documenting what was found. The investigation should begin as soon as the Mental Health Community Services Agency learns about the critical incident.

The investigation needs to be unbiased, fair, and in keeping with due process guidelines. In the course of an investigation, it is important to balance the need to protect vulnerable participants with the requirements of the program.

Purpose of Critical Incident Investigation

The goals of an investigation are:

- Obtaining accurate information about the alleged critical incident;
- Adhering to due process and fairness, and
- Balancing the need for the:
 - Safety of persons in care;
 - Rights of the participant;
 - Rights of any alleged perpetrator;
 - Requirements of DHS/DMH, federal, state and local laws and regulations.

Essentially an investigation seeks to answer traditional 'journalist's questions.'

- What happened?
- Who was involved?
- Who witnessed or was aware of the event?
- How did it happen?
- When and how often did it happen?
- Where did it happen?
- Why did it happen?
- How serious or significant were the consequences?

Investigation Methods

Once the information needed to complete an investigation is formulated, there are many methods that can be used to prove or disprove a report of a critical incident or determine compliance with the individual's risk mitigation plan. Some of these include:

- Reviewing hospital and/or police records
- Observing and inspecting the site of the incident
- Reviewing provider or caregiver records and record keeping processes
- Interviewing the individual
- Interviewing witnesses and collateral contacts such as family, landlords and peers
- Securing written statements if needed
- Retrieving documents from other agencies involved in the incident
- Consulting with DHS/DMH

While all of these methods may be used in conducting an investigation, the three most common methods used in critical incident investigations are:

- Observation
- Interviewing
- Record/document review

These three methods enable collection of the most comprehensive and immediate data about an incident. Data collected by these methods can also be corroborated by the other methods listed above.

Documentation

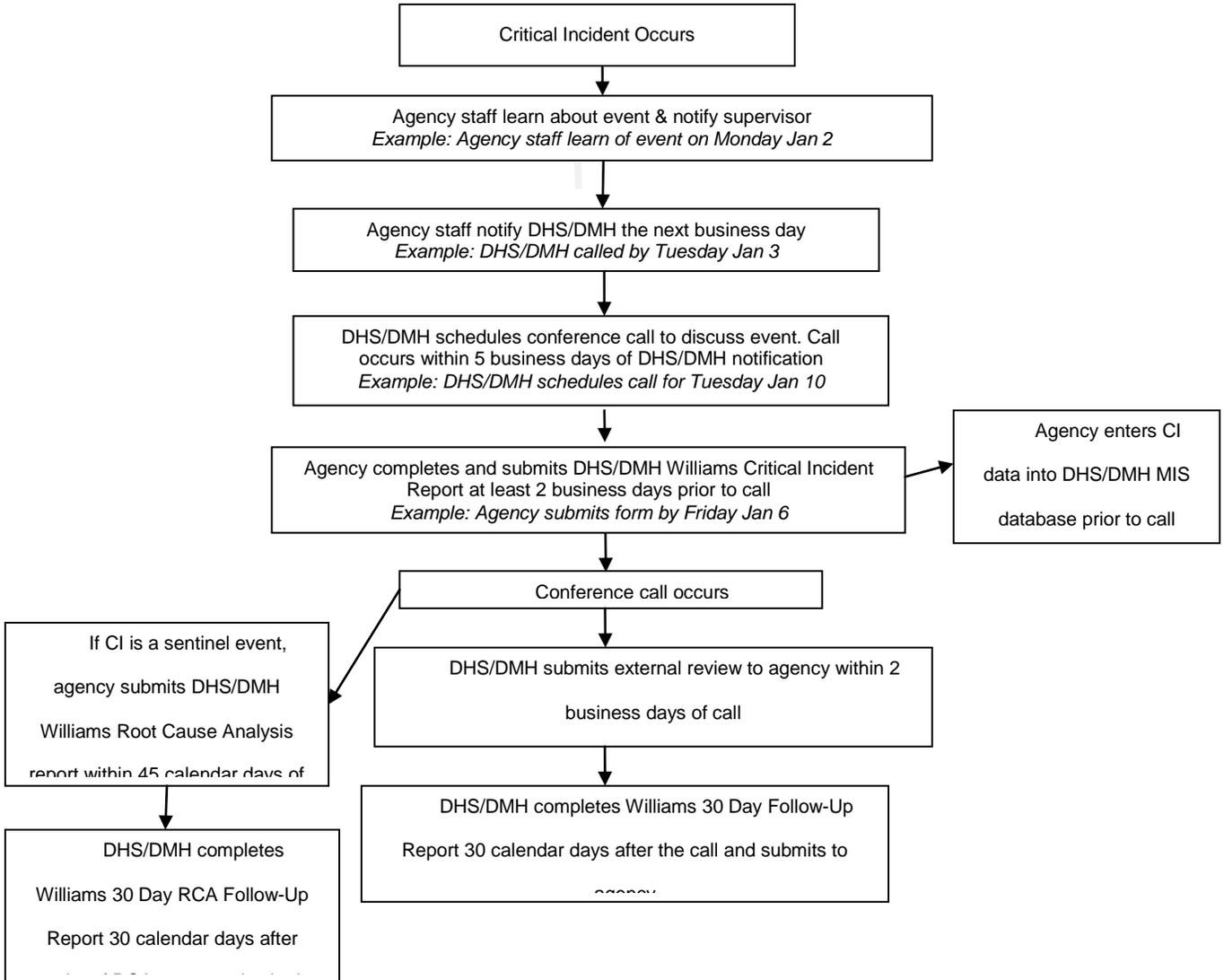
Any investigation is only as good as the documentation of the information collected. No matter how well information is collected, documenting what was found in a concise, fair and factual manner is essential to the success of the effort. This is equally important for a routine investigation of minor incident or a serious incident involving serious jeopardy to the individual or others.

Critical Incident Reporting: General Procedures

The critical incident reporting process begins as soon as the Mental Health Community Services Agency learns that a critical incident has occurred. Guidelines for completing reports are outlined in the next section. The timeline for reporting incidents and submitting reports to DHS/DMH is as follows (see diagram):

1. The Mental Health Community Services Agency staff should ensure that their supervisor is aware or notified of the incident. The Executive Director should be notified of all sentinel events.
2. The Mental Health Community Services Agency staff must report the critical incident to the DHS/DMH Associate Deputy Director for Transition by the next business day.
3. The DHS/DMH Associate Deputy Director for Transition will schedule a critical incident review conference call to discuss the event with the Mental Health Community Services Agency staff and the DHS/DMH Quality Bureau. The call will take place within 5 business days of DHS/DMH notification of the critical incident.
4. The Mental Health Community Services Agency will complete the informational and internal review sections of the DHS/DMH Williams Critical Incident Report prior to the scheduled conference call. These pages of the report must be submitted to the DHS/DMH Associate Deputy Director for Transition at least 2 business days prior to the call. If the incident occurred within a Class Member's first year of transition to the community, the agency WQA is responsible for completing and submitting the report to DHS/DMH.
 - a. The Mental Health Community Services Agency must also enter critical incident data into the DHS/DMH MIS database. Data should be entered prior to the conference call.
 - b. If the critical incident is a sentinel event, the Mental Health Community Services Agency must also complete the Root Cause Analysis (RCA) report. The RCA report must be submitted to DHS/DMH within 45 calendar days after the conference call. (See RCA reporting procedures below).

5. The critical incident review conference call will be conducted with the Mental Health Community Services Agency staff who have primary responsibility for providing services to the participant, other relevant agency staff, the DHS/DMH Associate Deputy Director for Transition, and DHS/DMH Quality Bureau staff. If the critical incident occurred within the Class Member's first year of transition to the community, the agency WQA also will participate in the conference call.
6. The completed pages of the Williams Critical Incident Report submitted to DHS/DMH will be discussed during the call. Following the conference call, DHS/DMH will complete the DHS/DMH external review section of the critical incident report, summarizing and documenting the incident review and DHS/DMH recommendations. A copy of the completed DHS/DMH review will be provided to the involved Mental Health Community Services Agency and others, as appropriate, within 2 business days of the call.
7. The DHS/DMH Williams Critical Incident 30 Day Follow-Up Report will be completed by DHS/DMH staff 30 calendar days after the conference call. This report will document the Agency's success in implementing recommended preventative steps to reduce the likelihood of similar incidents occurring for the Class Member, updates to the Class Member's risk mitigation plan, and other corrective actions. A copy will be supplied to the involved Mental Health Community Services Agency and others, as appropriate within 5 business days.
 - a. If the critical incident was a sentinel event, the DHS/DMH Williams Root Cause Analysis 30 Day Follow-Up Report will be completed by DHS/DMH staff 30 calendar days after receipt of the RCA report.
8. Landlords who wish to report a critical incident must contact the Bridge Subsidy Administrator. The Bridge Subsidy Administrator is responsible for reporting the critical incident to DHS/DMH.



Documentation: DHS/DMH Williams Critical Incident Report

The DHS/DMH Critical Incident (CI) Report is used to document basic information about the event (i.e., date the incident occurred, type of incident, individuals involved), the agency’s response to the event, and DHS/DMH’s initial review of the event. As described in the reporting procedures section, the CI Report is to be completed by the Mental Health Community Services Agency staff and submitted to the DHS/DMH Associate Deputy Director of Transition. If the incident occurred within a Class Member’s first year of transition to the community, the agency WQA is responsible for completing and submitting the report to DHS/DMH. If the participant is one year post-transition, the staff member who has primary responsibility for the Class Member should complete and submit the CI Report.

The CI Report consists of the following sections:

- General information about the incident (page 1)
 - Date, time and place that the incident occurred
 - Individuals involved in the incident and their relationship to the participant
- Incident type (pages 2-3)

- Detailed description of and response to the incident (page 4)
- Community Agency review and recommendations (page 5)
- DHS/DMH review recommendations (page 6)

The Mental Health Community Services Agency staff responsible for preparing and submitting the CI report must complete pages 1-5 of the report. Fax (312-814-4832) or send these completed pages to DHS/DMH at least two business days prior to the scheduled conference call. Guidelines for completing each section of the report are listed below.

Agency information (page 1): Complete all items. List the names and contact information for both the WQA and staff person with primary responsibility for the Class Member regardless of which of these staff are responsible for submitting the report to DHS/DMH. Please be sure to document the date that critical incident information was entered into the DHS/DMH MIS database.

Incident information (page 1): Complete all items with one exception: fill in the last item only if other individuals were involved in the incident. If the Class Member is the only person involved in the incident, leave the last item on page 1 blank.

Incident type (pages 2-3): In this section, first check all categories that describe the incident. For example, if the participant set his/her bed on fire, check “fire” and “property damage/destruction”. Next, complete the information listed for each checked category. For example, under “fire”, check whether the fire was started intentionally or accidentally by the participant. Under “property damage/destruction”, check whether the destroyed bed was the provider’s, participant’s or someone else’s property. If the incident involved a serious injury to the participant (page 3), be sure to check how the injury occurred and whether it resulted in a loss of a limb or functioning.

Detailed description of the incident (page 4): Please provide a detailed description of the event. Use the “journalist’s questions” on page 3 of this document to describe what happened; who was involved; when and where the event took place; why the event occurred (contributing factors); how and when agency staff were notified; the agency’s response; and the outcome or consequences of the incident. Please answer questions #1 and #2 on page 4. For item #1, please be sure to check all responses to the incident.

Repeated critical incidents (page 4): Complete both items in this section.

Community agency review (page 5): As part of the critical incident investigation process, the Mental Health Community Services Agency should conduct an internal review of the event. At a minimum, the internal review team should consist of the agency’s WQA and the staff person who has primary responsibility for the Class Member. The community agency review should include: a discussion of the factors that contributed to the event; the individuals involved in the event and the roles they played (e.g., neighbor had an argument with the participant that led to him/her starting a fire; roommate tried to stop the participant from starting a fire; another neighbor called police); and any potential strategies and changes that could be implemented to reduce the likelihood of the event occurring again for the participant. The community agency’s quality assurance and improvement team may have additional guidelines and policies for conducting the internal review.

Please list the date of the internal review and the names and titles of all agency staff who participated in the review. Briefly summarize the staff’s discussion of the incident and their recommendations for reducing the likelihood of similar incidents re-occurring for the participant.

DHS/DMH review (page 6): The DHS/DMH external review will be completed by DHS/DMH staff following the critical incident review conference call. The recommendations made by DHS/DMH will be based on the CI report and the conference call discussion. A copy of the completed external review will be sent to the involved Mental Health Community Services Agency and any appropriate others within two business days of the call.

Root Cause Analysis²

A Root Cause Analysis (RCA) is the more extensive process of identifying the basic underlying causal factors of a sentinel event. It focuses on systems and processes, not individual performance. The goal of the RCA process is to find out what happened, why it happened, and to determine what can be done to prevent it from happening again. The focus of an RCA is not on punishment but prevention.

A RCA must be completed for all sentinel events. Because an RCA involves intensive inquiry by a team of agency staff and requires several weeks to complete, RCA reports are not due to DHS/DMH until 45 calendar days after the conference call. DHS/DMH staff will complete the DHS/DMH RCA 30 Day Follow-Up Report 30 calendar days after the receipt of the agency's RCA report. Specific guidelines for completing an RCA and the DHS/DMH RCA Report are listed in the forthcoming DHS/DMH RCA Reporting Procedures document.

² Adapted from Lynn Goldman's *Root Cause Analysis* March 10, 2000 training which was adapted from "Conducting a Cost-Effective Root Cause Analysis" (www.ccdsystems.com) and the United States Department of Veterans Affairs patient safety website (www.patientsafety.gov/vision.htm)

DHS/DMH Williams Critical Incident Report

Instructions: This form is to be completed after a serious or traumatic event which causes, or is likely to cause, physical and/or emotional distress, risk or change in health and well-being to an individual transitioning or transitioned to community placement. This is an important step in the process of preventing new critical incidents, improving the care, treatment, and services for participants, and changing systems and processes to improve outcomes. Complete and submit this report DHS/DMH at least 2 days prior to the scheduled Agency/DMH critical incident review conference call. If the incident occurred within the Class Member's first year of transition to the community, the agency's Williams Quality Administrator (WQA) should complete and submit this report to DHS/DMH. If the incident occurred a year or more after the participant's transition to the community, the staff person with primary responsibility for the participant should complete and submit the report to DHS/DMH.

Date of Report (MM/DD/YYYY): _____ Participant RIN: _____

Participant Name: _____

Current Address: _____

Agency Name and Address: _____

Williams Quality Administrator (WQA) Name: _____

WQA phone number and email address: _____

Name of Staff Person with Primary Responsibility for Participant: _____

Primary Staff Person's phone number and email address: _____

Date critical incident information was entered into the DHS/DMH MIS database: ____/____/____

Incident Information

Date of Incident (MM/DD/YYYY): _____ Time of Incident: _____ a.m. or p.m.

Date incident discovered by agency staff (MM/DD/YYYY): _____

Did the incident occur when a provider was present or was scheduled to be present? Yes No

Where did the incident take place?

Participant's apartment Relative's home/apartment Provider/agency office

Neighbor's apartment Friend's home/apartment Other (specify): _____

Were other individuals involved in the incident? Yes No

If other individuals were involved, list the names, phone numbers and relationship to participant

First and Last Name	Phone	Relationship to participant
	()	<input type="checkbox"/> Family <input type="checkbox"/> Provider <input type="checkbox"/> Landlord <input type="checkbox"/> Other (specify): _____
	()	<input type="checkbox"/> Family <input type="checkbox"/> Provider <input type="checkbox"/> Landlord <input type="checkbox"/> Other (specify): _____
	()	<input type="checkbox"/> Family <input type="checkbox"/> Provider <input type="checkbox"/> Landlord <input type="checkbox"/> Other (specify): _____

Incident Type: Check all that apply (If participant re-institutionalized, select Nursing Facility/IMD Placement). Asterisked incidents also require that a Root Cause Analysis Report be completed and submitted 45 calendar days after the critical incident review conference call.

***Death (Preventable, Questionable, or Unexpected)**

- Accidental
- Suicide
- Unusual circumstances
- Other unexpected or sudden death

Alleged Fraud/Misuse of Funds

- By participant
- By provider
- By both
- Other (specify):

***Suicide Attempt**

- First known attempt
- Repeated attempt

Nursing Facility/IMD Placement

- Re-admitted to IMD

Reason:

Unexpected Hospital Visit/Admission

- ER visit – illness
- ER visit – injury
- Medical hospitalization
- Psychiatric hospitalization

Property Damage/Destruction

- Damage/destruction of provider property
- Damage/destruction of participant property
- Damage/destruction of someone else's property (describe):

Behavioral Incident Involving Participant (Injures or Threatens to Injure Self or Others)

- Injuries sustained
- Threats of injury only

If yes, explain:

Criminal Activity (police were called and/or activity resulted in arrest or incarceration)

- Alleged victim
- Alleged perpetrator
- Participant arrested
- Participant incarcerated

***Assault**

- Sexual Assault – alleged victim
- Sexual assault – alleged perpetrator
- Physical assault – alleged victim
- Physical assault – alleged perpetrator

***Missing Person**

- Law enforcement contacted
- Law enforcement not contacted

***Fire**

- Intentional – started by participant
- Intentional – not started by participant
- Accidental – started by participant
- Accidental – not started by participant

Vehicle Accident

- Participant vehicle
- Public transportation
- Other vehicle
- Pedestrian
- Other (specify):

Suspected Mistreatment (abuse, neglect, exploitation)

- Alleged victim of physical abuse
- Alleged victim of verbal abuse
- Alleged victim of neglect
- Alleged victim of exploitation

Was suspected mistreatment reported to DHS OIG?

- Yes
- No

Physical Altercation

- Individual to individual – alleged victim
- Individual to individual – alleged perpetrator
- Did altercation involve the participant's landlord?
 - Yes
 - No
- Did altercation involve the participant's neighbor(s)?
 - Yes
 - No

Eviction (Participant evicted or asked to vacate housing unit by landlord using official recourse)

- Refusal to pay rent
- Argumentative/combative with neighbors/others
- Disturbing privacy
- Destruction of landlord's property
- Destruction of others' property
- Physical violence/aggression
- Fire setting
- Drug trafficking
- Other (specify):

Other Serious Injury to Participant (Injury required medical treatment)

- Fall
- Medication related
- Bruising
- Bleeding
- Cut or puncture wound
- Sprain/strain
- Worsening pressure ulcer/non-healing, existing wound
- Burn
- Other

How did the serious injury occur?

- Inflicted by self
- Inflicted by caregiver
- Inflicted by peer
- Inflicted by other (describe relationship to participant):
- Fall
- Transfer/Handling equipment
- Insect/animal bite
- PICA/eating non-food items
- Seizure
- Environmental
- Unknown
- Other (Specify):

Did serious injury result in loss of limb or functioning?

- *Yes: If Yes: Complete Root Cause Analysis report
 - No
-

Please describe the details of the critical incident:

1. Response to Incident (check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> First aid rendered | <input type="checkbox"/> Law enforcement notified | <input type="checkbox"/> Other, describe: _____ |
| <input type="checkbox"/> Emergency room visit | <input type="checkbox"/> Refused treatment | _____ |
| <input type="checkbox"/> Physician notified | <input type="checkbox"/> Participant/family interviewed | _____ |
| <input type="checkbox"/> Reported to DHS-OIG | <input type="checkbox"/> Reported to Elder Abuse | _____ |

2. Did the individual who reported the incident to agency staff discuss with the participant activities to prevent a similar incident from occurring in the future?

- Yes. Brief description of what was discussed with participant:
 - No
 - Not applicable (specify):
-

Repeated Critical Incidents (complete Root Cause Analysis form if response is "yes" to either of the questions below)

Has the participant had 3 or more psychiatric and/or medical hospitalizations in a two month period?

- *Yes
- No

Has the participant had 5 or more other Critical Incidents in a three month period?

- *Yes
- No

Attended agency service planning meeting(s) for participant on (date): _____

In-person and/or phone meetings with:

Agency staff who has primary responsibility for participant

Williams Quality Administrator

Agency's Executive Director

Other agency staff (specify): _____

Review of clinical documentation (check all that apply)

Comprehensive Service Plan

Risk Assessment

Risk Mitigation Strategies and Plan

24 Hour Back-Up Plan

Resource List

Hospital report

Other (specify): _____

Date of agency staff's most recent in-person meeting with participant (MM/DD/YYYY): _____

Attach a copy of the DHS/DMH external review and answer each question below.

1. Was each recommended strategy (i.e., preventative steps and changes recommended to reduce the likelihood of the incident happening again) implemented by the agency?

Yes

No

If No: List each of the strategies that were not implemented. Briefly describe the reasons why the strategies were not implemented.

2. Were the strategies successful? That is, did the strategies as implemented by the agency reduce the risk and help prevent similar critical incidents from occurring for this participant?

Yes

No

If No: In your opinion, why were these strategies unsuccessful in preventing similar critical incidents from occurring?

3. Do additional strategies need to be implemented to further reduce the risk of future, similar critical incidents from occurring?

Yes

If Yes: List the additional strategies that should be implemented to reduce the occurrence of similar critical incidents.

No

4. Did any new, similar critical incidents occur since the recommended preventative strategies were implemented?

Yes

If Yes: Briefly describe the critical incident(s). Include the date(s) of the incident(s) and the individuals involved. Note: A DHS/DMH Critical Incident Report must be completed for the new events.

No