DDQR-1000 7/2018 Date_____ Reviewer Initials_____

Provider Agency Name:
ISC Agency Name:
Person:
Gender: DOB:
Primary Program:

Additional Program Codes:

IL Department of Human Services
Division of Developmental Disabilities
Bureau of Quality Management
FY19 Quality and Waiver Performance Measure Data Sheet

Number	Yes	No	NA	NOTE: The word "Guidelines" refers to: The DHS: Person Centered Planning Policy and Guidelines for DD Waiver Services	Comments	Correction During Review	Correction Required
1				Were the following in the agency record? Discovery Tool Yes_____ No_____ Personal Plan Yes_____ No_____ Implementation Strategy Yes_____ No_____			
2				Is there evidence that the provider agency provided a copy of the Implementation Strategy for all required parties? Person and/or Guardian date sent: _____			
3				Did the person and/or guardian review and sign the Implementation Strategy? Dates: Person: _____ and/or Guardian _____			
4				Have the Implementation Strategies been updated annually or as needed? Current Date: _____Prior Date: _____ Revision Date if applicable: _____			
5				Does the Implementation Strategy contain the required information as outlined in the Guidelines?			
6				Are copies of both CILA and Day Program services (Implementation Strategies) available to staff as outlined in the Guidelines?			
7				Were provider agency assessments completed as directed?			
8				Do the Implementation Strategies reflect ongoing monitoring?			
9				If the person has restrictive interventions, were all procedures followed as required? (PM G-7)			
10				Does the person receive the coordination and support needed to access healthcare services contained in the personal plan? (PM G-8) A			
~~11~~				~~Is the Agency connected to and utilizing the CIRAS system? (Answer question 1 time for agency)~~	Not scored – reviewer will assure that agency		
12				~~If answer to 11 is no, did BQM Reviewers provide information and assistance for agency to connect to the CIRAS system? (Answer question 1 time for agency)~~	Has access to CIRAS and educate if agency does not		

DDQR-1000 7/2018 Date_____ Reviewer Initials_____

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Number	Yes	No	NA	NOTE: The word "Guidelines" refers to: The DHS: Person Centered Planning Policy and Guidelines for DD Waiver Services	Comments	Correction During Review	Correction Required
13				Is there documentation of a process of this person/guardian receiving not only information; but also, *education* about how to report abuse, neglect, exploitation and other critical incidents? (PM G-1)	*Education* is for CGH only		

COMPLETE QUESTIONS BELOW FOR PERSONS RECEIVING HOME-BASED SUPPORTS AND SERVICES

14				Does the record contain a written Service Agreement completed between the participant and each service provider?			
15				Does the Service Agreement define the terms of the services to be provided including the effective date, the rate of payment, the maximum units of service to be provided each month and the maximum monthly charge?			
16				Is the Service Agreement updated annually and as changes occur?			
17				If applicable, were copies provided of the revised Service Agreement to the Fiscal Employer Agent?			
18				Was the Employer of Record Implementation Strategy completed within 20 calendar days of the Personal Plan date?			
19				For those who will purchase SDA, was the Implementation Strategy completed within 20 days of initiating SDA services?			
20				~~Is it clear that the Self-Directed Assistant (SDA) is assisting the individual/family as desired by the individual/family and within the Division guidelines? The SDA should not complete the form on behalf of the individual/family, but teach the family to complete the form?~~	Not Applicable – change occurred after reviews began for FY19		
21				Are details about what will be provided when SDA services are purchased included in the Employer of Record Implementation Strategy?			
22				Is there evidence that the SDA provider agency maintains a detailed chronological log of all activities performed for audit purposes and to verify their billing?			
23				If SDA services are purchased from agency, is the SDA a QIDP?			

DDQR-1000 7/2018 **Date_____ Reviewer Initials_____**

Provider Agency Name:
ISC Agency Name:
Person:
Gender: DOB:
Primary Program:

Additional Program Codes:

Guardian Interview

Guardian Name: _____

Guardian Address: _____

Guardian Phone(s): _____ Guardian Relation to Person: Parent_____ Relationship _____

Date of Initial Guardian Contact: _____ Second Attempt Date: _____ Third Attempt Date: _____

Letter Sent Date_____ (*Please include Reviewer initials after each entry)*

Yes	No	
		1) Are all services that are needed by *(name of person)* addressed in the PCP? PM D1 (22D) Comments / Problems Noted:
		2) Are all services listed in the PCP received by *(name of person)*? PM D11 (26D) Comments / Problems Noted:
		3) Does guardian report any issues with neglect, exploitation, restraint, seclusion or restrictive interventions? Is *(name of person)* free from abuse, neglect or exploitation? Comments / Problems Noted: *(use reverse of paper if needed)* ***If the guardian reports any issues in any of these areas, follow mandated reporter guidelines. Call Springfield Central office for direction if needed.***
		4) Are all environments accessed by *(name of person)* safe?
		5) Does *(name of person)* have the best possible health?
		6) Does *(name of person) have friends and family he/she spends time with?*
		7) Does *(name of person)* want to work? Does *(name of person*) have a paying job?
		8) Does *(name of person)* make decisions about (his/her) life?
		9) Does *(name of person)* contribute to his/her community? Does *(name of person)* participate in life of his/her community?

Guardian Interview Notes:

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Date_____ Reviewer Initials_____

Provider Agency Name:
ISC Agency Name:
Person:
Gender: DOB:
Primary Program:

Additional Program Codes:

Guardian Interview (continued)

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DDQR-1000 7/2018 **Date_____ Reviewer Initials_____**

Provider Agency Name:
ISC Agency Name:
Person:
Gender: DOB:
Primary Program:

Additional Program Codes:

IL Department of Human Services
Division of Developmental Disabilities
Bureau of Quality Management
FY19 Personal Outcome Measure Data

Date of Interview: _____ Initials of Interviewer_____

Personal Outcome Measures Recommendations to ISC agency

	Personal Outcome Measures (ADD ONLY) *– (Guidance Personal Outcome conversation and decision-making worksheet):*	**Outcome** Present – 1 Not Present - 0	**Support** Present – 1 Not Present - 0
1	**People are connected to natural supports**		
2	**People have friends**		
3	**People choose where they work**		
4	**People choose personal goals**		
5	**People participant in the life of the community**		
6	**People are safe**		
8	**People have the best possible health**		
8	**People exercise rights**		
9	**People are free from abuse and neglect**		
10	**People choose where they live**		

DDQR-1000 7/2018 **Date**_____ **Reviewer Initials**_____

Provider Agency Name:
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Person:
Gender: DOB:
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Additional Program Codes:

Based on time spent getting to know the person during the Personal Outcome Measures meeting, make up to five recommendations for the person and his/her planning team:

1._____

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2._____

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3._____

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4._____

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5._____

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